Journal of
COMMUNITY SAFETY & WELL-BEING

Envisaging the Future Special Supplement Issue: Foreword

Norman E. Taylor*

When we launched this peer-reviewed, open-access journal in 2016 (Taylor, 2016), I wrote in my opening Editorial about the dual challenges of discovery and invention.

> We may discover that society generally acts in ways that are regular and predictable enough to be defined. But we must also invent the experimental techniques, research methods and organization for testing, exhibiting, and ultimately applying what we learn. In effect, we must invent the means to travel from research, to practice, to the ultimate alignment of the systems that are intended to serve.

In outlining the ambitious mission upon which we were then embarking, I added:

> [The Journal stands] to both contribute and gain from wider participation in global efforts to advance new solutions, and to back up those solutions with genuine knowledge, proven practices, and relevant social science research. Together, we can discover and invent, and with the clarity of social science to guide us, we might just change the way we all do business.

In May of 2016, I also offered this: "This Journal emerges into a time of important and necessary discovery."

Oh, what times they have turned out to be.

Thus, it is with enormous pride on behalf of our full journal team that today I introduce this milestone publication, our first Special Supplement Issue. It is an issue simply packed with the fulfillment of many of those early ambitions.

The in-depth lead-off Editorial from our Guest Editors, along with the Editorial from Lauren Jackson, representing our Supplement Sponsor, both do a far better job than I could of positioning the "Envisaging Healthy and Safe Communities: Worldwide Lessons in Police and Public Health Partnerships" research project and the resulting papers. Suffice it to say the scope is truly global, the span of the collaborative models explored is broadly instructive, and the work of the contributing authors is simply equal parts inspired and inspirational.

One of the challenges of publishing a truly global collection of voices in an English-language publication is to balance consistency and readability with the authenticity of the works. We have tried our best to achieve the former with full respect to the latter. It is important, in our view, that the local nuances in language and practice, along with the wide variety of political structures and social realities reflected, continue to come through as clearly as possible. We thank all of the contributing authors for their patience, flexibility, and cooperation throughout all stages of this production. We extend similar thanks to the wide array of peer reviewers for their work in supporting these aims, while ensuring high standards of editorial quality in all of the papers.

In leading this effort, Guest Editors Nick Crofts and Marc Krupanski have been outstanding and tireless in their multiple roles as mentors to the authors, ambassadors for the mission, and curators of an exemplary worldwide collection. In cooperation with Senior Contributing Editor Matt Torigian, they have all passionately championed this project every step of the way.

Our unparalleled publishing team at SG Publishing have held the baton throughout to ensure that every stage of the publication process would remain on track and on tempo, while gently guiding and supporting an enormous cast, yours truly included.

And finally, none of this would have been possible without the generous support of our Supplement Sponsor, Deloitte. As a worldwide professional firm that frequently serves and interacts with the entire spectrum of community safety and well-being sectors, they have clearly recognized the urgency of responding to our times and the importance of advancing a rich and growing body of evidence to support proven and promising practice.

We extend to them our gratitude for helping us all to share, to discover, and to invent our way to better solutions for global society.

CONFLICT OF INTEREST STATEMENT

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

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EDITORIAL

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Envisaging the future of policing and public health: A commentary on the findings

Marc Krupanski* and Nick Crofts†

There is a growing recognition globally that we are in urgent need of new approaches to address long-standing societal problems—behavioural health issues, such as drug use and mental health; poverty-related issues, such as homelessness, loitering, and vagrancy; and serious personal crime, namely, gun violence, sexual violence, and gang activity. There is increasing acknowledgment that our usual ways of addressing these problems have not worked or, worse still, have systematically made things worse. This "standard" approach has involved an over-reliance on punishment, coercion, and incarceration, a broad-reaching and one-size-fits-all response to problems which can be highly individualized, contextual, and specific to certain people and places.

In jurisdictions around the world, practitioners, policymakers, researchers, and community members have noticed an emphasis on punitive, enforcement-based approaches that centre on the coercive powers of law enforcement, a steady underinvestment in health and social services, or a public health apparatus that can take its own punitive approach. And, in country after country, we far too frequently see the sectors that are intended to uphold life, safety, and well-being—namely, law enforcement and public health—operate in silos or even in competition, when they are clearly addressing the same problems with the same root causes.

The recognition has been building for some time that we cannot solve enduring problems with the usual strategies and approaches that have been tried year after year with little success. Actors across the public safety and health spectrum are voicing this concern. Many in law enforcement express frustration with what seems like an endless list of societal problems that they are ordered to resolve, while being held to a limited and inadequate enforcement toolbox with which to do so. The result is the "revolving door" phenomenon whereby people are arrested and detained on a range of low-level and nonviolent offenses only to be released and re-arrested, with each arrest and incarceration increasing the likelihood of further arrest and incarceration.

Likewise, community members, especially those from marginalized communities—such as racial and ethnic minorities, poor people, people experiencing homelessness, people who use drugs, sex workers, LGBTQ people, people living with mental illness—have also expressed frustration and outrage at feeling discriminated against, having their rights violated, or being targeted for abuse or extortion.

