



**THE  
PUBLIC  
HEALTH  
CASE**

**AGAINST THE  
POLICING  
BILL**

**medact**

## ABOUT THE REPORT

This report was written by members of the Medact Research Network.  
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## ABOUT MEDACT

Medact is a global health charity that uses evidence-based campaigns to support health workers to take action on structural barriers to health equity and justice, in an effort to bring about a world in which everyone can access their human right to health.

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# EXECUTIVE SUMMARY

- The UK government has co-opted the language of public health to win support for the Police, Crime, Sentencing and Courts Bill. This briefing argues the bill will in fact harm public health.
- Punitive tools such as policing and prisons are ineffective, merely addressing symptoms while exacerbating root-cause social conditions.
- They are also deeply harmful, and have racially disproportionate impacts – which, in the case of the policing bill, the government has sought to justify.

## SERIOUS VIOLENCE AND CONFIDENTIALITY

- The policing bill emphasises particular forms of violence and deprioritises others, in ways which play into racialised ideas about criminality and distract from ‘upstream’ causes of violence.
- Despite naming World Health Organisation principles for violence reduction, the government’s proposed new measures depart markedly from these principles.
- The policing bill’s ‘Serious Violence Duty’ is a police-led, enforcement-driven, ‘downstream’ measure which will seriously undermine confidentiality and is widely opposed by the health community.
- In common with other anticipatory surveillance duties placed on public bodies, it is highly likely to produce harmful racialised outcomes – in particular affecting young Black men – undermining access to healthcare for groups already vulnerable to institutional mistrust.

## POLICING

- Standard policing practices such as stop and search harm the physical and mental health of targeted communities.
- Direct police violence is racialised, gendered and classed, as well as ableist – around half of those who die in police custody have a mental health condition.
- More broadly the social function of policing reproduces the structural violence which lies at the root of both crime and health inequalities.
- The policing bill’s ‘Serious Violence Reduction Orders’ will likely be ineffective at reducing

crime but by the Home Office's own acknowledgement will disproportionately target minoritised groups, especially young Black men.

## SENTENCING AND PRISONS

- Racial, gender and class oppression shape the prison population. Prison exposes people to multiple forms of violence, including increasing rates of self-harm and suicide.
- People in prison often already had health problems prior to incarceration, and imprisonment produces notably worse mental and physical health outcomes. These impacts of incarceration spill over into families and communities.
- The policing bill's harsher sentences will mean more people spending more time in prison but will not reduce crime. The government's own impact assessment for the bill concedes that deterrence does not work.
- Instead the bill will entrench and perpetuate a cycle of poor health, criminalisation, imprisonment and harm. Money would be better spent on a public health approach addressing root-cause social conditions within communities.

## GYPSY, ROMA AND TRAVELLER HEALTH

- Pervasive racism towards Gypsy Roma and Traveller (GRT) communities includes a long history of discriminatory state practices and criminalisation.
- Local authorities have long failed to provide adequate site space, forcing GRT people into unauthorised settlements, often without proper access to water, education or healthcare.
- This housing insecurity leads to and compounds the socioeconomic marginalisation and severe health inequalities experienced by GRT communities.
- The policing bill's measures will increase nomadic communities' precarity, exacerbating a harmful cycle of criminalisation, exclusion and poor health. They constitute an attack on GRT communities' culture and way of life.

## PROTEST AND PUBLIC HEALTH

- History provides numerous examples of vital public health advancements won through protest and social activism.
- As such, protest can be seen as a public health intervention, allowing communities to address and end inequalities at the root of health problems.
- Some evidence suggests protest can also produce positive public health outcomes such as reducing police homicides.

- ▶ The policing bill's restrictions on the right to protest will have a deleterious impact on public health, further silencing and deterring already over-policed communities whose voices need to be heard the most, as well as health workers whose careers could be damaged by a criminal record.

## CONCLUSION

- ▶ The PCSC Bill epitomises longstanding attempts to “police away” social problems through criminal justice measures, efforts which are both ineffective and harmful, especially to minoritised communities.
- ▶ We argue that a public health approach which takes racism, state violence and structural violence seriously would provide a more effective, compassionate and just response to social issues.
- ▶ We urge the UK health community to engage with these issues and in particular the American Public Health Association's 2021 motion calling for society to move away from carceral systems and build “just and equitable structures that advance the public's health” instead.

# 1. INTRODUCTION

**POLICE**

**The Police, Crime, Sentencing and Courts (PCSC) Bill – also known as the policing bill – is a lengthy piece of legislation sponsored by the Home Office and Home Secretary Priti Patel. First published in March 2021, it covers numerous areas of criminal justice and protest law.**

**This briefing examines the policing bill through a public health lens. While the government has branded the bill a “public health approach” to combating serious violence<sup>1</sup>, we show that due to its reliance on policing and prisons, it merely tackles symptoms not causes, leading to punishment not prevention. The bill will entrench racial discrimination, worsen inequality, undermine confidentiality and damage trust in, and access to, health services. We argue that it therefore poses a threat to collective health, wellbeing and equity and epitomises longstanding attempts – which are both ineffective and harmful – to “police away” social problems<sup>2</sup> through criminal justice measures. Real public health prevention, we argue, would look very different.**

## **THE POLITICS OF THE POLICING BILL**

The policing bill can be situated within a long lineage of laws premised on narratives about a rising crime threat and positioning policing and prisons as a means to protect public safety. Such ideas ignore the harmful impacts of policing and prisons on physical, mental, social and emotional health which we outline in this briefing, and in particular, omit the fact that such harms disproportionately affect racially minoritised groups.\* This begs the question – whose “safety” do the state and police protect?

Proponents of expanding harmful carceral (prison) ‘solutions’ frequently draw upon rhetoric which demonises minoritised groups<sup>3</sup> – whether Black people, Muslims, or Gypsy, Roma and Traveller communities – associating “racialized others with violent criminality”.<sup>4</sup> These serve to legitimise state violence targeting minoritised groups (through, for example, the ‘war on gangs’, ‘war on terror’ and the ‘hostile environment’

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\* We use the term “minoritised” following the arguments in Selvarajah, S., Abi Deivanayagam, T., Lasco, G., Scafe, S., White, A., Zembe-Mkabile, W., & Devakumar, D. (2020), “Categorisation and minoritisation”, *BMJ Global Health*, 5(12), available at: <https://gh.bmj.com/content/5/12/e004508>.

to counter so-called 'illegal' immigration), but also detract attention from the harms inflicted by the state's neglect of the upstream causes of criminalised behaviours.<sup>5</sup>

In the case of the policing bill, the Home Office is aware of, and has explicitly justified, the racially disproportionate impacts it will have as “objectively justified as a proportionate means of achieving [a] legitimate aim”.<sup>6</sup> In this sense, the bill is helping to entrench a society in which, as a recent British Medical Journal article puts it, “the privileged among us are recipients of a safety that is predicated on violence and harm against minoritised communities.”<sup>7</sup> It is also a concrete manifestation of racism, defined by scholar Ruth Wilson Gilmore in structural terms as the “state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death”,<sup>8</sup> since the state is further enabling violence towards communities who, as a function of their oppression, already experience worse health outcomes.

