PEDIATRICS PERSPECTIVES

Police, Equity, and Child Health

Rhea W. Boyd, MD,[a] Angela M. Ellison, MD, MSc,[b] Ivor B. Horn, MD, MPH[c]

From Oakland and Ferguson, to Cleveland and Baltimore, cities across the country mourn young African-Americans whose tragic deaths, following contentious encounters with police, illustrate the violent exchange that can erupt between law enforcement and people of color. Because police are vital pillars of community safety, these events raise important questions about how they influence the life course of children of color.

Despite public concern for how police impact black lives, few publications in the medical literature contextualize police behavior within a clinical framework. Those that do,rarely explore the extent to which police treatment functions as a social determinant of health, with unique implications for children.[1] These implications provide pediatricians an opportunity to examine and address how police exposure affects child and adolescent health.

Police exposure begins in neighborhoods, where police discretion determines who is suspicious and sets the latitude with which the law is enforced. That latitude varies based on public policy, institutional culture, and budget pressures. When subject to explicit and implicit racial bias, thisstructures how police engage communities. For example, from 2002 to 2013, policies permitted New York City police to "stop-and-frisk" pedestrians if the officer had reasonable suspicion the pedestriancommitted or were about to commit a crime. Of the ~5 million stops, almost 9 in 10 were innocent. And though blacks and Hispanics only represented 50% to 53% of the population, they comprised >80% of those stopped.[2] While no longer legal, the impact of similar policing strategies contributes to a continuum of trauma that cannot be disentangled from the trauma associated with the disproportionate arrest, prosecution, and incarceration of individuals of color.

Today, while nearly 1 in 100 adults are behind bars, >60% are people of color, and most are men of color. Imprisonment rates for black males are 3.8 to 10.5 times greater, at every age group, than for white males, and greatest for black males aged 18 to 19 years.[3] If unchanged, of those born in the year 2001, 1 in 3 black men will be jailed in their lifetime, compared with 1 in 6 Hispanic men and 1 in 17 white men. This also applies to women. Black women now face a 1-in-18 lifetime risk of imprisonment, compared with a 1-in-45 risk for Hispanic women and 1-in-111 risk for white women.[4]

[a]Department of Pediatrics, Stanford University, Palo Alto Medical Foundation, Pediatric Urgent Care, Palo Alto, California; [b]Division of Emergency Medicine, The Children's Hospital of Philadelphia, Department of Pediatrics, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, Pennsylvania; and [c]Center for Diversity and Health Equity, University of Washington School of Medicine, Seattle, Washington

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Address correspondence to Rhea W. Boyd, MD, Palo Alto Medical Foundation, Department of Pediatric Urgent Care, 795 El Camino Real, Palo Alto, CA 94301. E-mail: rheaboydmd@gmail.com

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These disparities reflect how local crime rates, concentrated poverty, structural racism, and institutional bias shape representation in the correctional system. For youth experiencing them as caregiver absence, custody transitions, or the criminalization of peers, these disparities also reveal how police exposure can be linked to events associated with loss or stress. This transforms routine police encounters into experiences that, in quantity or severity, may affect youth health.

Three types of police exposure can influence child and adolescent health:

1. Exposure to Racial Profiling: Policies that incentivize police contact with civilians for minor infractions or perceived criminality result in neighborhoods where police contact is relatively common or unduly hostile. Among young men who report frequent encounters with police, symptoms of anxiety and trauma are more common.[5] Thus, individuals who are repeatedly, incorrectly deemed suspicious, and subsequently questioned or searched, although not arrested, may harbor stress as a result of those encounters. In youth, the cumulative impact may lead to adverse adult health outcomes.
2. Exposure to Police Violence: While victims of police violence are at-risk for arrest, incarceration, injury, disability, or death, the witnesses may also be affected. In youth, witnessed violence culminates in symptoms of posttraumatic stress disorder (PTSD), substance abuse, depression, poor self-rated health, attentional impairment, poor school performance, and school suspensions and expulsions.[6]
3. Exposure to Caregiver Encounters With Police: When caregivers are incarcerated, injured, or killed as a result of a police encounter, it is traumatic to witness, and in the aftermath, the family and community must function without that caregiver's social and economic support. That void undermines the social networks on which youth rely and restricts access to vital resources because ex-felons face barriers to employment, public housing, federal cash assistance, student loans, food stamps, and voting. Parental incarceration is also strongly associated with children's increased risk for depression, PTSD, anxiety, asthma, and migraines.[7]

A PEDIATRIC FRAMEWORK

The nature, frequency, and outcome of police encounters for youth and their caregivers are powerful social determinants of health that would benefit from investment and expertise across disciplines in pediatrics.