More recently, public health practitioners and researchers have begun to voice concerns about problems for which they feel they can offer solutions but find themselves excluded from the table for political, funding, or structural reasons. This initially focused on issues related to behavioural health, such as blood-borne infections among people at risk for HIV or Hepatitis C, for example, but these concerns are now beginning to include matters such as gun violence. However, despite the shared frustration, for the most part, law enforcement and public health practitioners and researchers have remained suspicious or dismissive of one another and have failed to find common cause despite facing shared problems that do indeed have common causes. Problems continue to occur and recur, frustrations continue to rise, but effective alliances and partnerships remain infrequent and limited.

Two years ago, the clear need for a new response to public safety and health was brought into sharp focus by the murder of George Floyd, an unarmed Black man, by an American police officer in Minneapolis, Minnesota. For nine minutes and 29 seconds, Officer Derek Chauvin placed his knee on Mr. Floyd's neck despite his pleas that he could not breathe and the admonishment from bystanders, one of whom captured the graphic incident on video. People across the world reacted to the murder—the latest and best documented in a continuing series of such highly publicized killings, made more so by technology: mobile phone cameras and police body-worn cameras—with a mix of pain and anger. The incident struck a nerve sensitized by persistent problems in policing—excessive use of force, racial and ethnic disparities in policing responses, and an over-reliance on police—from Rio de Janeiro to London to Nairobi. One outcome has been a burgeoning hope for a better path forward for public safety and policing and mounting enthusiasm for exploration of alternatives.

The fact that George Floyd's murder occurred in the early months of the global COVID-19 pandemic gave greater resonance to the demand and need for new approaches and partnerships to community safety and health. The COVID-19 pandemic upended normal life in communities around the

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world, shifting understandings of what it means to feel and be safe and healthy and raising questions about the appropriate role of law enforcement and public health actors in providing and ensuring safety and health. This was nowhere more exemplified than in the heavy-handed policing of public health measures such as lockdowns and curfews, which, in a number of countries, resulted in police killings of citizens unable—often for reasons of economic survival—to adhere to the regulations.

The emerging invigorated interest in alternative responses to the wide range of long-standing societal problems has brought into focus some fundamental questions. What sort of partnerships between relevant sectors can be developed that better address social problems while minimizing harm? What kind of investments can government and international donors make to ensure safe and healthy communities while upholding people's rights and liberties? How can government, academic, and nongovernmental organizations work together to advance both community safety and public health? And most importantly, rather than go through another cycle of outrage to inaction, or simply make the same criticisms repeatedly without meaningful action, what kind of pragmatic and solutions-focused measures can be taken? What has already been tried, where, how, and what impact did it have? This special edition of the *Journal of Community Safety and Well-Being* represents a contribution to this dialogue on a new path forward.

When we began looking to respond to these questions, it quickly became apparent that there was little collected information—let alone evidence or rigorous evaluations—publicly available as to what initiatives or strategies already exist and work at the community safety and public health nexus. This is especially the case for community-based initiatives. This is not to say that such projects and initiatives do not exist, but rather that they had not yet received sufficient attention, study, or investment.

In response to this historic moment and need, the Global Law Enforcement and Public Health Association (GLEPHA) launched an ambitious project to help document efforts from countries around the world that have taken alternative approaches to community safety and health needs, by operationalizing a public health-based response and working in partnerships with law enforcement. The project focused on regions around the world—North America, Latin America, Western Europe, Eastern Europe and Central Asia, Africa, and East Asia—and was carried out by researcher collaborators based in those regions. The hope was to remedy the dearth of information on existing public health and law enforcement projects and to offer a comparative perspective on challenges, opportunities, and strategies for success from countries across the world. The articles in this special issue represent a sample of these findings.

Through the course of this project, it has become abundantly clear that greater research and investment in alternative responses to community safety and public health are necessary, including responses that involve police partnerships with public health. While the regional researchers were able to identify a host of projects and initiatives, their research is limited to those that have some written documentation or were identified through their regional networks. Certainly, many projects and initiatives exist that were not captured. For those where information does exist, the depth and rigour of that information varies greatly, often with little or no evaluation and with inconsistent details regarding processes, funding structures, operations, and impact, among other areas.

Importantly, it is worth noting that when looking for international comparisons and models to learn and build from, not everywhere has the same definition of "alternative," as different countries have widely varying criminal, legal, and public health systems. Gun control laws, for instance, vary greatly from country to country. Supervised drug consumption sites are banal normality in one jurisdiction, felonious in another. Non-police responses to mental health emergencies are not new or radical in some countries, and public investment in preventive and long-term health care is an established norm. In such settings, police agencies are decentralized, and officers have substantial discretion to innovate and to divert from the criminal justice system to alternative responders; in other settings, a centralized and national police agency means individual officer discretion is greatly reduced.