As this briefing outlines, considerable evidence shows that the 'tough-on-crime' law enforcement approach adopted by the policing bill is not even effective at reducing the very problems it claims to respond to. This is because such punitive approaches fail to address the social and economic conditions that result in criminalised behaviours and instead increase state power and reproduce violence, as we will show.

**Punitive approaches fail to address the social and economic conditions that result in criminalised behaviours**

Despite this, at the time of writing, the policing bill is already at an advanced stage in the legislative process and is likely to become law. But it has not gone unopposed: the 'Kill The Bill' movement has organised grassroots resistance to the bill through protests which have themselves been repressed heavily by severe policing, with several people imprisoned on 'riot' charges.<sup>9</sup> Regardless of whether the bill passes into law, this briefing has been written in solidarity with targeted communities and aims to contribute to the ongoing movement against the racist, repressive and ultimately ineffective carceral approaches which it exemplifies. We do so by highlighting the radical potential of public health interventions as effective and transformative alternatives to punitive criminal justice, in the hope of further engaging the health community on this issue.

## **PUBLIC HEALTH: A CONTESTED FIELD**

At its core, public health concerns the wellbeing of entire populations. However, its meaning and practice are contested. Historically, public health measures have sometimes been weaponised and implemented in repressive political contexts or used as a pretext for oppression – including by the British state, both domestically<sup>10</sup> and in former colonies<sup>11</sup>. Today, the policing bill is being pushed through parliament within the context of an “unprecedented level of societal control” for which the COVID-19 pandemic has arguably paved the way.<sup>12</sup>

At the end of the twentieth century, a biomedical model of public health preoccupied with pills and vaccines prevailed. This “crowded out the space” for considering the social, political and economic conditions which shape our health – the so-called 'social determinants of health'.<sup>13</sup> The more recent dominance of

the behavioural model of public health – an approach which advocates behaviour change as opposed to addressing structural problems – has further sidelined such material concerns. This approach “fits neatly with the contemporary neoliberal economic mindset”, and the logic of individual responsibility.<sup>14</sup> It also contrasts profoundly with the famous statement by Rudolf Virchow, the father of social medicine, that “medicine is a social science and politics is nothing else but medicine on a large scale”, which has been called “public health’s biggest idea”.<sup>15</sup> This tension between individualised versus structural approaches holds relevance, too, for the analysis of approaches to crime, violence and harm which this briefing presents.

### RACISM: A PUBLIC HEALTH CRISIS

Racism has been called “the public health crisis we can no longer ignore”.<sup>16</sup> The COVID-19 pandemic provides a clear recent example of racially differentiated health outcomes, but beyond this a large body of literature attests to the multiple pathways through which racism has detrimental impacts on both psychological and physiological health. Racial discrimination can reduce access to employment, housing and education and is associated with poorer mental health outcomes including depression.<sup>17</sup> The psychosocial distress and trauma of racism also have embodied impacts which affect physical health. Exposure to interpersonal and systemic racism throughout the lifecourse is an environmental stressor, which triggers a stress response. The accumulation of stress can, over time, increase allostatic load and this in turn may heighten racially minoritised individuals’ vulnerability to certain diseases.<sup>18</sup> High allostatic load may also be passed onto offspring intergenerationally through epigenetic mechanisms, leading to poor health outcomes for children whose parents experienced racism.<sup>19</sup> Recent evidence also suggests that discrimination can decrease telomere length, accelerating biological aging in minoritised groups and heightening the risks of chronic disease and inflammation.<sup>20</sup>

Racism is a social determinant of health.<sup>21</sup> It harms health in multiple ways, as outlined in the box above, and can also increase exposure to health risks such as contact with the police.<sup>22</sup> However, the negative health impacts of policing and incarceration, which have disproportionately harmed minoritised communities since their inception, have rarely been taken seriously by the public health community. Increasingly though, there are signs of change. Steps range from the call to treat deaths in custody as public health data,<sup>23</sup> to the recent adoption by the American Public Health Association at its 2021 conference of a motion advocating “moving towards the abolition of carceral systems and building in their stead just and equitable structures that advance the public’s health”, such as through investing in housing and employment.<sup>24</sup>

Conversely, the language of public health is simultaneously being co-opted by the government and other advocates of pre-crime ‘anticipatory policing’. For example, the counter-extremism industry’s professed “turn to public health”<sup>25</sup> rests on the latter’s promise of prevention and the appeal of its epidemiological methods for risk-mapping, which hold significant potential for misuse as tools to

