EDITORIAL

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Collaborations for CSWB: The groups that everyone needs to join

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Having spent nearly 30 years in the US public safety and community health fields, 26 years in active law enforcement, and the past 9 years working to support community safety and well-being within my community, other municipalities, counties, and states across the country, I am inspired to see public safety, public health, and community partners working together with common goals, saving lives and positively impacting vulnerable populations across all communities. Throughout the early part of my public safety career that was rarely the case, with these partners often operating in silos.

As a municipal police officer, former drug task force investigator, and later chief of police, having started my career in the mid-1990s, my training and focus were almost always reactive, responding to, investigating, and working to solve crimes. Although there were and continue to be countless effective community policing programmes, many of which I participated in, I discovered that my and my fellow officers' daily focus was always incident-driven, centred on crimes, crime statistics, number of arrests, and traffic citations. We judged our officers' productivity not by evaluating their positive impact on improving the community safety and well-being of our residents, but by how many arrests, drugs seized, traffic stops, citations, and calls for service they could tally. We neglected to prioritize and assess the officer engagements, proactive outreach, and positive interactions within our communities, as an outcome measure of their impact and success.

The tools on our tool belts for substance use and mental health disorder issues were extremely limited. In years past, many communities addressed these issues by either filing a court order for mandated treatment, convincing a vulnerable person to go in the ambulance to the emergency department (where they were often sitting idle for hours), or effecting a minor arrest charge to diffuse a situation. We would often then return to this same location, engaging the same individual(s) days later, repeating this same cycle, over and over. What we lacked was the awareness and understanding that these disorders should be treated like other medical disorders and not through traditional enforcement tactics.

For me, my perspective changed as I began thinking about alternatives to arrest for these calls, listening and learning from public health and community-based organization experts. My philosophy changed dramatically in 2013 when I met a local mother from my community who championed as an agent for change. Due to the personal impact the opioid epidemic had on this mother and her family, she pledged to find any state or local government official who would listen to her, and help her, other families, and individuals who were being overwhelmed by opioid use disorder. The only leader to answer her letters was my boss, the police chief. As a police supervisor, at the time, I met with this mother at her local, grassroots coalition meetings, listening to her and other family's personal stories whose lives were being ravaged by this epidemic. This mother's passion and leadership caused me to recognize that we (law enforcement leaders) needed to change our responses to these behavioural health situations, learning how to police with a public health perspective.

My journey began with realizing that we (police) had a "front row seat", one which we could leverage to partner and collaborate with community members, community-based organizations, persons with lived experience, and other professionals that we should have but weren't communicating with. Through our local coalition, we created a volunteer drop-in centre at a local church to support persons with substance use disorders (SUDs), family members, and loved ones, which saw over 1,000 people come through our doors in just under 18 months. While volunteering at the drop-in centre, as a local police supervisor, and later chief of police, I was able to see the power and positive impact that a grassroots-led effort, in partnership with law enforcement, could have to forge a system of change. We became the group that you did not, not want to be a part of.

The drop-in centre quickly evolved into a formal collaboration across our entire county, bringing police, community coalitions, hospitals, treatment providers, government agencies, peer recovery organizations, and public health experts together. We focused on proactively engaging, post-overdose survivors, their family members, and loved ones impacted by overdoses and SUDs. Our collaboration would become one of, if not the first US county-wide outreach initiatives (population of 550,000), in which police officers, and peer recovery specialists, alongside clinicians and social workers, would respond to vulnerable persons with SUDs at their homes and

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in their communities, meeting with them in living rooms and at kitchen tables, with the sole purpose of supporting them and helping connect them to treatment and behavioural health professionals.

We learned about the strong stigma surrounding SUDs, the importance of using proper language, and harm reduction, and that the treatment system has many challenges and obstacles that prevent those in need from finding support and recovery. I began hearing about other community-based models and initiatives that had been implemented in the United States and Canada. I, as an early adopter of what was being referred to as pre-arrest diversion, deflection (deflecting vulnerable populations away from the justice system and emergency departments, connecting them instead to treatment, care, and recovery), immersed myself in learning as much as possible from the public health and community-based experts.

Our county-wide deflection initiative quickly realized our efforts could not focus solely on opioid use disorder and overdoses, although those were our highest-risk populations. We adapted the deflection co-response model to address persons at acutely elevated risk (AER), mental health disorders, drug-exposed children, and victims of domestic violence, sexual assault, and other traumatizing incidents. Our deflection initiative's goals expanded to tend to the needs of all underserved, marginalized populations. We worked with our drug court judges, prosecutors, and jails to ensure that we were truly promoting a county-wide, whole system of care approach, meeting vulnerable persons along all the intercept points.

Having established our co-response initiative, already aware of the first US-based "Situation Table" an hour away in Chelsea, MA, known as the Chelsea Hub (Chelsea 2023) (https://chelseapolice.com/community_services/hub.php), our deflection leadership team recognized the need to incorporate a situation table, which would expand our collaborative reach meeting the needs of those persons and families at AER. We knew through our overdose response efforts who many of the highest risk of our high-risk populations were (i.e. those at AER). We built four situation tables across our county to support and complement our deflection efforts. We ensured that the situation tables would integrate with the county-wide deflection initiative, and not exist as a separate, siloed model. Our public health partners and colleagues (the "smart people in the room") had taught us ("the cops") to recognize that our efforts would be more impactful and efficient, by building upon our strong collaborative partnerships.

As my team and I at O2SL and QRT National engage with communities, counties, and state leaders across the country (having now partnered and collaborated in 27 states), we see our role as being ambassadors to improving community safety and well-being through a whole system approach, utilizing the recognized best practices that continue to evolve through deflection initiatives in partnership with situation tables. These initiatives complement one another so effectively that you truly become the "group that everyone wants to be a part of". Let's continue to push the envelope so that public safety, public health, and community partners eliminate silos and work together to help our communities save lives. There really is no excuse not to.

CONFLICT OF INTEREST DISCLOSURES

The author has continuing business interests that include providing advisory services to communities, police services, and related human service agencies.

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