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**Aligning policing and public health promotion:
Insights from the world of foot patrol**

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Aligning policing and public health promotion: Insights from the world of foot patrol

Abstract

Foot patrol work is rarely described in relation to public health, even though police routinely encounter health risk behaviors and environments. Through a qualitative study of foot patrol policing in violent ‘hotspots’ of Philadelphia, we explore some prospects and challenges associated with bridging security and public health considerations in law enforcement. Noting existing efforts to help advance police officer knowledge of, and attitudes toward health vulnerabilities, we incorporate perspectives from environmental criminology to help advance this bridging agenda. Extending the notion of *capable guardianship* to understand foot patrol work, we suggest that the way forward for theory, policy and practice is not solely to rely on changing officer culture and behavior, but rather to advance a wider agenda for enhancing collective guardianship, and especially ‘place management’ for harm reduction in the city.

Keywords: Philadelphia Foot Patrol Experiment, public health law research, qualitative research, environmental criminology, place management

Introduction

Police work is rarely described in terms of its relation to public health work, despite the fact that law enforcement officers routinely manage health risk behaviors and environments (Burriss et al., 2010). The police constitute one of a few groups of front-line workers who witness the determinants of health in a localized and textured way. On a daily basis, they encounter addiction, mental illness, homelessness and co-occurring issues in their ecological contexts. In foot patrol work especially, police experiences of health risk behaviors and environments are ‘particularized’ (Bittner, 1967) by virtue of officers being assigned to small territories (Wood, Sorg, Groff, Ratcliffe & Taylor, 2013). The micro-spatial context of foot patrol work provides opportunities for officers to understand as well as influence, at least indirectly, human behaviors and environments in furtherance of public health.

Such opportunities, however, have received little attention by public health researchers in collaboration with criminologists. Instead, public health researchers have been more narrowly focused on the concern that the police pursuit of order and security has ‘won out’ at the expense of public health. Harmful outcomes of police work have been noted to include the criminalization of people with mental illness (Teplin, 1984), the displacement of sex workers to riskier environments (Blankenship, 2002) and the discouragement of harm reduction practices (Beletsky, Macalino & Burriss, 2005; Burriss et al., 2004; Cooper, 2005; Davis, Burriss, Kraut-Becher, Lynch, & Metzger, 2005).

This paper works to further integrate perspectives from public health and criminology to identify an agenda for aligning the missions and cultures of local law enforcement and urban health promotion. Understanding the factors which shape police behavior when managing health risk behaviors and environments is critical to this agenda because established research suggests that issues of police knowledge, attitudes, culture and organization do get in the way of seeing

social problems through a public health lens (Beletsky, Macalino & Burris, 2005; Small, 2005). Policy-makers and practitioners in Philadelphia and across the globe have recognized such barriers, and made strides in advancing police knowledge and attitudes, especially in terms of recognizing the signs of mental illness and considering appropriate response options (Oliva & Compton, 2008; Steadman et al., 2001; Watson, Morabito, Draine, & Ottati, 2008). This paper both acknowledges and moves beyond these notable efforts by outlining a broader vision for situating policing within a larger system of urban health and security delivery. As Burris points out, efforts are needed to bridge security and health in our concepts and practices (Burris, 2006).

Based on focus groups with officers who policed violent ‘hotspots’ during the Philadelphia Foot Patrol Experiment (Ratcliffe, Taniguchi, Groff, & Wood, 2011), we first describe existing mentalities and practices of foot patrol. Our characterization of foot patrol draws from and extends the notion of *capable guardian*, a term established in the field of environmental criminology to originally depict the ability of police, by virtue of their presence, to make criminal behavior less attractive.¹ Foot patrol officers are confined to small spaces of the city and are therefore more likely to know and interact with potential offenders more frequently. In addition to this traditional guardianship role, foot patrol police work to improve ‘quality of life’ by influencing the social and physical environments of the small beat areas, in line with Wilson and Kelling’s understanding of incivilities-based policing (1982).

