

Broadening the public health approach to policing

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ABSTRACT

There is growing interest in a public health approach to policing. In Britain, it has attracted major government investment and is advocated as a way to improve understanding and prevention of violence. We largely support efforts better to integrate public health and policing. We do, however, argue in this paper that the current conception of public health is unduly narrow, focussing overwhelmingly on early intervention and paying little attention to situational measures directed at more immediate causes of crime. We argue that the neglect of situational intervention rests on a partial interpretation of the public health literature, and ignores a long history of situational measures being effectively used to reduce harmful behaviours. If a public health approach is to generate improvements in policing and crime prevention, we argue that a broader conception of public health is needed.

INTRODUCTION

Interest in a public health approach to policing has increased significantly in the past decade. The approach is now widely advocated in Britain by politicians, practitioners and academics. It is increasingly impacting funding and practice around violence reduction, most obviously through investments in Violence Reduction Units (£35 m) and the Youth Endowment Fund (£200 m) (Brown, 2019). References to a public health approach also appear in key policy documents including *Policing Vision 2030*¹ and the Government's *Beating Crime Plan*² and *Serious Violence Strategy*.³ Developments in Britain reflect similar developments in the USA, where the role of public health has figured large in debates about the prevention of gun violence (Braga, 2022).

Enthusiasm for public health as a framework to inform policing can be attributed to several factors. Public health is an applied science with a long history and many successes. Lives and livelihoods are clearly better for advances in public health. There are many convergences between policing and public health, both in terms of *function* (e.g. responding to calls about violence, road traffic collisions, mental health concerns) and *effects* on personnel (e.g. stress, trauma, suicide ideation). There are numerous case studies of successful police-health collaborations, most notably the Cardiff model for violence prevention⁴.

Moreover public health processes—define and monitor a problem, identify risk and protective factors, develop and test prevention strategies, facilitate widespread adoption⁵—share much with SARA processes in police problem-solving—scanning, analysis, response and assessment (Christmas and Srivastava, 2019).

We largely support the embrace of public health, and have written previously on how developments in public health might profitably be applied in policing (Sidebottom *et al.*, 2012) and criminology (Sidebottom and Tilley, 2011). We are, however, concerned that the common conception of public health is unduly narrow, and reflects a partial interpretation of the public health literature. The crux of our argument is this. A public health approach to policing, as currently conceived, focusses overwhelmingly on population-based, early intervention designed to address the so-called ‘causes of the causes’ of crime, often referred to as adverse childhood or community experiences (ACEs). Situational measures focussed on more immediate causes of crime are largely absent from discussions of a public health approach to policing. This disregard of situational interventions is noteworthy for three reasons. First, it is not a true reflection of public health, within which there are many examples of situational measures being used to help reduce threats to public health—think seatbelts, smoking bans and COVID-19 lockdown restrictions. Second, disregard of situational interventions risks ignoring the extensive body of evidence which demonstrates the effectiveness of situational measures to reduce crime, including violence (see Guerette, 2009; Eck and Guerette,

⁵<https://www.cdc.gov/violenceprevention/about/publichealthapproach.html>.

¹<https://www.npcc.police.uk/SysSiteAssets/media/downloads/publications/policing-vision/policing-vision-2030.pdf>.

²<https://www.gov.uk/government/publications/beating-crime-plan>.

³<https://www.gov.uk/government/publications/serious-violence-strategy>.

⁴<https://www.cardiff.ac.uk/documents/2665796-the-cardiff-model-for-violence-prevention>.

2012). And third, a prevention strategy oriented towards population-based, early intervention marks a significant departure from other highly effective crime prevention strategies—most notably problem-oriented policing (Hinkle *et al.* 2020), hot spots policing (Braga *et al.* 2019) and focussed deterrence (Braga and Kennedy, 2021)—all of which are tightly focussed and direct prevention efforts at those people and places where crime is repeatedly found to concentrate.