Likewise, one of the benefits of an international comparative experience is to identify emerging and existing best practices, to find the common principles underlying their success, and to promote them for adaptation and uptake in various jurisdictions. In practice, this often takes the form of technical assistance provision and peer exchange. Indeed, this is a core mission of GLEPHA; previous international Law Enforcement and Public Health Conferences have issued declarations, such as the 2013 "Amsterdam Declaration on Police Partnerships for Harm Reduction." At the same time, it is important to consider local and national contexts to adjust for what is possible and to gain useful self-reflection. For instance, one of the guest editors was involved in an international technical assistance and peer exchange on pre-arrest diversion for drug-related offenses in Kyrgyzstan. While the goal of the pre-arrest diversion program was to move up the point of diversion within the sequential intercept model (i.e. to have the person have less interaction further within the criminal legal system), this was limited in Kyrgyzstan due to the criminal legal system, which only introduced a probation and parole system. Thus, rather than a pre-arrest diversion, the local adaptation was limited to post-conviction as an alternative to incarceration. While this may appear routine or even disappointing from one international perspective, such a change to probation and parole represents a significant change in Kyrgyzstan. On the other hand, while conducting a similar peer exchange in municipalities in Ukraine, local police officers in Sumy, for instance, were already diverting people who use drugs to harm reduction services instead of arresting them. Thus, the idea of formalizing and establishing a pre-arrest diversion program was both less transformative and less necessary—and gave the helpful reminder that what may be considered innovative best practices in North America or Western Europe may already be regular practice in other countries. Indeed, this last reflection raises the critical and under-resourced point that international best practices and technical assistance can and should also emanate from the Global South. South–South exchanges can often provide more appropriate and impactful international exchange and assistance; and countries in the Global North can also learn a great deal from those in the Global South. This same les-

son applies in the case of Indigenous communities, where much can be learned from traditional conflict resolution and restorative justice approaches.

Indeed, notwithstanding regional, national, and local variation and context, there are important lessons, challenges, and opportunities that the authors in this special issue identified that can be informative for other jurisdictions. Best practices from various countries have been documented and shared elsewhere, whether in Mexico or Vietnam, and have helped make important progress and implement change in the effectiveness and efficiency of addressing long-standing societal issues.

Among the lessons identified is that moments of shared crisis can be used as an opportunity for partnership and adjustment. In Kyrgyzstan, for instance, the onset of the COVID-19 pandemic led to a new and ground-breaking partnership between law enforcement and public health officials and practitioners to prevent and respond to increased instances of domestic violence. The partnership incorporated public health guidance and analyses and hopefully will remain a feature of Kyrgyzstan's domestic violence policy and response in the years to come. Meanwhile, in the United States, the murder of George Floyd sharpened long-standing critiques on the limits and harms of policing as currently designed and brought attention to the equal need for reform and reinvestment in public health. Both are driving demands for a range of alternative and public health–based responses to community safety, ranging from community responder (non-police) models to police and mental health co-responder models to models of "public health policing." This interest in alternative responses, coupled with an increase in violent crime, has also, for instance, spawned greater investment in public health–based responses to gun violence, using community violence interventions and hospital-based violence intervention programs.

Institutionalizing public health approaches to violence has become standard in the UK, where there are Violence Reduction Units in most major police jurisdictions. The public health inspiration for such approaches promotes a preventive, whole-system approach to violence reduction, including multi-agency and multisectoral involvements, data sharing and analysis, and an evidence-based approach. Aligned with and underlying this has been an emphasis on understanding trauma as the cause and effect of much criminal or criminalized behaviour; trauma-informed policing has become the new norm.

Across all of the regions, a common finding is the importance of trust in and legitimacy of police; the research has exemplified the ways in which partnerships with public health and a public health–based response to community safety can help build and advance this trust and legitimacy. Too frequently, communities experiencing high levels of police activity see police as an external and abusive force. Complex patterns of violence and high crime rates coupled with low accountability mechanisms and increasing police militarization and powers have driven reports of human rights violations. At the same time, these factors have also driven an opportunity for alternative approaches. Community-oriented policing practices that incorporate public health responses and make partnerships have generated significant progress in localities across Latin America, for instance.

Significant transformation is under way across multiple regions regarding drug policy. While challenges and roadblocks—whether from prohibitionist drug laws or abstinence-based health services—continue to exist, there is significant opportunity for greater transformation in drug policy. Vietnam, for instance, initiated a pilot program in two districts in Hanoi between 2018 and 2020 to improve collaboration between law enforcement, public health, and labour sectors to strengthen the capacity of community services to divert people who use drugs from compulsory residential treatment and to support them across medical, social, and legal services in their communities. This represents a significant transformation from Vietnam's official view of illicit drugs as a "social evil" that must be eradicated, with drug addiction being named in its 1992 Constitution as a "dangerous social disease." Likewise, new housing-first and harm-reduction models for drug use, in partnership with (and occasionally led by) law enforcement, have emerged in cities across the Americas, from Canada to the United States to Brazil, as well as across the UK and some European countries. These programs, such as Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) in the US or Programa Atitude and the now-ended Braços Abertos program in Brazil, have shown positive results in terms of a reduction in crime and recidivism, lower costs and a reduced burden on the criminal legal system, and better health and well-being outcomes for participating individuals and their communities.