**The language of public health is being co-opted by advocates of pre-crime anticipatory policing**

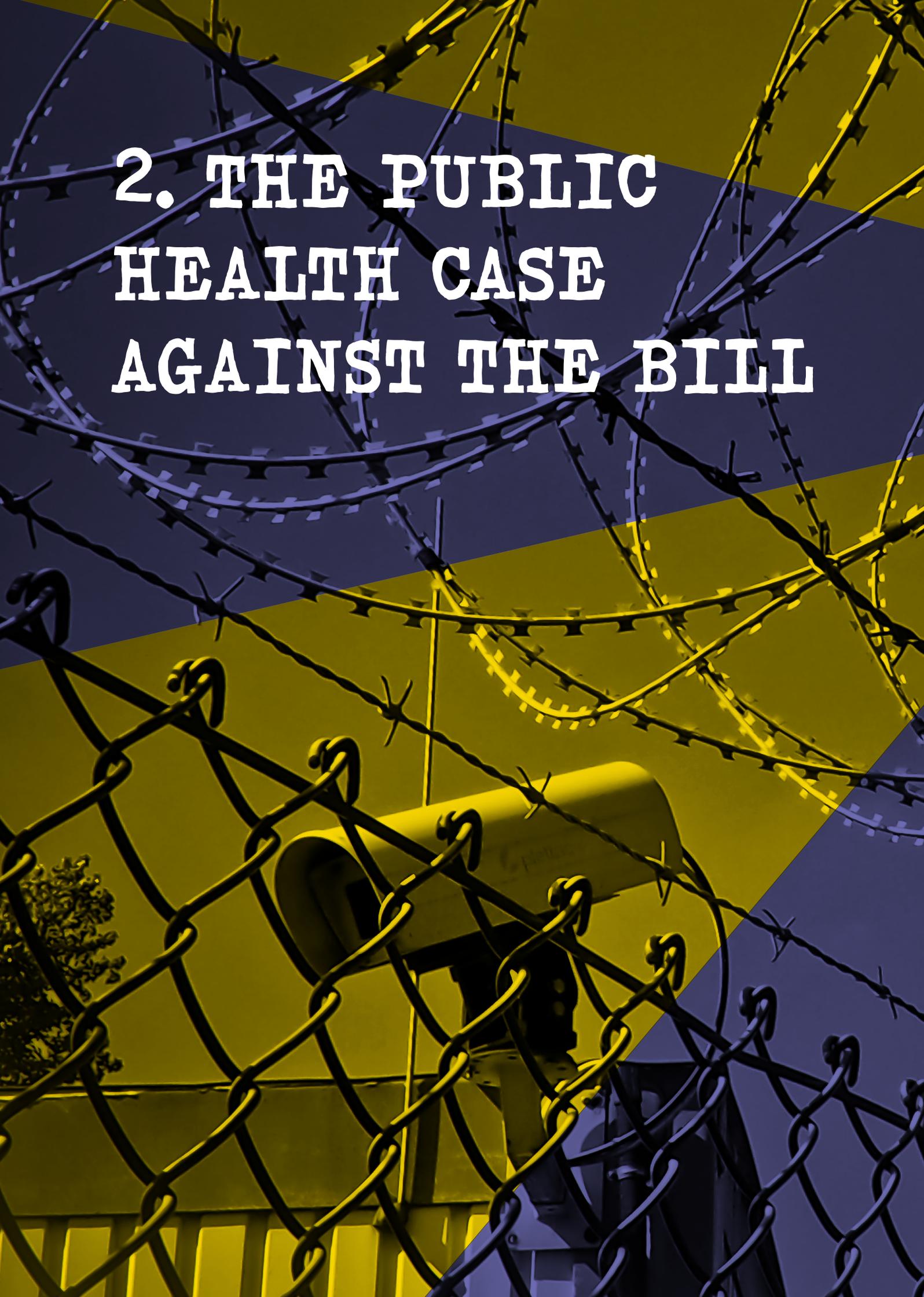
profile and enhance surveillance of certain communities. Similarly, in its consultation on the policing bill, the UK government claims that “policing and public health are intimately related” and, as we will outline, the bill aims to strengthen police presence within healthcare.<sup>26</sup> We argue against the enmeshment of policing and public health, and instead for a public health approach which seeks to provide a more effective, compassionate and just response to social issues, rooted in fairness and collective wellbeing.

## BRIEFING STRUCTURE

This briefing examines five major areas of the policing bill and critiques them from the perspective of public health.

- ▶ Section 2.1 interrogates the ‘serious violence’ measures which create a ‘duty’ for multi-agency information sharing with the police, noting that they will erode confidentiality and produce racially disproportionate outcomes, making them incongruent with a “public health” approach.
- ▶ Section 2.2 explains how the bill expands policing powers and enhances stop and search by introducing Serious Violence Reduction Orders (SVROs), arguing that as well as harming health directly, policing perpetuates and compounds the conditions that create crime in the first place.
- ▶ Section 2.3 shows that harsher sentences for certain offences mandated by the bill (leading to more people spending more time in prison) will harm health and wellbeing, and entrench racial inequalities which occur at every stage of the criminal justice system – without actually reducing crime.<sup>27</sup>
- ▶ Section 2.4 explores the health inequalities faced by Gypsy, Roma and Traveller communities, which will be exacerbated by the bill’s extension of longstanding patterns of criminalisation and discrimination.
- ▶ Finally, Section 2.5 argues that political protest can constitute a profound public health intervention and that the bill’s restrictions on protest will harm people’s collective ability to change society in ways which improve health.

In concluding, we argue for a fundamental paradigm shift away from punitive criminal justice measures such as the policing bill towards a truly preventative, alternative public health vision rooted in collective wellbeing and justice.



## 2. THE PUBLIC HEALTH CASE AGAINST THE BILL

## 2.1 SERIOUS VIOLENCE AND CONFIDENTIALITY

**Violence in society – whether interpersonal, intercommunity or as perpetrated by the state – clearly negatively impacts health. Yet the Home Office’s claim that the policing bill takes a “public health approach” to what it calls “serious violence” deserves interrogation. The upstream conditions giving rise to poor health, in the presence of certain risk factors or absence of protective factors, overlap almost entirely with those behind crime and violence. A truly preventative, public health approach to both would therefore seem apt. However, what the policing bill professes as a public health approach is in reality a punitive response which departs markedly from established public health principles for violence reduction.**

**This section asks which forms of violence are being highlighted by the bill and whose safety is being prioritised. It notes key differences between the Scottish Violence Reduction Unit popularised in Glasgow and the versions rolled out in England and Wales. And it shows that the bill’s flagship ‘Serious Violence Duty’ targets symptoms not causes, leads to punishment not prevention, and will embed discrimination, undermine confidentiality and worsen inequality.**

### WHICH VIOLENCE, WHOSE SAFETY?

The World Health Organization maintains that understanding violence as a public health problem, rather than a criminal one, necessitates a holistic view of the range of violence in society. It emphasises the complex, interconnected nature of different forms of violence, and argues against an isolated focus on any one type of violence, with an understanding that doing so “perpetuates the concentration on certain highly visible forms of violence – notably youth violence – while paying much less attention to other types”, such as domestic violence, suicide or state violence.<sup>28</sup>

However, the policing bill displays precisely this narrow view, focusing on certain high-profile forms of interpersonal violence – specifically what the government calls “serious” violence, defined as “homicide, knife crime, and gun crime”.<sup>29</sup> The emphasis placed on particular forms of violence and deprioritisation of others reflects underlying ideas about whose suffering is legitimate, who is ‘deserving’ of protection and care,<sup>30</sup> and ultimately whose lives are valued most. As the briefing introduction noted, crime narratives also play on race. Knife crime and ‘serious youth violence’ are quintessential examples,<sup>31</sup> constituting “a contemporary moral panic” which is “racialized in the national imagination”,<sup>32</sup> in particular drawing on associations between Blackness and aggression which are deeply historically ingrained and often rooted in colonial constructions of threat.

The policing bill and most, if not all, criminal justice initiatives also ignore “structural violence” – which describes the long-term physical and psychological harms inflicted, often gradually and invisibly, on individuals and populations as a result of the systematically unequal organisation of social, economic and political systems.<sup>33</sup>

## PUBLIC HEALTH APPROACHES TO VIOLENCE

Public health approaches to violence reduction emerged in the late 1970s and are grounded in decades of research by the World Health Organization (WHO) and others. They depart from the observation that like other health problems, violence is not distributed evenly across population groups<sup>34</sup> and that “many of the key risk factors that make individuals, families or communities vulnerable to violence are changeable, including exposure to adverse experiences in childhood and subsequently the environments in which individuals live, learn and work throughout youth, adulthood and older age”.<sup>35</sup> The WHO advocates an “ecological model” which recognises that risk factors for violence (notably also root causes of health inequalities) interact over the lifecourse and exist on multiple interconnected levels:

- individual (e.g. drug use)
- relational (e.g. violent parental conflict)
- community (e.g. unemployment)
- societal (e.g. inequality).<sup>36</sup>

Importantly, the WHO distinguishes between crime prevention, which focuses on criminal justice deterrence by threatening individuals with punishment, and the public health approach to violence prevention, which focuses to a large extent on primary prevention at the population level. In other words, public health approaches should operate at the societal as well as the individual level, and unlike contemporary behavioural models, take into account structural violence.