To be clear: the argument presented here in no way minimizes the importance of and evidence for early intervention and addressing ACEs (for a review, see Homel and Thomsen, 2017). Attending to ACEs is important in and of itself. But emphasizing early intervention, we argue, risks steering police responses unnecessarily towards a particular understanding of criminal behaviour and with it the neglect of preventive measures that are not to do with social inequality but which nevertheless are shown to reduce crime and the suffering it causes, often with immediate as well as enduring effects. If a public health approach is to bring about improvements in policing and crime prevention, we argue that a broader conception of public health is needed in accordance with its history of pragmatism.

The remainder of this paper is organized around three questions which are central to our argument presented here. The first question asks: ‘where is the evidence to show that the focus so far in public health approaches to policing largely ignores situational interventions?’. We answer this question by analysing the content of eleven recent policy documents relating to policing and public health in Britain. The second section examines the question: ‘where is the evidence to show that situational interventions have been effective at reducing harmful behaviours in public health and crime prevention?’. We answer this question by presenting case studies where violence (and other harmful behaviour) has successfully been reduced through changes to the environment. The final section, building on that which comes before, considers the question: ‘what now for policing and public health?’ Here we call for a broader conception of public health in policing, one which pays greater attention to situational interventions and therefore is more congruent with public health measures as they apply to other public health issues.

ON PUBLIC HEALTH APPROACHES TO POLICING AND THE NEGLECT OF SITUATIONAL INTERVENTIONS

Before going any further, it is important for us to set out what we mean by situational interventions in the context of policing and crime prevention. We take situational interventions to mean changes to the immediate environment in which crime takes place. Crucially, situational interventions do not attempt to change the dispositions of individuals or the sources that might give rise to those dispositions. Situational interventions instead focus on removing or reducing opportunities for crime in the settings where crime occurs, be that through increasing the (perceived) risks of crime, increasing difficulty, reducing the (perceived) rewards from committing a crime, as well as through reminding potential offenders that committing crime is inexcusable and avoiding provoking criminal behaviours (Clarke, 1980, 1992, 1995; Eck and Clarke, 2019). The focus of ‘situational crime prevention’ is normally on specific crimes and the

immediate situations that are conducive to them, rather than on the person and their criminality. An action research approach is typically taken whereby preventive efforts are trialled, adopted, adjusted or abandoned according to the results. As we will show in the next section, both public health and crime prevention share a rich history of using situational interventions to reduce harm.

We now turn to the question of whether situational interventions are considered in popular accounts of a public health approach to policing. To assess this, we reviewed the content of a sample of documents relating to policing and public health. In the interests of impartiality, we took as our sample those documents identified in the recent *Policing and health collaboration: Landscape review 2021*, published by the College of Policing (2002) and developed with support from the Public Health and Policing Consensus Task Force and Network. As part of their review, the authors identified ten key policy documents published between 2018 and 2021 intended to support a public health approach in policing (for a list see Annex 1). To these ten we added a further document published in 2023 by the Association for Police and Crime Commissioners and Public Health and Police Collaborative: ‘A guide to taking a public health approach for Police and Crime Commissioners and their officers.’ We add this document because of the crucial role played by Police and Crime Commissioners in shaping local policing in England and Wales. A reading of these documents revealed three themes considered relevant to this paper.

First, it is clear that a public health approach to policing, as represented in the assessed documents, is strongly oriented towards population-based, early intervention programmes. This is illustrated in the College of Policing’s seven principles of a public health approach (2019) which include ‘seeking to prevent an issue for your population as a whole, and intervening early with at-risk groups’. Moreover, many of the initiatives described in the sampled documents are early intervention programmes. An example is provided by the Sussex Violence Reduction Unit: ‘Partners have adopted a public health approach that has included embedding tactics such as: early interventions to help vulnerable young people and educate them on the consequences of criminality; training staff in schools and hospitals; and working with local community organizations’.