At the same time, and regarding challenges, the politicization of innovation and alternatives threatens their sustainability regardless of what the evidence says. In Latin America, for instance, innovative partnerships between law enforcement and public health to address issues related to homelessness, drug use, gang activity, or homicides can often be precarious due to the threat of its politicization. A program may become political fodder in an electoral campaign or dismissed with a change in administration due to political optics and ideology rather than to evidence and impact. This occurred to promising programs in Brazil, Colombia, and Mexico. It has also been the case across much of Africa, especially in relation to sexual identity, with homosexuality criminalized in a majority of African countries. Police partnerships with health interventions for prevention of HIV transmission are therefore fraught with conflicting goals and pressures. Such partnerships have proven difficult to initiate or to sustain, but training of police and sustained advocacy and policy guidance has been shown to bolster support for harm reduction.

Many of the programs and initiatives are in pilot stages. They have been initiated with seed funding and require further investments to bring them to scale and to sustain them beyond the pilot period. Too frequently, regardless of promise, pilot projects have been left simply as a pilot and often with little documentation or publicity outside of their immediate geographical impact.

A global view makes it clear that much is known about alternative and effective approaches to the wide range of societal problems currently criminalized or over-policed. But, as noted, the need for documentation, evaluation, and communication of these programs is something observed across all the regions. While this project marks one effort, it is not nearly enough, but rather offers an opening glance. Researchers and program managers should take up the charge to document and evaluate this emergent and transformative field;

government and donors need to invest in bringing pilots to scale. This latter is the urgent challenge facing us now: how to reinvent the currently siloed institutions so as to integrate law enforcement and public health at the societal scale.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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EDITORIAL

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The time is now for a unified vision of a systems-approach to community safety and well-being

Lauren Jackson*, Partner, National Security & Justice Leader

The policing sector is under intense scrutiny. Long-standing systemic issues have been brought to the centre of public discourse as a result of various judgments in Canada on cases where police have responded inappropriately to incidents, in the wake of George Floyd's murder and the social unrest that followed. From the renewed Black Lives Matter movement to the COVID-19 pandemic, public and political opinion has oscillated between defunding the police and increasing the emphasis on security. While perspectives around the role and involvement of the police differ, what is common across all is what they are trying to ultimately achieve—ensuring that the right people are delivering the right services at the right time based on personalized citizen need. The system is evolving, but not necessarily with a clear, unified vision of a future model. And such a vision is essential.

My career over the last 14 years has focused on safe, secure, and future-forward transformation across the security and justice sector. I have also spent time within a provincial health agency and had the honour of serving as a senior civilian member within a municipal police service in Canada. While there has been much evolution across the sector, a constant has been the need for new, innovative, and integrated approaches to advance the health, safety, and well-being of communities. On a practical level, this means being part of a community where there is less violence, crime, poverty, unemployment, illness, mental suffering, addiction, homelessness, and other social conflicts. On a strategic level, it means those responsible for ensuring the safety, health, and welfare of a community jointly owning the problems, solutions, and innovations. Effective collaboration is also part of community safety and well-being, and it is the keystone to reimagining, planning, and delivering what a future, systems-based approach to community safety and well-being might look like.

The next era of community safety and well-being does not remove police from the equation. Instead, it focuses on collaboration between police services, community organizations, social services, public health, and other agencies to address the social determinants of well-being, often accompanied by the social attributes of crime. By working together, we can reduce vulnerability to criminality and help close the gaps so that people don't fall into criminality in the first place. So, what does collaboration look like? The obvious example is co-responder models, where police partner with another service provider, such as a social worker or domestic abuse advocate, to effectively respond to calls for service. However, collaboration extends beyond *response*, and can also help with *prevention* and *control*. For instance, in diversion programs, police officers have the discretion to offer an individual treatment and services in lieu of arrest in cases where a person's criminal activity is linked to an underlying issue, such as mental health or substance use. Other examples of effective collaboration include co-location of agencies to enable data-sharing, or embedding clinicians or social service providers within call centres to determine appropriate triage and response. Additionally, collaboration can take the form of co-owned projects, where organizations can pool resources and expertise and have shared accountability for outcomes.