The public health literature on violence reduction is clear that inequality (whether socio-economic, gender or racial) is conducive to violence.<sup>37</sup> Furthermore, according to core principles outlined by the WHO and others, public health interventions to reduce violence should:

- Be evidence-based<sup>38</sup>
- Address root causes

- Intervene ‘upstream’
- Adopt long term solutions
- Work with and for communities<sup>39</sup>
- Foster equity.<sup>40</sup>

Notably, the government’s consultation on its self-declared “public health approach” to serious violence measures makes explicit reference to the WHO’s principles and even asserts that the policing bill constitutes a “new approach to policing, which prevents and mitigates adverse childhood experiences”.<sup>41</sup> However, in practice the bill’s approach runs drastically counter to these public health principles – and the UK government has a record of watering them down.

In 2005, the Scottish government established a Violence Reduction Unit in Glasgow, which would become renowned for its successful application of public health measures to dramatically reduce violent crime<sup>42</sup> in the city. While the Glasgow model actually included standard policing tactics, its distinctive characteristics were its social policies, which included reducing school exclusions and significantly investing in youth services and mental health provision.<sup>43</sup> When, in 2019, the Home Office provided funding for Violence Reduction Units to be established in eighteen areas of England and Wales, the approach adopted placed even less emphasis on investing in youth projects and other services,<sup>44</sup> and even more on “tough law enforcement tactics, such as stop and search campaigns”.<sup>45</sup>

## UNDERMINING CONFIDENTIALITY, EMBEDDING DISCRIMINATION

### THE POLICING BILL WOULD:

- Place a new statutory duty on public bodies including healthcare providers, to “collaborate with each other to prevent and reduce serious violence”
- Legally oblige these bodies to hand over information upon request by a local policing body, and enable the Secretary of State to mandate compliance
- Override professional duties of confidentiality and other restrictions on disclosure.<sup>46</sup>

The policing bill moves even further away from a public health approach concerned with the social conditions at the root of violence. Its flagship policy is the introduction of a ‘Serious Violence Duty’. As the box above outlines, this would make it a statutory duty for healthcare providers and other public bodies to “prevent and reduce serious violence” by collaborating with and providing information to the police. It has therefore been dubbed “a Prevent duty for knife crime”,<sup>47</sup> since it mimics the Prevent counterterrorism policy through which health workers and other public sector staff are asked to report signs of potential “extremism”. Like Prevent, the Serious Violence Duty targets symptoms not causes.

The government's 2018 Serious Violence Strategy identified issues like school exclusions and deprivation as risk factors for violence.<sup>48</sup> The latter in particular is shown in the literature to be strongly related to violence, with emergency hospital admission rates linked to violence around five times higher in the most deprived communities in England than the most affluent.<sup>49</sup> The consultation for the policing bill, however, lists issues like “changes in the drug market” and “social media” as risk factors.<sup>50</sup> Its focus on the individual level de-emphasises the larger structural and environmental contexts shaping patterns of violence in the long term and neglects to make ‘upstream’ interventions at community and societal levels.<sup>51</sup>

**The Policing Bill's focus on the individual level de-emphasises the larger structural contexts shaping patterns of violence**

The Serious Violence Duty is police-led and enforcement-driven, leading to punishment not prevention. Health workers and others will, in effect, be obliged to share information on individual patients perceived to be “at risk” of “serious violence” (whether as perpetrators or victims), overriding data protection as well as legal and professional duties of confidentiality which already allow for disclosure in exceptional public interest or safeguarding cases. Whereas public health approaches stress the importance of *anonymised* data collection to understand risk factors and inform interventions,<sup>52</sup> the policing bill gives police new powers to legally compel other bodies to share *identifiable* confidential health information. The National Data Guardian, General Medical Council, British Medical Association,<sup>53</sup> Royal College of Nursing,<sup>54</sup> British Psychological Society, and the British Association for Counselling and Psychotherapy, have all voiced serious concerns.<sup>55</sup> Just as Medact's research on the hostile environment in healthcare exposed a deterrent effect,<sup>56</sup> these measures will similarly undermine well-established confidentiality duties and – by further making health services an arena of policing – have a “damaging impact on the relationship of trust between doctors and their patients”, ultimately harming public health.<sup>57</sup>

Critically, the impacts of both the hostile environment and Prevent are deeply racialised. The Serious Violence Duty takes the same approach and will embed discriminatory securitisation of minoritised groups in a similar way. Black people are “massively overrepresented on police gang databases”,<sup>58</sup> including in London where in 2018 the Met's gangs matrix (based on “intelligence”, not convictions) was 70% made up of young Black men,<sup>59</sup> and in Manchester where minoritised groups make up 89% of the police force's gang database but account for only 23% of serious youth violence.<sup>60</sup> Medact research has shown that similar forms of anticipatory surveillance based on racialised risk criteria leads to Muslims being disproportionately referred to Prevent based on pervasive perceptions of the figure of ‘the terrorist’<sup>61</sup> – similarly, the Serious Violence Duty is very likely to see disproportionate referrals of young Black men due to racialised narratives around knife-crime and ‘gangs’.<sup>62</sup>

The policing bill will, in this way, exacerbate racialised health inequalities by undermining access to healthcare for groups already vulnerable to institutional mistrust. It cannot be said to work with and for communities, nor foster equity, fairness, inclusiveness and empowerment, as public health principles mandate. Nor is it based on robust evidence of efficacy, and therefore cannot be considered consistent with a public health approach.