We assess the implications of this extended guardianship role – with its twin focus on behaviors and environments - for the promotion of public health. In line with some previous

¹ Routine activity theory conceptualizes capable guardians as including any person who might potentially intervene in a criminal event. While most people immediately think of police officers and security guards, the term includes any other persons present in a situation. The notion of capable guardianship also includes specific categories of potential guardians, namely ‘place managers’ (Eck, 1995) and ‘intimate handlers’ (Felson, 1986). Place managers include individuals who have a connection to a place such as store employees, landlords, and parking attendants who represent potential partners for police. Intimate handlers discourage offending behavior through emotional connection to the potential offender and can include relatives, teachers, and coaches, among others. Both are pertinent to our discussions here.

research, we found that the exercise of guardianship by foot patrol police can trump, and could possibly undermine, public health objectives, and we identify the advantages and opportunities, as well as limitations of foot patrol as an intervention for bridging security and health practices in the city. We argue that the future of public health promotion rests on enhancing the collective guardianship capacity of city agencies and businesses with various roles in urban health and safety promotion. We suggest that the concept of guardianship - traditionally associated with the management of crime - should include elements of both deterrence and prevention while moving beyond a focus on criminal behavior to health risk behavior more generally. With this re-casting of guardianship, the work of the police could be seen as nested within, rather than marginal to, wider city efforts to make cities both safe and healthy.

Background and methods

This research formed part of a larger study on the effectiveness of foot patrol as a targeted intervention in the reduction of urban violence, which involved a randomized controlled trial (RCT) and two qualitative components, one of which involved field observations (Wood et al., 2013). New graduates of the police academy were placed in 60 violent ‘hotspots’ in the city. These ‘treatment’ areas were compared with 60 ‘control’ sites that received traditional police interventions. Foot patrol officers were assigned to relatively small areas that averaged 1.3 square miles of streets and 15 street intersections and were instructed to stay in their beats to ensure reliability and consistency in the ‘dosage’ at each site. Violent crime decreased in the foot beat areas by 23% compared to the control areas (Ratcliffe, et al., 2011), although this effect was not sustained after the termination of the experiment (Sorg, Haberman, Ratcliffe & Groff, 2013).

We conducted group interviews with foot patrol officers to learn about their perceptions and experiences during the foot beat initiative, including their approaches to managing disorder

and crime as well as public health-related issues involving individuals exhibiting signs of drug use, alcoholism and/or mental health issues.² A total of 20 sessions took place with 129 different participants between February and May of 2010. This represents just over half, or 52%, of the total complement of officers (n=240) who participated in the experiment.³ All participants were “rookies” (new academy graduates), so the sample is skewed towards perceptions and experiences that may be reflective of a general lack of experience with, and wisdom gained from the occupation of policing. These meetings functioned as ‘focus group interviews,’ centered on fostering interaction among peers with the shared experience of working as foot patrol officers (see, Kidd, 2000; 1994; Morgan, 2004). The groups were organized to accommodate 10 officers, but due to logistics, the number of participants in each session ranged from 2 to 12. In 15 of the groups, the number of participants ranged from 4 to 9 officers. Three sessions had less than 4 participants (1 session had 3 officers, while 2 sessions had 2). One session had 10 officers and another had 12. Due to various obligations, some officers were late to the sessions. Sessions ranged from 40 minutes to nearly two hours with an average session length of 80 minutes.⁴ The group interviews followed core probes, although flexibility was built in to accommodate emerging insights within and across the groups. Fourteen groups were audio recorded and transcribed and detailed notes were taken for all sessions. The transcripts, along with detailed notes from the six sessions that did not have transcripts, were uploaded into the qualitative analysis software, *Atlas.ti* for coding and analysis.⁵

² All references to people and places (including police districts) have been replaced with alternative names or numbers.

³ This calculation is based on 125 officers, because there were 4 officers out of 129 who were not part of the foot patrol experiment, but had been doing foot patrol in a city area. Their perceptions and experiences were nevertheless relevant to this study.

⁴ The first 10 to 15 minutes of each session were spent having officers complete a mapping exercise and survey, which were not used in the analyses for this paper.

⁵ Considering the level of detail recorded in the notes, including direct quotes when possible, no differences in results were observed between the sessions with transcripts and the sessions with notes only.

Police guardianship in relation to health risk behaviors and environments

From the perspective of environmental criminology, foot patrol officers accumulate local knowledge of three essential elements that converge to produce criminal behavior: (1) motivated offenders; (2) desirable targets or victims; and (3) places or settings that are easy to access and minimally regulated (Cohen & Felson, 1979). Our data revealed that foot patrol officers sought to influence one or more of the above elements (Eck, 1994). They did so by serving as ‘capable guardians’, but in a broader sense than that depicted originally. We found that officers not only performed traditional guardianship functions of deterring criminal behavior by certain motivated offenders, but also sought to influence the normative and social environments of both would-be offenders and potential victims.