The second noteworthy theme concerns the rationale for prioritizing early intervention programmes. Many of the sampled documents refer to the criminogenic effects of ACEs such as poverty, neglect and exposure to domestic abuse. ACEs are cited 25 times in Christmas and Srivastava (2019). They are cited 21 times in the recent guide for Police and Crime Commissioners. The use of early intervention is generally proposed as a way to mitigate the negative effects of adverse experiences in early life, and thereby to reduce the likelihood of offending, victimization, and other negative outcomes.

Those familiar with recent public health discussions will not be surprised that accounts of a public health approach to policing focus mainly on population-based, early intervention directed at the ‘causes of the causes’. To a large extent this has become the standard model of public health, and is an expressed preference of many public health advocates, often captured in the mantra: prevention is better than cure. What is surprising, to us at least, is the extent to which a preference

for early intervention appears to have side-lined situational approaches as a means to reduce violence. This brings us to our third theme. None of the assessed documents explicitly mentioned situational crime prevention. This includes guidance around the recent *Serious Violence Duty*, whose stated purpose is to work collaboratively better to understand and reduce serious violence. Given that there is extensive evidence to show that situational crime prevention is effective at reducing crime (Guerette, 2009; Eck and Guerette, 2012), and given that a core feature of public health is to be evidence-based, we find the neglect of situational crime prevention noteworthy.

Perhaps we shouldn't be surprised at the lack of attention paid to situational crime prevention. Studies show that as humans, we seem hard-wired to explain other peoples' behaviour in terms of dispositional factors and to discount the causal role of situational factors. Put differently, we tend to blame people rather than understand situations. Psychologists have a name for this bias: the 'fundamental attribution error' (Ross and Nisbett, 1991), and it can act as a source of resistance to efforts to modify behaviour through situational means. Take the problem of unintended shootings in the USA—a problem in whose prevention the police as well as public health have an interest. Distinguished public health scholar David Hemenway has written at length and with frustration at injuries caused by guns in the USA. The gun lobby is invested in the fundamental attribution error. They stress that people kill people, not guns. We must, they argue, look to the perpetrator rather than the weapon to reduce injuries and fatalities from shootings. This means severe punishment for offenders or attention to the root causes of their violence. But we know that controls on the availability of guns can reduce (accidental as well as deliberate) injuries from shootings (as described below). Moreover, Hemenway shows that changes in the design of guns and the market in guns, short of legislation restricting ownership, can reduce injuries and fatalities (Hemenway, 2017). These design changes can make it difficult to kill someone (or oneself) accidentally and can also make illegal use of firearms riskier and hence less likely.

ON PUBLIC HEALTH AND THE EMBRACE OF SITUATIONAL INTERVENTIONS

If public health is all about early intervention then our argument here would be null and void. Public health, however, is not all about early intervention. Indeed, to quote Hemenway and Miller, 'a virtue of the public health approach is that it is *pragmatic* rather than *dogmatic*' (2013, p. 3, emphasis added here). We interpret this pragmatism as a willingness to engage in all and any intervention in pursuit of finding that which benefits the most and harms the least. Hemenway and Miller say as much in the same paper, arguing that a distinctive feature of public health is a commitment to being 'broad and inclusive—it examines all possible interventions, including changing social norms and passing new laws, and it tries to engage as many people and institutions as possible in a multifaceted way' (2013, p. 1). And so, whilst public health does *favour* population-based early intervention, it is not the case that public health eschews efforts to change the environment in the interests of improving health outcomes. Indeed, some of public health's major success stories have come from

situational measures—the manipulation of immediate conditions that jeopardize public health. Here are some examples.