Across the world, research—such as that captured in this special edition issue of the *Journal of Community Safety & Well-Being*, "Envisaging Healthy and Safe Communities: Worldwide Lessons in Police and Public Health Partnerships"—documents the impact and benefits of alternative approaches to community safety and well-being that focus on collaboration between sectors and agencies. In our recent article, *In Pursuit of Next-Era Community Safety and Well-Being*, we documented many examples of progressive police initiatives that are contributing to safety and well-being by reshaping policing models at the community level. Five common threads are woven across all examples that provide a collective Call-to-Action to help get us to the next era of community safety and well-being. The first is taking a systems-based approach to root causes. People served by the police experience complex, multi-layered, and often systemic issues that cannot be tackled by the police alone. The second is a focus on the "service" in police service. Next-era community safety and well-being will require challenging traditional thinking and the existing service delivery model to make the expectations of services provided by the police more sustainable. Third, make "being connected" the raison d'être. The

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next era of community safety and well-being must be one in which the relevant parties are intrinsically connected and where data-sharing and systemized reporting across services is the norm, not the exception. Fourth, get uncomfortable. Moving to more integrated systems that tackle root issues might require unconventional approaches that are historically difficult to navigate. Lastly, democratize, share, and use data to drive better outcomes. Police have a wealth of data from calls for their services that can be used to examine and understand the nature and frequency of interactions with the communities they serve and, in turn, help shape new approaches.

As this special edition of the *Journal of Community Safety & Well-Being* captures, these models of collaboration illustrate a clear delineation of positive first responder and preventive outcomes focused on citizen need. In doing so, the "Envisaging Healthy and Safe Communities: Worldwide Lessons in Police and Public Health Partnerships" project highlights that these issues, while occurring across unique jurisdictions and local circumstances, are neither unique nor local. Their commonality amplifies the need for continued innovation and collaboration to determine how the successes of the strategies shared can be scaled and replicated, and to continue to push this collaboration upstream, from response to intervention to prevention. The time to understand and scale the factors that make these initiatives successful is now.

The *Journal of Community Safety and Well-Being* and the Global Law Enforcement and Public Health Association (GLEPHA) provide forums to not only curate and amplify research around this important topic, but also to drive meaningful change at a policy and program level. Ongoing evaluation and reporting on outcomes are critical to the success of driving change. Evaluation should be embedded at the outset of any pilot project or program and should include a systematic and clear approach to data gathering, analysis, and reporting. In the absence of evaluation and outcomes-based reporting, it is far more difficult for government and lawmakers, as well as the agencies that deliver the services, to understand the efficacy of alternative approaches and what is required for successful implementation. And while there is global recognition that there is value in alternative approaches, the overarching systems that dictate how approaches are funded and delivered are often disconnected. Local problems need local solutions, but scalability of the attributes that make these local solutions effective requires changes at the system level. This may include novel cross-ministry or interdepartmental planning and funding that shifts community safety and well-being from being an unguaranteed annual budget item vulnerable to other priorities to being part of a systemized approach to budget planning. Integrated delivery should start with integrated planning and funding.

We must all challenge each other to think differently about the next era of community safety and well-being. Ultimately, it is one where policing, community organizations, social services, public health, and other agencies are connected—much like the complex and deep-rooted issues that bring about the need for their services in the first place.

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Alternative approaches to achieving community safety and well-being across law enforcement and public health: Western European findings

Michelle A. McManus* and Rachael Steele†

ABSTRACT

This paper provides the results from Western Europe of a wider project (Envisaging the Future of Policing and Public Health Globally) for the Global Law Enforcement and Public Health Association (GLEPHA) which aimed to identify policing and public health alternative initiatives to provide community safety and well-being. A desktop review of projects that included evaluation evidence and/or impact of innovative delivery were selected for the study. The criteria allowed the inclusion of international, national, regional, and local initiatives that fit the broader aims of the global "envisaging the future" GLEPHA project. In total, 41 projects were reviewed with varying levels of information on approach and evaluation. Data capture recorded the country, location, funder details, themes (e.g., violence, mental health, drugs), key words, program descriptions, and any links and key findings from evaluation studies. A number of key themes, drivers, and challenges were identified in collaborative work between policing and public health. These included elements of communication and generating a shared language, the need for evaluation to be embedded in the project plan and mobilisation, and the problems with "hot-topic" issues and short-term funding. This paper also outlines two case studies of projects within Western Europe: Violence Reduction Units in the United Kingdom, and the Stockholm prevents Alcohol and Drug Problems (STAD). Key aspects of these projects are presented and the successes and potential challenges discussed. Key recommendations regarding the future of law enforcement and public health–related initiatives are discussed.

Key Words Public health; public safety; violence prevention; multi-agency working.

INTRODUCTION

Complex social issues that pose challenges across criminological, political, public-health, and welfare spheres can also result in serious pressures and challenges for law enforcement. Often, communities, families, and individuals disadvantaged by these issues are criminalized, as the effects of these social issues become acute. However, dealing with issues that are rooted in disadvantage is difficult, and no one-sector approach can be successful. As part of the Envisaging the Future of Policing and Public Health Project, this paper will review the existence and evidence base of multi- and cross-sector approaches to law enforcement in Western Europe, with a particular focus on violence prevention and drug use.