Officers deployed a range of mechanisms, including arrests, pedestrian stops, spatial control (including asking someone to ‘move along’) and negotiation (establishing behavioral rules). In short, they sought to deter and persuade as well as constitute a normative standard of behavior on the beat. They also sought to manage the physical environments of their beats, working to make places less attractive as sites of harm. In the next section, we describe these different dimensions of guardianship, with an emphasis on citizen problems of substance use and mental disturbance/illness.

Influencing behaviors and social environments

Foot patrol police are constantly on the watch for ‘problem’ people, and they work to ‘keep an eye’ (Bittner, 1967) on their patterns and movements. During their frequent contact with individuals engaged in risky health behaviors, officers generally employed traditional policing tactics, such as making arrests, issuing citations, conducting pedestrian stops and

negotiating order. We suggest that prior to, and during the performance of these diverse guardianship roles, officers acquire knowledge of health risk behaviors and environments. Unsurprisingly, though, this knowledge is not filtered through a public health lens, as seen in the case of drugs.

In efforts to influence drug-related behaviors and the structure of drug markets, officers devoted most of their energies to deterring drug dealers and users. Choices of legal and non-legal tools were influenced in part by officer style; some officers, or officer pairs, were more aggressive in orientation, while others were more amenable to softer tactics (Wood et al., 2013). For instance, one officer stated, ‘my partner and I...we were aggressive as hell.... If they saw us walking, they were going to move’ (focus group [FG] 10). In contrast, a different officer stated, ‘[w]e wouldn’t just go up to a guy and [say] ‘all right, you’re locked up for this, or you’re getting a citation for this’, and throw him against the wall, and things of that nature. It was just like ‘all right’, you give them a warning, you give them that fair warning. And then if they didn’t follow that warning, yeah, we did what we had to do. You got to have a backbone’ (FG 11).

Tactics of persuasion and negotiation appeared useful to officers when it came to handling ‘vice’ behaviors such as prostitution and public drinking where there was no clear ‘victim’. For instance, an officer commented on an arrangement they made with a ‘lady of the evening’ [prostitute]: ‘[W]hen you [the lady] see me, you knew you’re going on the other side of ABC Avenue where I wasn’t. But, you know, if I wasn’t there, if you want to be on LMN Street and sell yourself on LMN Street, go right ahead. I’m not there. I’m not locking you up’ (FG 10). This technique achieved ‘spatial sorting’ (1999); the shifting of people out of spaces in order to maintain standards of behavior in particular territories.

Pedestrian stops were used as tools for influencing those suspected of being involved in behavior that had a wider health impact on the community, especially drug dealing and violence. A pedestrian stop was used for both spatial sorting and punishment purposes. Stopping someone to ask them what they are ‘up to’ and to see their identification can, in and of itself, inconvenience people and disrupt their potential plans. Pedestrian stops were also seen to net bigger gains, such as the discovery that a person had an outstanding warrant or that they possessed drugs or a gun. As one officer claimed, ‘[w]arrants, weed. I found so many bags...’ (FG 20). Another officer recounted, ‘I locked up a guy with 26 bags of crack on him, just by drinking a beer in the park.’ (FG 1).

Order maintenance objectives could trump any potential concerns with substance users’ health. Official data revealed that drug-related incident detections increased by 28% after foot patrol officers were placed in their beats and all arrests increased by 13% in the target areas (Ratcliffe, et al., 2011). Officers referred to a larger organizational pressure to use legal tools to shape behavior. When asked about what they were instructed to do during their foot patrol assignments, an officer replied, ‘you are to generate numbers’ (FG 8). Some suggested that police managers (captains and sergeants) at the district level would ‘set the tone’ for the kind of style expected in the foot beats. As one officer put it, ‘there’s different mentalities in different districts. The 99th mentality was you see a drinker, you know, use common sense, because if we’re busy, we don’t have time to send a car out to deal with all that stuff. Now, the 75th, that particular captain wants them locked up...there’s very few exceptions to that’ (FG 16).