## 2.2 POLICING

Narratives legitimising the policing bill posit the existence of new and increasing threats to public safety and situate increasing police powers as a necessary and effective response. However, we argue that policing should in fact be considered a threat to public health. This section explains why the policing bill's expansion of police powers, in particular the introduction of Serious Violence Reduction Orders, will be discriminatory, harmful and also ineffective. As well as harming health directly, it shows how policing and punitive responses to social problems perpetuate, compound and "reproduce the social conditions that in turn beget criminalised behaviours" and harm public health over generations.<sup>63</sup>

### POLICING AS A THREAT TO PUBLIC HEALTH

While the murder of George Floyd (re)ignited global consciousness and outrage about police brutality in the USA, the UK is not innocent.<sup>64</sup> Since 1990, there have been 1,798 deaths in police custody\* in England and Wales.<sup>65</sup> Until the recent conviction of the police officer who killed ex-footballer Dalian Atkinson, none of these had resulted in a successful prosecution for murder or manslaughter, demonstrating the persistent impunity of the police.<sup>66</sup> Police violence is racialised, gendered and classed. It is also ableist given its impact on people with mental health conditions, which we outline. Black people are five times more likely than white people to have force used against them by police.<sup>67</sup> Meanwhile, the recent killing of Sarah Everard, the violent police response to vigils commemorating her life, and the misconduct which followed the murders of Bibaa Henry and Nicole Smallman, have starkly highlighted the epidemic of police-perpetrated gender-based violence.<sup>68</sup>

It is important to recognise, however, that the harms of policing occur not as a result of isolated acts of aberrant brutality perpetrated by individual 'bad apples' but as part of the ordinary and intrinsic societal function of policing. Understanding policing's colonial origins helps to illuminate how and why police institutions are racist and classist by design,<sup>69</sup> since their purpose has always been "to maintain racist and other power hierarchies".<sup>70</sup> The many ways that racism harms health, including its embodied impacts affecting physical health, were outlined in the introduction of this briefing. Policing specifically negatively impacts the health of targeted and criminalised communities – disproportionately minoritised groups – in a range of ways besides the obvious outcomes of direct violence such as injury or premature death.<sup>71</sup>

For example, intensive police surveillance is associated with psychological distress<sup>72</sup> and worse physical health outcomes.<sup>73</sup> Exposure to police violence is linked to worse mental health.<sup>74</sup> These negative health outcomes can feed a vicious cycle, since – as the 2017 Angiolini Review noted – when people already

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\* Inquest, a UK charity focusing on state-related deaths, defines police custody deaths as deaths that take place while the individual is in contact with police, whether or not they have been arrested, or that happen shortly after that contact. The death may not necessarily have occurred inside a police station and do not include self-inflicted deaths following contact with police or deaths as a result of domestic violence where the police have been involved.

experiencing mental distress come into contact with police, the “use of force and restraint...poses a life threatening risk”.<sup>75</sup> Indeed, around half of all those who die in custody have a mental health condition.<sup>76</sup> The deaths of Roger Sylvester (1999), Sean Rigg (2008), Olaseni Lewis (2010), Leon Briggs (2013), and Kevin Clarke (2018) are just a few examples – all of them Black men. On a more basic level, recent evidence suggests UK police stop and search practices during the COVID-19 pandemic may have endangered public health.<sup>77</sup>

More generally, the impact of policing on public health and the social determinants of health is much wider and broader. Contrary to popular misconception, policing does not prevent crime. Indeed, it is arguably counter-productive in this sense. At a macro-level, by harmfully criminalising people who are minoritised, marginalised and disadvantaged, policing reproduces the structural violence which the previous section pointed out lies at the root of both violence and health inequalities. It then proceeds to use crime as a justification for increased policing<sup>78</sup> and thus perpetuates “a cycle of community harm by criminalising the conditions it reproduces”, over individual life courses and over generations.<sup>79</sup> The investment in policing rather than in programmes to tackle the root causes of crime is a political choice. Ultimately, policing fails to address “the upstream social, economic and political issues that give rise to crime”,<sup>80</sup> and instead, as the WHO notes, “divert[s] scarce financial resources away from public health and educational programmes that have been shown to significantly reduce crime”.<sup>81</sup> Given the above, the policing bill’s expansion of police powers should be seen as a serious threat to public health.<sup>82</sup>

**Policing reproduces the structural violence which lies at the root of both violence and health inequalities**

## SERIOUS VIOLENCE REDUCTION ORDERS: DISCRIMINATORY AND INEFFECTIVE

### THE POLICING BILL WOULD:

- Create a new civil order which can be imposed by a court, the Serious Violence Reduction Order (SVRO)
- Allow police to stop and search any individual subject to an SVRO at any time in a public place without the need for reasonable suspicion
- Give courts the power to impose SVROs on any individual who “ought to have known” that another person who committed an offence would be carrying a weapon, not only on those convicted of using weapons themselves.

As explained above, ordinary police practices such as stop and search harm over-policed communities’ wellbeing. Minoritised groups are four to five times more likely than white people to be subject to stop and search,<sup>83</sup> with Black people nine times more likely.<sup>84</sup> The policing bill would compound this highly

discriminatory situation, in particular through the creation of the Serious Violence Reduction Orders (SVROs), outlined in the box above. Presented as a measure to tackle “known knife carriers”, SVROs make previous convictions a justification for targeted police stop and search. In this way, they run counter to the long-established legal principle that previous convictions should be treated as irrelevant until sentencing.<sup>85</sup> Moreover, SVROs can in fact also be imposed by a court without any evidence that an individual has *themselves* ever handled a weapon and merely in response to an incident in which they “knew or ought to have known” that another person who committed an offence would be carrying a weapon.<sup>86</sup>

An individual subject to an SVRO could be stopped and searched by the police at any time in a public place *without* the “reasonable suspicion” which is normally required – a heightened level of discretionary power known to worsen racial disproportionality.<sup>87</sup> As such, SVROs constitute an extension of anticipatory surveillance approaches targeting Black communities. By the government’s own admission “a disproportionate number of Black people...Black males in particular” are likely to be subject to SVROs, and “ethnic minorities who are subject to an SVRO are more likely to be searched in practice”.<sup>88</sup> The human rights organisation Liberty condemns SVROs as a “highly oppressive tool, unlike anything currently on the statute books”.<sup>89</sup> Yet the Home Office has explicitly rationalised the racial disproportionality which SVROs will entail as “objectively justified as a proportionate means of achieving [a] legitimate aim”.<sup>90</sup>

**The Home Office has rationalised racial disproportionality as 'objectively justified'**

However, the Home Office’s own research has notably found that previous stop and search operations had “no discernible crime-reducing effects”.<sup>91</sup> Similarly, as Liberty highlights, ten years’ worth of data from London found “only a very weak and inconsistent association” between stop and search and crime, and no significant links between stop and search and violence reduction.<sup>92</sup> SVROs will likely therefore be ineffective, in common with policing more generally, and merely feed and exacerbate a damaging cycle of criminalisation and harm as opposed to actually breaking the cycle of violence by “redress[ing] the unmet needs of chronically under-resourced communities”.<sup>93</sup>

## 2.3 SENTENCING AND PRISONS

The UK has the highest imprisonment rate in Western Europe.<sup>94</sup> The policing bill would increase custodial sentences for a number of offences – some of which are outlined in the box below – continuing the inflationary trends in sentencing of the last 20 years.<sup>95</sup> While the government characterises this as “tougher punishment” for “serious criminals”, amongst the changes would be a dramatic hike in the maximum sentence for damaging a memorial from three months to 10 years’ imprisonment.<sup>96</sup> In practice, increasing sentences would mean more people spending more time in prison. By definition punitive, not preventative, these measures undermine any public health approach which the government claims to have adopted in other parts of the bill.