METHODOLOGY

A desktop review was undertaken of all suitable initiatives taking place in Western Europe. In total, 41 projects were reviewed, including, for example, initiatives that targeted knife crime reduction, drug and alcohol services, and mental health services. Priority for review was given to initiatives that displayed elements of innovation in addition to the availability of information and evidence, in particular information gained from evaluation for each project. These projects were not limited by size and included both small- and large-scale projects. For some projects, information was readily available (for example, on a project website), while for others, it was necessary to contact the individual organizations involved in the projects to obtain the evidence. Additional information was

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requested via e-mail asking for specific responses relating to the parameters of the data collection spreadsheet, including, but not limited to country, area, thematic area(s), key words, type of program, brief description, funder information, links for evaluation reports, and key findings from evaluations. A thematic analysis of the information provided by each project identified a number of key themes across these Western European law enforcement and public health projects. In addition, two projects were examined in more depth as case studies. Details of these findings are presented below.

FINDINGS

Overarching Common Themes of Initiatives

From the data collected from the 41 projects, key similarities emerged based on the thematic analysis completed. A main theme identified was a focus on *violence against women and girls and child exploitation*. Another key theme that appears to have been gathering pace in recent years was a concentration on the development and roll-out of *trauma-informed approaches*. Within Western Europe and the United Kingdom, evidence showed specialist multi-agency teams and statutory partnership arrangements working together to tackle a range of issues such as mental health and domestic violence, with models showing increased use of *co-responder models* (e.g., police and health domestic abuse advocates). A final key theme identified across initiatives was the issue of *substance and alcohol misuse*. All of these issues have been exacerbated by the ongoing COVID-19 pandemic. Evidence suggested that these pre-existing issues have worsened, but also that a new wave of victims will have been created by the pandemic (Bhaskar, 2020). This resulted in a final key common theme of the need for a focus on *workforce well-being and community recovery*.

Key Drivers to Effective Collaboration within Law Enforcement and Public Health Initiatives

A common finding across various initiatives was that the people served by these initiatives were experiencing multi-layered, complex, and often deep-rooted issues, which could not be tackled by law enforcement alone. There was an acknowledgement from key leaders that there is a need for a deeper understanding of the complex origins of the issues at hand, and therefore a need to begin to tackle the causes, not just the symptoms, of the issue. Those projects that were directed at government level to work as part of a multi-agency team subsequently provided confidence to operational staff to work more effectively together using innovative approaches.

Multi-Agency Work

The multi-agency approach resulted in a range of co-produced projects allowing specialized agency staff to engage with vulnerable populations, but also with each other (e.g., between law enforcement and health systems). Sharing of knowledge and expertise led to these co-owned projects more effectively tackling the root causes of vulnerability in communities rather than each agency working in isolation to tackle vulnerability that falls within their remit (e.g., health, or specific types of criminal behaviour). Working together, agencies were able to better pool expertise and resources in order to understand how best to operationalize services on the ground. This sometimes resulted in co-location of agencies to help facilitate data sharing across different systems. One way this was best achieved was through the development of shared language on key issues. Labels and traditional forms of language used within different agencies can create barriers to change. Developing a shared language can overcome traditional approaches within service delivery, for example overcoming the dichotomous labels of "victim" and "offender" and instead allowing for the identification of, and focus on, the needs of the person regardless of the label. Many agencies are shifting towards trauma-informed approaches to language, for example using "person first" language, such as "a person diagnosed with schizophrenia" rather than "a schizophrenic." Developing a language that allows different agencies to communicate effectively without falling into linguistic silos was seen as the first essential step towards effective co-production and delivery.

Need for Planned Evaluation within Mobilization

Evaluation and providing evidence of success are key elements for any project, particularly those with significant or short-term funding. However, too often, project evaluation felt like an add-on rather than being a fully incorporated strand of the project's implementation. Many of the projects reviewed only began evaluation activities several months into the implementation of the project's work, or even at the end, when the funding cycle was drawing to a close. One of the reasons cited for this was that, often, timescales and budgets are very tight and evaluation activities were not seen as a priority. For others, the necessary skills to plan and execute project evaluation were not available in the early months of project design and roll out, due to a lack of connections to established evaluators who could be commissioned and engaged within the life cycle of the project. However, lack of early evaluation planning and data capture can have serious implications for the project, affecting the quality of data and causing key voices to be lost which are often integral in evidencing the practical, real-world impact.

Some of the more government-funded projects had clear expectations regarding the requirement of evaluation activities from the outset, but these tended to include more structured and rigid expectations of short-term outputs and outcomes that might not reflect the reality of the initiative, rather than long-term, softer outcomes. This push for early indicator outputs can mean that the evaluation activity is at risk of not capturing or measuring the real success (or otherwise) of the project. In many cases, the time between alerts for funding and submission deadlines necessitates quick turnarounds of project plans and aims, with little time to plan and create teams that can help build accurate measures at point-of-design before implementation has begun. Therefore, time needs to be built into the release of funding opportunities to allow for wider consultation and a more methodical approach.