Some officers, however, looked cynically upon the need to generate activity, especially when arrest was proving ineffective, even in maintaining order. ‘You can only lock up the same drunks over and over again,’ one officer explained (FG 6). A different officer said, ‘how do you

threaten someone with jail when they don't care about their life?' (FG 5). As discussed below, this perception that arrests are sometimes ineffective may be a valuable impetus in encouraging officers to view recidivist behavior through a public health lens, and to enlist other formal guardians with alternative mechanisms of influence.

It was challenging for officers to conceive of addicted drug users as vulnerable people at higher risks of morbidity and mortality. As has always been the police mandate, officers were more concerned about protecting the public from the health risks of the criminal behavior associated with drug markets. In public health terms, the public protection mandate of the police would over-ride the principles of individual harm reduction. This was especially the case for injection drug and crack cocaine users who were seen by some officers as having no desire to abstain from drugs in the long term. As part of this belief, methadone programs simply served to substitute one drug for another. Methadone, an officer argued, simply 'gets them high at a lower dose' (FG 9). Another officer said, '[p]eople will claim that they've been clean because they've been going to methadone, but it's the same thing with the same effects; people are still 'zombies'' (FG 4).

Syringe exchange programs were regarded by some as perpetuating addiction rather than promoting abstinence. 'Maybe [the] level of sharing needles went down [with the program]', an officer stated, [but] it's 'legal heroin' (FG 7). Officers were also skeptical about the potential for crack cocaine users to reduce or cease their behaviors. A sense of fatalism was apparent when an officer said, '[t]hey're fiends. That's all they know. I had a guy one time, there was four officers in a marked car right in front of us, and he went up to a dealer and he said, 'do you got any rock on you'? He did not even care that we were standing there' (FG 13).

Some did not think that all clients of syringe exchanges would use such programs for their intended purpose, but would rather exploit the opportunity to acquire more needles. One officer commented that the program might help cut down on rates of infectivity and the numbers of people going to the hospital. However, s/he thought there was the potential for these programs to increase drug use. ‘Guys would turn a profit from their needle exchange program’ [referring to the problem of users selling their clean needles] (FG 6). A similar view was expressed about the potential for clients of methadone clinics to sell the methadone that was prescribed to them. ‘I see them spit in a cup and sell it to somebody’, an officer claimed (FG 3).

Compounding their views regarding drug users was officers’ grave concerns about their own health and safety as well as that of the general public. In one comment, an officer revealed what s/he perceived as a general disregard on the part of drug users for the health and safety of children. ‘They would shoot heroin, smoke crack right out on the street. They didn’t care if little kids were walking by. They don’t care. They have no respect for human life. They’ll do whatever they want. They’ll do anything to get their drugs’ (FG 3).

More fundamentally, some officers perceived something inherently unclean about drug users, as illustrated in this excerpt:

Officer 1: They’re very nasty. They smell. Like you can smell them from here to where [you] are, you can smell them. I don’t like touching them. I don’t want bugs on me, and I don’t want to contract anything, if they decide to like fight me or like bite me or something. I don’t want to have this on me... I’d rather go get the person that sold it to them.

Interviewer: So you focused on the dealer.

Officer 1: I wanted the dealer. I didn’t care about the user because they’re done anyway.

(FG 15)

This rather fatalistic view that users are ‘done anyway’ may in part reflect an assumption, held by at least some officers, that users have no desire to get healthy. It could also reflect a lack of understanding of the nature of addiction, or alternatively, a lack of confidence in wider systems of treatment and support, which may be seen as having failed if officers are routinely encountering such vulnerable people on the streets.

While challenging for officers to conceptualize drug users as vulnerable people with heightened health needs, officers were more inclined to view people affected by mental illness as more vulnerable than threatening. Officers therefore seemed more willing to enlist others to help when needed. Their practical knowledge of people’s conditions, and occasionally, knowledge of the whereabouts of families and friends was of considerable value. For example, in some situations, family members would let the officers know to call them if they saw a particular person known to suffer from a mental health condition (FG 12). Some officers would enlist family members to help. ‘Family members help a lot. If you can get them involved, they can come’ (FG 9). When asked whether they would work to discover the whereabouts of family members, this officer replied, ‘[e]veryone knows the neighborhood, so you ask around. ‘Oh, yeah, there’s her number’’ (FG 9).