John Snow's work in the mid-nineteenth century is known to all those concerned with public health (Snow, 1856). Famously, Snow mapped cases of cholera in London. Detailed analysis of the sites where infections were most common showed that they were concentrated in places served by particular water suppliers. This observation eventually led Snow to recommend that a handle be removed from a pump that drew water that was infected. Snow comments on the very poor living conditions found amongst those dying from cholera, but his painstaking analysis also showed that in some places the better off suffered higher rates of cholera than those nearby who were worse off. It depended on the water supplier. Situational measures changing the available water supply were crucial to generating improvements in public health.

Ignaz Semmelweis's nineteenth century work on childbed fever in the Vienna General Hospital furnishes another example of the effective use of situational measures (Semmelweis, 1860). Semmelweis noted persistently higher rates of childbed fever in wards served by physicians compared to those served by midwives. He tested several different theories as to why this was the case, before undertaking an experiment involving hand washing in chlorinated lime as doctors went into maternity wards from the adjacent morgue where they conducted autopsies. The rates of childbed fever then fell to a level similar to those in the ward served by midwives. The situation in the hospital—morgue located next to children's ward and little provision for handwashing—had facilitated transmission of childbed fever in the wards served by the doctors. Changing it was a quick way to effect improvements. Semmelweis's insights are part of a body of work showing the importance of hand hygiene (see Stone, 2001). Changing situational contingencies has been important in improving hygiene in the treatment of patients in hospital. These improvements translate into public health benefits.

A more recent example can be found in the work of Peter Pronovost (Pronovost and Vohr, 2010) and Atul Gawande (2011). Both have conducted important studies focussed on reducing unintended adverse events in hospitals by looking in detail at the situational contingencies in which they occur and what might be done to remove those contingencies. The kinds of adverse events that occur can take place, for example, in the course of surgery, in the administration of drugs, and in the insertion of catheters. By changing the situations within hospitals, through adopting different procedures or implementing simple checklists, they show that adverse events can be reduced. In doing so, they provide lessons for public health: by attending to the details of procedures, we can find out how they can go wrong and what changes are needed to reduce risks.

What about public health concerns more closely aligned to policing and crime prevention? For this we turn again to David Hemenway, who has written up a variety of 'success stories in injury and violence prevention', focussing heavily on situational contingencies (Hemenway, 2009). One such success story relates to suicide. Hemenway gives an account of the reduction in suicides in Britain following the gradual switch from town gas to natural gas, the former containing lethal levels of carbon monoxide. The change in gas supply removed a

convenient and pain-free method of killing oneself that had literally been on tap. The introduction of natural gas did nothing to lessen the root causes of suicide ideation. It just took away one convenient method (see also [Clarke and Mayhew, 1988, 1989](#)). It thereby saved lives. Crucially, restricting access to one method of suicide did not lead to corresponding increases in other (more available) methods of suicide, as would be predicted by those who explain behaviour by way of dispositions. Displacement to other methods of suicide was minimal. There is now a large body of evidence to show that restricting access through changes to the environment can reduce suicide (see [Okolie et al., 2020](#)).

A third of Hemenway's examples relate to youth homicides in Boston, Massachusetts. Analysis of the problem revealed that most victims and offenders were associated with youth gangs in conflict with one another. There were 60 of these gangs, comprising 1% of the relevant age cohort in Boston. Gang members carried guns, many out of fear that they would lose face if they walked away from a fight. Guns were mostly obtained through illegal trafficking. Part of the intervention Hemenway describes focussed on disrupting the illegal trade in guns. Another part directly targeted publicity to gang members assuring them that severe penalties would follow from any incident of serious violence, and that it would also trigger much-intensified police enforcement attention to all gang members. This enforcement attention would include, for example, curfew checks, attention to all minor violations, crackdowns on drinking in public, strict application of street drug laws, rigid follow-up on adherence to probation conditions, and pursuit of all outstanding arrest warrants. This response to violent incidents itself garnered extensive publicity. Youth homicides quickly fell (see [Braga et al., 2001; Kennedy, 2020](#))⁶.