Consequences of Short-Term Projects and Funding

This rush to *funding and findings* misguides well-intentioned aims and practices to focus on hard, measurable, short-term outputs, which may not be connected in any real way to the

complex, softer, harder-to-prove outcomes desired within the project. Short-term funding results in the increased use of seconded staff or employees on a fixed-term basis—and no matter how well-developed their skills or knowledge might be, this may limit their ability to maximize the potential of the role. Indeed, fixed-term contracts were seen to result in higher turnover of staff, with staff looking for more secure, permanent roles and often leaving well before the completion of the project, resulting in significant gaps, often at the most important stage of the project's funding. Given that many of the projects deal with vulnerable populations, the high staff turnover was seen as a real concern in supporting the clients, who may disengage from service support due to inconsistent provision.

Care with Targeted Funding

A related issue is the way that funding has been targeted. Many areas reported that the notion of targeted funding, or "hot-topic" issues, meant that the majority of funding was targeted at particular high-profile problem areas without consideration of the wider vulnerabilities and needs within communities. While these current high-profile problem areas, such as County Lines, may attract the attention of both the public and the policy-maker, localized vulnerabilities are being ignored by funders. The decay of universal support across a range of key agencies and sectors working in community safety was found to be a common issue throughout Western Europe. The reduction, and often complete removal, of funding for ground-level, frontline services has had the most impact on those with multiple vulnerabilities and needs. This lack of support has only been exacerbated by the COVID-19 pandemic, which saw a reduction or removal of the services that were available within local communities.

Trauma-Informed Language and Practice

There was clear evidence across most of the projects that their service delivery was seeking to embrace a more trauma-informed language and approach. For example, it is necessary to challenge victim-blaming language, as some agencies still refer to victims of child sexual exploitation as "promiscuous," rather than identifying the grooming process to which victims are subjected (IICSA, 2022). However, although there was clear agreement on the importance of trauma-informed language and practice, many evaluation reports, such as IICSA (2022), conclude that encouraging a trauma-informed approach was not being targeted where it was most needed, in early intervention and across multi-agency efforts that work with vulnerability before crisis occurs. The COVID-19 lockdowns exacerbated adverse impacts on society's most vulnerable (e.g., increased poverty and struggle for daily survival, digital poverty in keeping engaged, overcrowded homes, etc.), and yet despite repeated recommendations for intervention, action has been slow. Government departments need to allocate resources more appropriately to these crucial universal services (e.g., schools and early health services), which are best placed to identify early need.

Case Studies

The following case studies from two locations in Western Europe illustrate how the themes and challenges identified in this paper have been operationalized.

United Kingdom: Violence Reduction Units (VRUs)

One of the key developments in the United Kingdom is the development of cross-agency and cross-sector responses to violence, with a focus on violence prevention. In 2018, the Serious Violence Strategy was introduced, providing a significant and large boost of funds, with 35 million pounds sterling being pumped into 18 of the 43 police forces in the United Kingdom. This money was designated to provide Violence Reduction Units (VRUs, n.d.) based on a previous similar and successful scheme in Scotland (see Scotland Violence Reduction Unit, n.d.). This was a novel approach for the United Kingdom, in that it adopted the World Health Organization's language and definition of a public health problem in focusing on factors that make people vulnerable to being a perpetrator or victim of violence, rather than focusing solely on law enforcement responses.

This public health approach to tackling violence requires the VRUs to produce two evidence-based strands. The first is a problem profile, or strategic needs assessment, and the second is a multi-agency response strategy. While this is certainly seen as a positive step, there were still issues that needed to be ironed out. For example, some practitioners prefer to develop the language beyond the vernacular of the "public health approach" to a "whole systems approach." This difference in use of language potentially points to some of the stakeholders struggling with understanding the term "public health approach," even though this was the core focus of the Serious Violence Strategy and subsequent set up of the VRUs. Ensuring a better understanding of and agreement on language would help practitioners across all involved agencies achieve clarity on the aims and goals of the initiatives and what the systems are trying to achieve.

Within the wider VRU approach, several areas of innovation were identified. Each of the 18 VRUs has a slightly different approach to what exactly they include under the umbrella of "violence." Within the Bedfordshire model, for example, the word "exploitation" was explicitly included as part of their violence reduction approach, making their VRU a VERU (Violence and Exploitation Reduction Unit, n.d.). This is certainly not a common approach to all 18 VRUs, some of which do not even include "domestic violence" within the remit of their unit. There is also mixed practice in providing evidence of the success and rollout of the work of the VRUs. The Wales Violence Prevention Unit (n.d.), indicates its strength as being a commitment to evaluation, evidence, and dissemination of their findings. In addition, the Merseyside Violence Prevention Unit displays real strength and innovation in its use of the life-course public health approach, as seen in its close working relationship with a public health institute.

There is evidence that funding for national services such as VRUs can encourage positive movement in terms of agencies providing and developing an evidence base in violence prevention. Additionally, the development of the strategic needs assessment and theory of change model as mandatory elements of these units has generated a positive progress plan to ensure consistent monitoring of activities. However, the annual funding model still generates the insecurities around staffing and provision outlined earlier. There is also the question of pre-determined short-term indicators (as required by the funder), which may not be aligned with the achievable and long-term outcomes of these initiatives. Of course, the

introduction of the 18 VRUs in the United Kingdom Police forces still leaves 25 forces that have not been given additional funding to develop a VRU, raising questions about how violence is being addressed in these areas.