In other cases though, officers would do nothing to intervene when only health issues (and not public safety issues) were present. This is because, by law, officers are not required to act if there is no imminent threat to public safety, and there is certainly no organizational reward for doing so. One officer said, ‘there was just this one guy, he would just have layers and layers and layers on [in the summer], so we kind of knew something was wrong with him. He didn’t bother us. We didn’t bother him. But there was a lot of them, you know, just wandering and walking around. But you knew they weren’t a threat. They were just, you know, crazy walking

down the street' (FG 20). Furthermore, officers were cognizant of the fact that they could upset certain people by engaging with them, so out of concern for potentially escalating a situation, they would leave them alone:

[P]eople used to say to us, 'why don't you make them leave'.... Like, I'm out here all day long. He doesn't bother anybody. He gets his beer. He walks up and down the street. But he doesn't bother anybody, so I'm not going to bother him. He might be a 302 [involuntary commitment history], but until he starts hitting people and throwing stuff around, I'm not going to bother him. I'm not going to antagonize him (FG 15)

Mental health law requires that officers intervene in ways that respect a person's dignity and autonomy. If there are concerns that a person's behavior might become threatening or criminal, compassionate foot patrol officers did try to de-escalate such situations. When asked whether they had situations where a person experienced a mental breakdown, an officer replied, '[n]ot where you had to lock them up or do something with them, but they start getting really upset and hostile. You just try your best to calm them down and steer them wherever they want to go to where it's not an issue where you're going to have to lock up somebody suffering from a disorder' (FG 19).

Mental health law therefore served to limit what officers could do to help those in the 'grey zone' of needed assistance (Wood & Beierschmitt, 2013). Providing assistance needed to occur on a voluntary basis. In other words, officers were reconciled with the notion that people need to want help in order to benefit from it. Consider the following exchange:

Interviewer: When these guys aren't being dangerous or [aren't] posing a threat to safety, do you think it's your role as officers to help them in some way with their issues and their mental health needs in terms of referring them or helping in any other way, or do you think you intervene only when they need it?

Officer 1: I think intervene only when needed. If they ask for help, then you give it to them. With my experience..., you don't try to impose referrals or anything you think they should do unless they ask for it... unless you have to do it.

Interviewer: It's not because you feel you don't have the authority to do it, or you just feel it's the right thing?

Officer 1: You have the authority, I mean, if you want to tell them 'hey, I think you need to go here'. Anybody can tell anybody anything. I mean, the suit doesn't make it any better. But at some point, some people just want to do their own thing. And they by their rights, they can do that. They don't want any help, [and] you can't force help on them unless there's a need for it.....

Officer 1: If they say you want my help, then I'll help you. If you don't want it, and you're not causing any harm to anybody then go ahead and -

Interviewer: But they initiate that? They've got kind of a low grade mental illness, you would help them if they initiated?

Officer 1: Yeah. But if I walk up to you or I encounter you and I ask you, 'you know, what's going on', and you're like, 'leave me alone'. And you're not a threat. Then I really don't -

Officer 2: And what if I walk up to you [pointing to the interviewer] and say 'hey, you look like you're mentally ill'. You're going to take that lightly? (FG 10; emphasis added)

From a legal and ethical perspective it was therefore difficult for police to persuade people to seek help if assistance was not requested, and it seemed that at certain points, officers would 'give up' trying to help. As one officer put it, you 'try to do the right thing and try to get them help and everything, but then you realize they don't want help' (FG 7). Officers appeared willing to collaborate with other service providers, but at the same time referenced their limitations. Even if a person's behavior met the requirements of an involuntary commitment action, for instance, officers knew that this legal tool was relatively short-term in effects (see Wood & Beierschmitt, 2013). 'They [302s] just get let out anyway... you'll see them walking out of Swisstown or whatever, with the bracelet on, two or three days later' (FG 4). One officer referred to these individuals as the 'regular guys' – those who had been sent to the hospital previously and subsequently released. The officer explained that after a while, they could

recognize when these ‘regulars’ were not taking their medications. Family members would tell the officers to call them when these individuals were seen on the streets (FG 12).

As another dimension of their guardianship role, officers also worked to influence the physical environments of the beats. As we discuss in the next section, they managed places using a repertoire of legal and non-legal tools.

Influencing physical environments

When describing drug- and mental health-related problems, officers often referred to broader ecological forces at work, including the infrastructural and place-based characteristics of their neighborhoods (e.g. abandoned houses, liquor outlets, convenience stores, parks). They told stories of places in and around their beats that were not only criminogenic, but served as sites of heightened health risks, what one might term ‘micro-places of harm’⁶. These are places that have unhealthy or unsanitary conditions or attract groups of people that collectively serve to increase health risks, such as intoxicated clients at bars.