Beyond the case studies described above, Hemenway makes some important general points about public health measures relating to injuries, including those that follow from violence. Rather than focussing only on *why* people behave in ways that lead to injuries, Hemenway suggests that we need also to focus on *how* those injuries come about and what we can do to prevent them from occurring. He illustrates this point using the example of road traffic injuries, which have fallen steeply and steadily over the past 60 years. As he says,

It wasn't until the 1950s that public health physicians asked a different question, not *who* caused the accident, but *what* caused the injury. Just looking at it in a different way, they thought, oh my goodness, people were being speared by steering wheels that went right through their chest. Their face is being lacerated by windshields, which were not made of safety glass. They were being thrown from the car and their heads would hit the cement or the hood of the car and they would die. They would leave the road for one second and they would hit lampposts and trees which were planted right along the sides of the highways. Public health physicians were saying, 'We don't plant lampposts along the side of airport runways. That wouldn't be very smart. Can't we make cars safer?

Can't we make roads safer? Can't we make the emergency medical system better?' ([Hemenway, 2019](#))

Seat belts, airbags, collapsible steering wheel columns, rumble strips, automatic lane corrections, safety glass, audible warnings of potential crashes, automatic braking when we might collide with a pedestrian, and crumple zones, for example, have all reduced injuries, with public health benefits, and also reduced demands on the police. They have not made people drive better or addressed the reasons why some people might drive recklessly. Hemenway's focus on *how* traffic-related injuries are brought about and how suicides are committed, rather than why either occurs, echoes the work of Snow on Cholera and Semmelweis on Childbed Fever. Snow and Semmelweis were concerned with how diseases were transmitted and what could be done to inhibit that transmission. The COVID-19 lockdown restrictions are another more recent effort by public health practitioners to inhibit disease transmission through changing the environment and associated social norms.

Hemenway's examples relating to crime, violence and injury, and the use of situational measures to prevent them, are far from the only ones. Here are three more.

Accidental and deliberate poisoning. Incidents of poisoning have reduced significantly following changes in the design of packaging. In 1982, seven people in Chicago died following the introduction of poison to Tylenol, an over-the-counter pain-killer. This event caused panic at the time, but also kick-started a revolution in the development of tamper-proof packaging which has prevented accidental deaths (e.g. of children) as well as murders ([Clarke and Newman, 2005](#)).

Driving while intoxicated. In New South Wales (Australia) in 1982, an initiative was taken involving random breath testing (RBT) applied to large numbers of drivers ([Homel, 1994, 2004](#)). The law enabling RBT was widely publicized and rigorously applied. It was not a short-term crackdown but a new form of policing. The arrest rate for those tested following the introduction of RBT was 0.4%. There was an instant precipitous drop of 19.5% in all fatal crashes, a fall of 30% during holiday periods ([Homel, 1994](#)), and a reduction of 36% in those that were alcohol-related ([Homel, 2004](#)). The falls were maintained for over a decade. [Homel \(2004\)](#) estimates that by mid-1991, there had been a cumulative sum of at least 2,000 fewer fatal accidents than would have been expected on the basis of previous trends. It seems likely that over time drink-driving habits had changed in accordance with active law enforcement.

'Glassing' and facial disfigurement. In 1997, almost half of all serious assaults in central Liverpool involved injuries from bottles or glasses. A highly publicized campaign focussing on removing glasses from the streets was put in place ('Operation Crystal Clear'). Eventually a local bye-law was passed giving police officers the powers to seize open bottles and glasses from any person carrying them in the City Centre. The initiative involved partnership work between Merseyside Police, Liverpool Health Authority, Liverpool City Council, Liverpool Vision, and the Brewers and Licensed Retailers Association ([Merseyside Police, 2001](#)). Operation Crystal Clear led to a 75% fall in the number of people treated for city centre glassing's at Royal Liverpool University Hospital (12/1000–3/1000). Another project to reduce glassing's ran in the western division of Lancashire. It included

⁶We note in passing a related debate about whether public health approaches to policing place sufficient value on the role of arrest and incarceration as possible mechanism to reduce crime ([Cook and Ludwig, 2019](#)).

the replacement of ordinary glasses that break into sharp shards causing serious facial injury when used as a weapon with hardened polycarbonate glasses that do not do so. Where venues used the new glasses, the average number of glass breakages fell from 17 to 0, and the proportion of customers suffering glass-related injuries fell from 11 to 6% (Clarke, 2020).