This section argues that prisons are deeply harmful to the health of both incarcerated people – disproportionately minoritised and marginalised groups – and society as a whole, since they reproduce and exacerbate the conditions which give rise to crime. Prisons are also ineffective, so the policing bill’s harsher sentences are extremely unlikely to meaningfully reduce crime, and could in fact be counter-productive, as the government’s own impact assessment concedes.

### WHO IS INCARCERATED?

Who ends up in prison? As with policing, this question is racialised, gendered and classed, and influenced by mental health, the outcome of laws which criminalise certain groups (such as ‘joint enterprise’ laws overwhelmingly applied to minoritised youth)<sup>97</sup> and a criminal justice system characterised at every stage by racial inequalities.<sup>98</sup> Black men are over 50% more likely to be given a custodial sentence than their white counterparts<sup>99</sup> and racially minoritised groups constitute a disproportionately high 25% of the prison population.<sup>100</sup> The incarceration of women has grown rapidly in recent years, with the majority imprisoned for nonviolent crimes.<sup>101</sup>

A high proportion of people in prison come from poor or working class backgrounds, with very high school exclusion rates, low literacy levels and special educational needs common. Moreover, imprisoned people often also come from communities disadvantaged by health inequalities, and tend to exhibit a higher prevalence of acute and chronic health conditions compared to the general population.<sup>102</sup> Among women incarcerated in the UK, 40% needed mental health care before prison<sup>103</sup> and as many as 53% have experienced some form of abuse.<sup>104</sup> In short, “prisons are filled with working-class and racialized people who have often experienced harm or violence themselves”.<sup>105</sup>

**“Prisons are filled with working-class and racialized people who have often experienced harm or violence themselves”**

**– Dr Adam Elliott-Cooper**

## HOW PRISON HARMS HEALTH

Prison compounds this trauma and harm. Poor conditions and high levels of overcrowding contribute to “dangerously high levels of violence”.<sup>106</sup> Due to reduced staff–inmate ratios, overcrowding means prisoners spend even less time outside of their cells, harming physical and mental health and restricting (already poor) access to healthcare.<sup>107</sup> Overall, the standardised mortality rate of UK prisoners is 50% higher than the general population<sup>108</sup> and inadequate healthcare provision is a significant factor in the “high proportion of premature and highly preventable deaths” in prison.<sup>109</sup> One recent report highlighted the “mental health crisis” in prisons, estimating that up to 70% of inmates may be living with (often – especially amongst minoritised groups – undiagnosed) mental health issues and only around 10% actually receiving care.<sup>110</sup> Relatedly, self-harm and suicide rates are far higher than in the general population and have been rising steeply. Rates of self-harm – consistently higher among women prisoners than men<sup>111</sup> – reached record levels for the seventh consecutive year in 2020, and on average one person every five days takes their own life in a UK prison.<sup>112</sup>

Practices like solitary confinement are known to increase the risk of self-inflicted violence.<sup>113</sup> Nonetheless, more than fifty prisoners in England and Wales continue to be held in so-called Close Supervision Centres under highly restrictive conditions which may amount to torture according to Amnesty International and a UN special rapporteur.<sup>114</sup> Moreover, since the onset of the pandemic, many prisoners have been forced to remain in their cells for 23 hours a day. Despite infection-control measures such as this (and the removal of all visitation), the extreme vulnerability to infectious disease created by incarceration has still seen COVID-19 death rates more than three times higher among people in prison than the wider population.<sup>115</sup> As well as damaging the health of prisoners themselves, imprisonment also inflicts harm on families through a range of social, psychological, financial, emotional and developmental channels,<sup>116</sup> with research suggesting higher rates of premature death among the children of imprisoned parents.<sup>117</sup> More abstractly, prison as an institution may be seen as inherently harmful because of the way it excludes and dehumanises people in prison.

If, then, we adopt a holistic perspective on violence and harm in society as it impacts the whole population, the policing bill’s harsher sentences (and consequently greater levels of incarceration) could themselves be seen as harmful to health.

**If we adopt a holistic perspective on violence in society, the policing bill’s harsher sentences could themselves be seen as harmful to health**

### THE POLICING BILL WOULD:

- ▶ Increase the requisite custodial period for certain violent or sexual offences, and increase sentences for assaults on emergency workers (90% of the latter relate to allegations of assault against on police officers)<sup>118</sup>
- ▶ Limit discretion to impose sentences below the minimum term for repeat offenders in cases of class A drug trafficking, burglary, or offences involving a weapon
- ▶ Change the law to allow an 18 year old to receive a whole-life tariff in exceptional cases and require courts to set longer tariffs in discretionary life sentence cases.<sup>119</sup>

## PRISON FAILS ON ITS OWN TERMS

Some might argue the aforementioned harms of prisons could be justified in the presence of an overall net gain – the reduction of crime – but the evidence does not show that punishment reduces crime. Historically, the original ‘penitentiaries’ owed their name to the religious notion that confinement and solitude would be rehabilitative for prisoners, whose crimes were believed to stem from individual sinfulness. Today, the rationale for prisons is usually assumed to be deterrence, or ensuring the safety of the law-abiding majority by imprisoning criminals. However, as the government’s own impact assessment for the policing bill concedes “there is limited evidence that longer custodial sentences reduce reoffending or have a deterrence effect on overall crime”.<sup>120</sup> Nor is rehabilitation working: almost half of incarcerated adults are already reconvicted less than a year after their release.<sup>121</sup> The policing bill’s proposal to decrease community rehabilitation could lead to even higher recidivism rates, the impact assessment acknowledges, due to the extra strain placed on family relationships – a key protective factor against reoffending.<sup>122</sup>

**“There is limited evidence that longer custodial sentences reduce reoffending or have a deterrence effect on overall crime”  
– government impact assessment**

If, then, prison is ineffective and fails on its own terms (deterrence, rehabilitation, and reducing crime), what is its purpose? Scholar and anti-prison activist Angela Davis argues that prison “functions ideologically as an abstract site into which undesirables are deposited, relieving us of the responsibility of thinking about the real issues afflicting those communities from which prisoners are drawn in such disproportionate numbers.”<sup>123</sup> The government is proposing to spend £90 million expanding the prison estate to meet the new “demand” for places created by increasing criminalisation under the policing bill,<sup>124</sup> and £4 billion on a broader prison building programme.<sup>125</sup> It is important to note that, rather than reducing overcrowding, prison expansion actually tends to lead to more prisoners and then more prison expansion, especially as the ‘prison industrial complex’ creates corporate incentives for prison growth (and in the UK, a higher proportion of prisoners are incarcerated in private prisons than the US or anywhere in Europe).<sup>126</sup> Instead, then, these resources could be spent more effectively and humanely on a public health approach which intervenes in harm by altering the root-cause social conditions highlighted by Davis.