Across the interview sessions, officers provided examples of such micro-places. Abandoned houses, for instance, served as sites of high risk activity, both because of their inherent health-risk conditions, as well as the opportunities they presented as sites of drug use, drug dealing and prostitution. One officer claimed, ‘[w]e had more abandoned houses where I was patrolling than people living in them. So that was a problem’ (FG 13). Another officer told the story of an abandoned building they visited once, even though it was outside of their beat: ‘There was this one place...called the ‘stool warehouse’. And they say that’s the closest thing to hell. As soon as you go in there, it’s feces....Needles [were] everywhere. Like if you fall, you have to go right to the hospital’ (FG 13).

⁶ This term is a variation of the criminological notion of ‘crime attractors’ (Brantingham, 1995).

Some ‘delis’ and convenience stores – often referred to as ‘Chinese stores’ – were also seen as sites of risk. They sold cheap alcohol, and were seen as helping to sustain alcoholism. One officer explained, ‘[there] was like a deli on every corner. And they could get a can of beer of like ‘211’ [a lager known for its high alcohol content] for like \$1.00. And they’d just drink that all day long. Like the poorest person had ‘211’. They’d be drunk by 10:00 in the morning’ (FG 15). Chinese stores were allegedly attractive to patrons because they would also stay open late, often past the closing times of bars (FG 13). It was claimed that store owners or operators were in an awkward position because a significant proportion of their patrons were people involved in criminal or disorderly activity. An officer explained, ‘if it’s [a patron] a drug dealer, they have all the supplies that they ever would need in that Chinese store. They have their ‘blunts’...they have their lighters. Anything is there...’ (FG 11). Some bars were a problem for officers as well because they would serve alcohol early in the morning (FG 19).

Methadone clinics were also seen as crime attractors and in our terminology, creators of micro places of harm. Some officers thought that while some clients of the clinic benefited from the treatment, there were also those who took the opportunity to sell their methadone. Officers described spatial patterns of human behavior that connected methadone clinics and pharmacies, both places where pills could be bought and sold.

Officer: *Another big thing in my area was pills. Pills was huge... We had a drug store right there at Elm and Church Street. And then we had like a...methadone clinic. So they were out there all day like zombies. Just all day....*

Interviewer: *So this was in and around the methadone clinic....*

Officer: *Yeah, the methadone clinic was like on Ruby Street. Somewhere around the corner, and then the drug store was right there. So they would hang in front of the drugstore all day and harass people when they’d go get prescriptions. Like, ‘Yo, you got pills? You got pills?’(FG 3)*

Officers worked to influence human flows into and out of problem places, including abandoned houses. As one officer put it, ‘we ruled abandoned houses; nobody went in those’ (FG 5). The law governing trespass was enabling in this regard:

Interviewer: ...[W]hat kinds of problems did these abandoned buildings cause for you?

Officer 1: *Stashing drugs in the building. Stashing drugs on the steps... They’re technically trespassing where they’re not supposed to be.....*

Interviewer: *They’re on private property.*

Officer 2: *Right. ‘You don’t belong here. Why are you here?’ (FG 11)*

The law governing trespass therefore gave the police legal authority to exert spatial control, but there are limits to what police can do as ‘place managers’ (Eck, 1995). The formal responsibility for securing, repairing and otherwise reducing the health risk conditions of abandoned houses does not rest with the police, but rather the city’s Licenses and Inspections Department. The management of places known to attract those engaged in risky health behaviors can also involve multiple other actors, such as employees of bars, landlords, caretakers of parks, and even regulatory authorities such as alcohol control bureaus, zoning commissions or insurance companies (Eck, 1995; Sampson, 2010; Scott, 2008).

As we discuss in the next section, locating the police within a broader system of urban health governance is critical to an agenda for improving not only the guardianship capacity of police, but the collective guardianship capacity of this urban system more generally. As part of this system’s view, the conception of capable guardianship developed in environmental criminology - which is traditionally linked to the management of criminal behavior - should be extended to link to health risk behavior more generally.