SO WHAT FOR POLICING AND PUBLIC HEALTH?

Public health and policing have multiple overlapping substantive interests, including the prevention of road traffic accidents, drug-related deaths, arson, various behaviours resulting from mental illness, alcohol-related injuries, suicides, armed robberies, and incidents of domestic violence, as well as serious assaults, shootings and stabbings. They also share a need to engage in partnership work, not only with each other but also with a range of partners including local authorities, fire services, licencing authorities, non-for profit organizations, community groups, NGOs and members of the private sector. In addition, both have embraced problem-solving which requires good, shared data, skilled analysis, and a commitment to evidence-based policy and practice. Indeed, being specific about the problem to address; testing hypotheses about what lies behind it; looking pragmatically for potential points of intervention to reduce harms; checking whether the measures put in place have been successful, unsuccessful, or have backfired; and then learning lessons from the results, both in the local situation and more generally, have been characteristic of the best in policing and public health. When it comes to shared problems, they are obvious bedfellows.

The many affinities between public health and policing make the recent ways of construing public health approaches to violence rather narrow and curious. They misrepresent the range of interventions used in public health. We are concerned that a public health approach to policing which focusses mainly on early intervention may lead to the neglect of practical situational interventions which can help reduce violence problems now and in the long-term.

To repeat: none of our argument is to minimize the value of attending to ACEs and the effects they have on life chances, including those related to education and employment as well as health and crime. Policies and practices aimed at reducing ACEs certainly don't turn on their association with criminal involvement or criminal victimization. Attending to ACEs has intrinsic value as an end in itself. If measures failed to reduce criminality or victimization in the long-term but otherwise improved the prospects of those in receipt of an intervention, then the case for those measures would not be weakened. Moreover, taking account of the social conditions limiting chances of law-abiding lives in the treatment of offenders could be warranted on grounds of justice as well as effectiveness in reducing future criminality.

This paper is not, therefore, an argument against using a public health approach to policing. Rather, it is an argument in favour of broadening it to include a focus on the situations that stimulate, permit, or give rise to violence and on what might be done to change those situations to produce less harm. This orientation recognizes the strong evidence in favour of situational crime prevention but also remains true to major public health

breakthroughs. Such a broadened approach to collaborative police and public health work could also apply to other shared interests, for instance the prevention of road traffic accidents, suicides and alcohol and drug-related injuries.

ANNEX 1: DOCUMENTS REVIEWED FOR THIS PAPER

- 1 Policing, health and social care: Working together to protect and prevent harm to vulnerable people (2018).
- 2 Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children (2018).
- 3 Public health approaches in policing. Public Health England and College of Policing (2019).
- 4 Principles of a public health approach in policing (2019).
- 5 Violence Reduction Unit interim guidance (2020).
- 6 PCCs making a difference: Violence Reduction Units in focus (2020).
- 7 Police, Crime, Sentencing and Courts Bill 2021: Serious Violence Duty factsheet (2021).
- 8 Serious Violence Duty: Strategic needs assessment guidance (2021).
- 9 Serious Violence Duty: Draft guidance for responsible authorities (2021).
- 10 Transforming the public health system: Reforming the public health system for the challenges of our times (2021).
- 11 APCC and Public Health and Police Collaborative (2023). A guide to taking a public health approach for PCCs and their officers.

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