As the WHO notes, providing jobs and child care produces far greater reductions in crime than the (hugely expensive) practice of mass incarceration.<sup>127</sup> This is precisely why, as the briefing introduction noted, the American Public Health Association recently passed a motion favouring “abolition of carceral systems” and building instead “just and equitable structures that advance the public’s health”, calling in particular for investment in the societal determinants of health such as housing and employment. While the government notes the need to “address the underlying drivers of offending, providing interventions early”,<sup>128</sup> the policing bill does no such thing. Instead, it entrenches and perpetuates a cycle of poor health, criminalisation, imprisonment and harm which itself inflicts violence, especially on minoritised communities.

## 2.4 GYPSY, ROMA AND TRAVELLER HEALTH

There are an estimated 300,000 Gypsy, Roma and Traveller (GRT) people in Britain,<sup>129</sup> a diverse range of communities, many from Irish Traveller or Roma ethnic backgrounds, who may have nomadic lifestyles or live in settled, permanent homes. Despite their cultural differences, GRT people are often grouped together under one acronym, to reflect their shared experiences of oppression.<sup>\*130</sup>

This section explains how specific measures targeting GRT people in the policing bill build on centuries of entrenched discrimination. While they will affect these communities in different ways – and will most directly impact those who practise a nomadic lifestyle – the bill will undoubtedly exacerbate existing health inequalities.

### RACISM, HOUSING AND HEALTH

It is vital to recognise that pervasive racism towards, and persecution of, GRT communities has a long history in the UK (and Europe more broadly).<sup>131</sup> Racist representations of GRT people often characterise these communities as “place invaders”<sup>132</sup> and innately “criminal”, and imply a relationship between nomadism and criminality.<sup>133</sup> These ideas feed interpersonal violence and hate crime – which one study found almost 80% of GRT people had experienced<sup>134</sup> – but are also, more importantly, both product and progenitor of discriminatory state practices, criminalisation and structural racism.

**Pervasive racism towards GRT communities is both product and progenitor of discriminatory state practices**

Local authorities in the UK have long failed to provide sufficient spaces on which GRT communities can legally live, let alone good quality sites. One 2016 study found that only 10 of 66 councils in south east

\* The designation ‘Gypsy’ usually refers to Romany or Romanichal Gypsies, Roma communities who settled in the UK centuries ago. ‘Roma’ is primarily used to refer to ethnically Roma migrants from Central and Eastern Europeans. While the majority of British Roma are no longer itinerant, a significant minority remains so and all are likely to face discrimination on the basis of other cultural signifiers. ‘Travellers’ is a loose and broad term for a range of traditionally itinerant communities, including Irish Travellers, who may now also live in permanent housing. We recognise the limitations of potentially homogenising or flattening groupings as GRT but use the term, following GRT-led community groups, to emphasise these shared and interlinked histories of oppression. See: Costache, I., (2018), “Reclaiming Romani-ness”, *Critical Romani Studies*, 1(1), 30-43; Richardson, J. and Ryder, A., (2012), “Setting the context: Gypsies and Travellers in British Society”, In *Gypsies and Travellers: Empowerment and inclusion in British society*, Bristol: Policy Press, pp. 3-20; Sigona, N., and Vermeersch, P., (2012), “The Roma in the New EU: Policies, Frames and Everyday Experiences”, *Journal of Ethnic and Migration Studies*, 38(8); “Frequently Asked Questions”, Friends, Families and Travellers, n.d., available at: <https://www.gypsy-traveller.org/about-us/frequently-asked-questions>; Women and Equalities Committee, “Tackling inequalities faced by Gypsy, Roma and Traveller communities”, 5 April 2019, available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html>.

England had planned for adequate site provision to meet GRT communities' needs.<sup>135</sup> As a result, GRT people are frequently forced into unauthorised settlements, often without proper access to water, education or healthcare. This housing insecurity, upheld through racism, leads to and compounds the socioeconomic marginalisation and severe health inequalities experienced by GRT communities.

While the NHS does not capture information about GRT health, creating vast knowledge gaps, we know that GRT communities experience significantly poorer health outcomes than the general population. Life expectancy for Travellers is 10-12 years lower and rates of infant mortality significantly higher.<sup>136</sup> Alongside physical and mental health impacts, discrimination and marginalisation also create widespread institutional mistrust.<sup>137</sup> This is a major barrier to healthcare access amongst GRT communities and becomes apparent in disproportionately low rates of routine vaccine uptake, heightening vulnerability to infectious diseases associated with poverty and marginalisation, such as measles and tuberculosis.<sup>138</sup>

## IMPACTS OF THE POLICING BILL

### THE POLICING BILL WOULD:

- ▶ Make 'trespass' a criminal offence and broaden the circumstances under which eviction can be triggered
- ▶ Lengthen the time people can be prohibited from returning to sites
- ▶ Restrict the number of vehicles permitted on a piece of land, and give police the powers to seize vehicles.<sup>139</sup>

GRT communities' housing struggles highlight, in microcosm, the way unaddressed structural issues harming minoritised communities are used to criminalise them. Local authorities' failure to provide legal sites forces GRT people into unauthorised encampments, from which police then hold powers to evict them.<sup>140</sup> This harmful situation will be deepened by the policing bill, which "takes an enforcement approach to something that is fundamentally a planning issue".<sup>141</sup>

**GRT communities' housing struggles highlight, in microcosm, the way unaddressed structural issues harming minoritised communities are used to criminalise them**

The policing bill's proposed new measures are outlined in the box above. These measures, in particular around trespass, eviction and police powers to seize vehicles – potentially including caravans in which people live – mean nomadic communities could be "effectively rendered homeless, forcing them into more precarity".<sup>142</sup> As such, the bill constitutes a renewed attack on GRT people's right to exercise their culture by moving freely, and will exacerbate a harmful cycle of racism, housing insecurity, criminalisation, exclusion and poor health.

## 2.5 PROTEST AND PUBLIC HEALTH

### THE POLICING BILL WOULD:

- Allow police to impose conditions on protests which may “result in serious disruption” or cause “serious unease” and create a statutory offence of causing “serious annoyance” or “serious inconvenience”
- Introduce Criminal Disruption Prevention Orders to prevent campaigners travelling to demonstrations
- Expand stop-and-search powers to grant police officers the ability to search protesters suspected – *without* “reasonable grounds” – of carrying so-called “lock-on” equipment.<sup>143</sup>

The policing bill’s most high profile measures propose to expand police powers to substantially curtail protest freedoms, as the box above outlines. Quite apart from the anti-democratic nature of these measures, we argue that restrictions on the right to protest will ultimately have a deleterious impact on public health.