Clinicians

The symptoms of adverse police exposures may present in primary care, school-based clinics, juvenile justice facilities, and emergency departments. Existing screenings may overlook these patients because although many Adverse Childhood Experience questionnaires inquire about caregiver incarceration, few ask about police contact.

Recommendations

- Augment well-child templates to include police interactions and associated symptoms of emotional, developmental, and physical stress. Documenting and monitoring these exposures and outcomes may prevent misdiagnosis of PTSD as attention-deficit/hyperactivity disorder or behavioral delinquency and prescription of unnecessary medications or ineffective disciplinary strategies that result in re-victimization.
- Refer affected patients to longitudinal mental health services and consider early screening for chronic disease associated with toxic stress.
- Recognize witnessed police violence may compound exposure to community violence and refer students with symptoms of PTSD to individualized education programs to identify potential learning barriers and prevent school failure and its associated negative health outcomes. Emergency departments caring for victims of police violence should consider extending similar school supports.
- Offer group visits to youth affected by caregiver incarceration to allow the therapeutic environment to rebuild fractured social networks. Introduction to medical legal partnership services during these visits may aid families in obtaining vital public benefits.
- Teach trauma-informed care to residents serving patients affected by adverse police exposures or caregiver imprisonment.

Researchers

As local governments explore community policing strategies, research is critical to minimize child health impacts.

Recommendations

- Collaborate with local government, public health, and policing agencies to study associations between police exposure, youth stress, and geographic distributions of chronic disease. Attention to relationships between caregiver incarceration and child poverty may reveal additional mechanisms for adverse health outcomes.
- Identify associations between police exposure and adult health outcomes by prospectively observing youth in juvenile justice facilities. Such studies should measure protective factors such

as employment pipeline programs that reduce recidivism.

- Include police violence in national surveys capturing childhood exposures to violence.

Advocates

Partnering with other leaders in child advocacy enables pediatricians to support legislative and community-based interventions that reduce the health impact of adverse police exposures.

Recommendations

- Partner with school administrators to support student disciplinary policies that minimize punitive contact with police.
- Join first responder training teams endeavoring to de-escalate police conflicts witnessed by youth.
- Co-locate social services (eg, food pantries) within clinics or use Web-based referral systems to seamlessly connect patients with community resources and address the unmet social needs of families with incarcerated caregivers.
- Support legislation that ensures youth access to public benefits regardless of their caregiver's correctional status.

CONCLUSIONS

Ultimately, issues of equity are issues of health. Pediatricians now have an opportunity to produce new screening guidelines, research agendas, and policy statements that structure how police exposure relates to disease prevention, health maintenance, and treatment strategies. Advancing pediatric knowledge, attitudes, and skills in this way affirms the pursuit of equity as foundational to pediatric practice.

ABBREVIATION

PTSD: posttraumatic stress disorder

REFERENCES

1. Ansell DA, McDonald EK. Bias, black lives, and academic medicine. *N Engl J Med*. 2015;372(12):1087–1089
2. New York Civil Liberties Union. Stop and frisk data. Available at: www.nyclu.org/content/stop-and-frisk-data. Accessed June 23, 2015
3. Carson EA. *Prisoners in 2014*. Washington, DC: Bureau of Justice Statistics; 2015
4. Bonczar TP. *Prevalence of Imprisonment in the U.S. Population, 1974—2001*. Washington, DC: Bureau of Justice Statistics; 2003
5. Geller A, Fagan J, Tyler T, Link BG. Aggressive policing and the mental health of young urban men. *Am J Public Health*. 2014;104(12):2321–2327
6. Boynton-Jarrett R, Ryan LM, Berkman LF, Wright RJ. Cumulative violence exposure and self-rated health: longitudinal study of adolescents in the United States. *Pediatrics*. 2008;122(5):961–970
7. Lee RD, Fang X, Luo F. The impact of parental incarceration on the physical and mental health of young adults. *Pediatrics*. 2013;131(4):e1188

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