Discussion

Much of what we see in the narratives of foot patrol officers could be taken from a page in history. Patrol officers are charged with enforcing laws that are sometimes contestable, such as those dealing with disorderly conduct or ‘quality of life’ issues, and they sometimes intervene in circumstances where their presence is not requested (Wilson, 1968). Where issues of physical and/or mental health are in the mix, an officer has the authority to construct a situation as one calling for a health intervention, or a criminal penalty, or perhaps no intervention at all. Traditionally though, the fact that a crime has taken place can pre-empt other non-legal considerations in the matter, including considerations of health vulnerability (Centre for Addiction and Mental Health, 2010).

Bittner’s early research on use of civil commitment laws found that officers were reluctant to use this option unless there was a serious threat to public safety. This general principle seems to hold in the minds of contemporary foot patrol officers, mainly because mental health law requires this (Wood, Swanson, Burris & Gilbert, 2011), but there are other variables at play as well. Referrals to hospitals can be time-consuming - and especially complex when substance abuse may be at play (Teplin, 2000) - with perhaps little perceived value in the long term (note our officer’s comment about people being released relatively quickly). Also, officers (especially new recruits) may lack competence in matters related to mental illness. Bittner (1967a) noted this decades ago.

Since Bittner’s observations, major strides have been made in addressing lack of police competence when it comes to mental health. Current approaches to improving police interventions with people experiencing mental illness have centered on improving officers’

knowledge of, and attitudes toward mental health and co-occurring disorders. The most common approach is the Crisis Intervention Team (CIT) model, now operating in hundreds of communities across the US (including Philadelphia), which provides training to select officers in order to enhance their ability to de-escalate threatening behaviors and consider non-arrest options during such encounters (for a review see Wood et al., 2011).

In relation to drug use, and heroin use in particular, recent efforts have been made to train officers in ways that demonstrate the public health value of syringe exchange programs. Part of this involves efforts to enhance officers' abilities to assess and manage occupational risks associated with needlesticks, while correcting a widely held view that such programs exacerbate drug use (Beletsky et al., 2008). Despite such efforts, levels of acceptance for programs like this have not reached desirable levels, so these and related efforts continue (Beletsky et al., Silverman et al., 2012; 2008).

On the foundation of these needed training-based approaches, there have been significant advances in environmental criminology which, we suggest, provide further opportunities to bridge urban security and health promotion by nesting the work of the police within the work of other health 'guardians' in the city, especially those devoted to 'place management'. The police are one among a wide array of place managers ranging from city regulators to property owners to caretakers who have the potential to collectively manage micro-places of harm (see Eck & Wartell, 1998). Bringing in other entities that can help provide an accurate assessment of health risks and how to manage them contribute to place-based harm reduction. Additionally, 'third party policing' can make creative use of criminal and civil legal levers to influence behaviors and environments (Gilboy, 1998; Mazerolle, 2005). Foot patrol officers, for instance, could identify abandoned houses where there is evidence of risk behaviors, or problem businesses that

may be in breach of health codes or other regulations. Officers could also report sites of dirty needle disposal with the help of mobile devices, including smartphones and geographic positioning systems (Koper, 2009). All such efforts would help to harness the untapped local knowledge of foot patrol officers in the promotion of urban security *and* health.

Conclusion

Law enforcement officers, and especially foot patrol police, serve as public health interventionists, despite the fact that this role is incidental both to the imagination of officers and the general public. In the course of their daily routines, foot patrol police encounter health risk behaviors and environments, yet there are improvements to be made both at the level of police knowledge and attitudes and more broadly at the city level where coordinated efforts to bridge security and health are critically needed.

The criminal law urges police to categorize people as either ‘victims’ or ‘offenders’, but a public health approach would require police to understand that the same people can travel through our systems of criminal justice and healthcare, with none of their needs addressed in the long term. Strides have been made, however, in helping officers re-construct social problems in ways that take health into account. This is especially the case in relation to police interventions with people experiencing mental illness.

There is scope to improve officer understandings of people and their health vulnerabilities, but with this ‘people-based’ approach comes opportunities to improve ‘place-based’ strategies that bridge security and health agendas and enlist wider city resources. Since Bittner’s classic observations on the exigencies of ‘skid row’ policing, advances in environmental criminology have prompted us to explore the value of ‘place’, and the need to assess and manage micro-places of harm. Just as environmental criminologists urge us not to rely

on police as the only capable guardian, a focus on bridging security and health requires this as well. Police officers, especially those on foot, possess a highly localized knowledge of our city spaces, places and inhabitants, but as always, there are limits to what they alone can accomplish.

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