Historically, vital public health advancements have been “achieved through hard fought battles that demand change”, not “handed out through benevolent powers”.<sup>144</sup> Examples range from the late 19th century matchwomen’s strike and other workplace organising pushing back against unhealthy working conditions,<sup>145</sup> through civil society activism around access to HIV/AIDS antiretroviral medicines via organisations like ACT-UP in the USA and the Treatment Action Campaign in South Africa, to Spain’s Yo Sí Sanidad Universal campaign for universal healthcare access.<sup>146</sup>

**“[Protest can constitute] a profound public health intervention”**  
– Dr Rhea Boyd

Similarly, if we take systemic racism seriously as a public health crisis, protests such as those organised by the Black Lives Matter movement can, American pediatrician Dr Rhea Boyd observes, constitute “a profound public health intervention”, since they enable society to “address and end forms of inequality”.<sup>147</sup> Indicative research from the US suggests that areas with Black Lives Matter protests between 2014 and 2019 did indeed see police homicide rates reduce between 15-20% in those years, with larger and more frequent demonstrations associated with the greatest reductions.<sup>148</sup> Accordingly, some recent thinking characterises civil unrest arising from police violence as a potentially important public health determinant – which may even provide direct health benefits to participants.<sup>149</sup>

Moreover, the impacts of the bill’s proposed measures will disproportionately affect already over-policed communities, further silencing the very groups whose voices need to be heard the most and preventing people from taking action to rectify their conditions. In the case of health workers – and other public sector

workers for whom a criminal record can seriously damage their career – the policing bill's repression of protest will limit their ability to take action to improve their conditions, which also has ramifications for public health.

# 3. CONCLUSION



**The policing bill is an attack on minoritised groups, especially Black communities and Gypsy, Roma and Traveller Communities. It silences those who want to use protest to speak out against injustice, and it seeks to position a carceral response to specific forms of violence as a ‘public health’ intervention. However, contrary to the evidence-based, holistic approach of public health which understands violence in its socio-economic context, the bill individualises both the causes of violence and, by effectively placing the responsibility for preventing violence on health workers, the solution too. As such, it epitomises a wider neoliberal political project in which the state defunds health, welfare and social care, while taking a punitive approach to the symptoms of resultant social problems.**

While the essence of the public health approach is to prevent violence before it occurs, the policing bill and other similar legislative initiatives push more people into the criminal justice system, perpetuating a damaging cycle of criminalisation, poverty and poor health. Policing and prisons inflict harm disproportionately on minoritised communities. Moreover, they fail on their own terms and will reproduce, rather than reduce, violence by compounding the social conditions which give rise to criminalised behaviours. While public health prides itself on engagement with communities, this bill and others like it serve to create barriers to accessing healthcare, as policing increasingly infiltrates health institutions, eroding confidentiality and trust.

We call for a fundamental paradigm shift away from punitive criminal justice measures such as the policing bill. We argue that the root cause of ‘serious violence’ is structural violence, a concept which encourages us to think more expansively about the nature of harm at the population level. Public health gives us important tools with which to reimagine the meaning of safety and security in transformative ways. Its fundamental contribution is to highlight the fact that true prevention begins upstream; the moment the police are involved, we have already failed. A public health approach to violence rooted in justice would take racism and state violence seriously and would ask the fundamental question: how do we create conditions for collective wellbeing in which all can thrive?

A recent article in the *British Medical Journal* calls such an approach “abolitionist public health”.<sup>150</sup> Critically, thinkers like Ruth Wilson Gilmore emphasise that the abolition of police and prisons is “about presence, not absence”, and about “building life-affirming institutions”.<sup>151</sup> The American Public Health Association’s 2021 call for “moving towards the abolition of carceral systems and building in their stead just and equitable structures that advance the public’s health”, such as through investing in housing and employment, aligns with a transformative justice approach rather than a criminal justice one.<sup>152</sup> Also in the USA, the People’s Response Act proposed by Congresswoman Cori Bush and supported by a range of grassroots groups, seeks

to begin transforming public safety, for example by funding a federal first responders unit comprising social workers, mental health counsellors and substance use counselors.<sup>153</sup>

We urge more of the UK health community to engage seriously with these ideas. We would emphasise that they are not to be dismissed as marginal. Indeed, former police chiefs have themselves said that the policing bill will “exacerbate violence”, putting “already marginalised communities at further risk of harm”<sup>154</sup> and have argued that cutting poverty and inequality is the best way to reduce crime.<sup>155</sup> The health community must challenge creeping erosion of confidentiality and co-option of the language of public health. We must resist the policing bill as well as all further securitisation attempts, and vigorously assert an alternative public health vision grounded in reclaiming funding for institutions which work with and serve communities, rather than punishing them.

# FURTHER RESOURCES

## READING

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## ORGANISATIONS & NETWORKS

- Docs Not Cops: [docsnotcops.co.uk](http://docsnotcops.co.uk)
- Race & Health: [raceandhealth.org](http://raceandhealth.org)
- Healing Justice London: [healingjusticeldn.org](http://healingjusticeldn.org)
- Centric Lab: [thecentriclab.com](http://thecentriclab.com)
- Medical Justice: [medicaljustice.org.uk](http://medicaljustice.org.uk)
- London ACEs Hub: [londonaceshub.org](http://londonaceshub.org)
- Black Lives Matter UK: [blacklivesmatter.uk](http://blacklivesmatter.uk)
- United Families and Friends Campaign: [uffcampaign.org](http://uffcampaign.org)
- Inquest: [inquest.org.uk](http://inquest.org.uk)
- StopWatch: [stop-watch.org](http://stop-watch.org)

- Sisters Uncut: [sistersuncut.org](https://sistersuncut.org)
- London Campaign Against Police and State Violence: [lcapsv.net](https://lcapsv.net)
- Northern Police Monitoring Project: [npolicemonitor.co.uk](https://npolicemonitor.co.uk)
- NetPol: [netpol.org](https://netpol.org)
- Liberty: [libertyhumanrights.org.uk](https://libertyhumanrights.org.uk)
- Sistah Space: [sistahspace.org](https://sistahspace.org)
- No More Exclusions: [nomoreexclusions.com](https://nomoreexclusions.com)
- 4Front Project: [4frontproject.org](https://4frontproject.org)
- Tottenham Rights: [tottenhamrights.org](https://tottenhamrights.org)
- Community Action on Prison Expansion: [cape-campaign.org](https://cape-campaign.org)
- Cradle Community: [@cradlecommunity](https://@cradlecommunity)
- Women in Prison: [womeninprison.org.uk](https://womeninprison.org.uk)
- Friends, Families, Travellers: [gypsy-traveller.org](https://gypsy-traveller.org)
- Release: [release.org.uk](https://release.org.uk)
- Abolitionist Futures: [abolitionistfutures.com](https://abolitionistfutures.com)

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