Though the Serious Violence Strategy (2018) and VRU (2020) approaches certainly have shown great success in further cementing collaborative multi-agency work, the fact that each VRU uses its own criteria to define "violence" and its own specific strategic approach for tackling violence is evidence of the complexities in trying to address such an issue. These approaches are no doubt influenced by those at a strategic level who influence the direction and remit of the work based on their own sector expertise. Work is needed to continue to examine how the various VRU models work alongside other partnerships that seek to tackle violence, such as Safeguarding Partnerships. Clearly there are dangers associated with using different approaches across areas, often with the same people, communities, and needs. For example, within the United Kingdom, there is a tripartite ownership, with statutory safeguarding arrangements (partnerships) held by police, public health, and local authorities (see The Child Safeguarding Practice Review Panel, 2021). These Safeguarding Partnerships already have a set of policies and structures that need to work in conjunction with VRUs, and not enough is understood about how these fit together, or even potentially overlap, which requires consideration in future evaluations.

Stockholm Prevents Alcohol and Drug Problems (STAD)

The Stockholm Prevents Alcohol and Drug Problems (STAD, n.d.) was seen as another example of effective collaboration between a range of sectors, particularly law enforcement and health, in achieving increased public safety. The initiative is a Swedish prevention strategy (1996) that specifically targets binge drinking and substance use in nightlife settings. The project has shown evidence of significant reduction in alcohol over-serving, a decline in underage drinking, and a reduction in alcohol-related aggression. The STAD project approaches heavy episodic drinking by adopting the following main mechanisms:

- Community mobilization
- Training in responsible beverage service
- Stricter enforcement

As well as traditional nightlife venues, STAD also focuses on festivals, drinking in public places such as parks, and drinking at home. Here, too, there is a real focus on community involvement in the prevention of crime and violence associated with binge drinking. The project shows clear benefits in a range of infographics and reports, highlighting key outcomes, including statistics such as a 29% decrease in violent crime in nightlife areas, increased compliance of legal age limit serving, with a cost savings ratio of 1:39 identified in one report (STAD in Europe, 2019).

SUMMARY

The desktop review of initiatives and projects across Western Europe that seek to achieve community safety and well-being through collaboration between law enforcement and public health has highlighted a number of key themes identifying what is working well, key drivers, and challenges experienced. Issues such as the need for longer-term funding, investment in universal services, workforce stability and buy-in from government and community leaders are key areas of concern when considering the success of these initiatives. There are also challenges in ensuring strategic plans and agreements are understood in language and practice across multi-agency initiatives to ensure successful outcomes. Potential barriers seem to be centred on tight turnaround when it comes to applying for funding, implementation, and the duration of many of these projects and programs. In addition, the COVID-19 pandemic has added stressors to those communities that were already experiencing adverse conditions, poverty, and difficulties due to unmet needs at a basic level. With support needed in the community more than ever, lack of visibility and access will have devastating and, no doubt, long-term impacts.

Therefore, a key consideration needs to be the recovery of our communities and a clear strategy to meet the surge in demand for support that is likely to surface. Central to this must be the support of our key workers and frontline workers who actually deliver these services, whether they be police officers, health and education staff, or social workers. Not only do resources need to be made available to support service delivery, but care needs to be put in place to support workers who have struggled to come through the pandemic themselves while trying to deliver essential initiatives to communities under immense pressure. The need to provide support for exhausted and burned-out staff, coupled with the exponential rise in mental health issues and trauma experiences within communities, must be the first consideration for any agency wishing to deliver real and lasting change in communities.

A further area of promising practice is co-production and co-responder models of work. These can range from street triage teams to co-led mental health responder models addressing issues from child exploitation to domestic abuse responses (see Operation Provide, 2020; UCL, 2016). However, despite apparent wide agreement that co-responder models are a more effective way of working, there still remains a lack of evidence to support the benefits of these approaches to service users themselves. There is also wide variation in how these models are delivered, with different projects having vastly different hours of provision, staffing, and incident response. Finding new ways to reach vulnerable and marginalized communities, particularly the young, is a challenge, especially after the COVID-19 pandemic. Employing new and innovative communication techniques, such as the use of specially designed digital platforms, will make up part of the future development of this work.

Linked to the above point in response to the pandemic, it was clear across all projects that urgent investment is required in universal services such as education and health care. The ability to identify unmet needs, potential harm, and exploitation is only possible if one is visible and heard, which requires resources. It was clear that although short-term targeted funding may help respond to key issues at the time, there is a lack of commitment to upstream approaches that truly take an early identification and intervention approach.

Finally, a note of caution. Although increasing funding can only be a positive step, there is concern that by focusing on the current "hot-topic" issues, the funding supplied may

be targeted more at the symptom than at the cause of the problem. Any hot-topic area, such as "county lines" within the United Kingdom, is actually a symptom of wider, overlapping vulnerabilities which are subject to a mixed set of policies and strategies around issues such as social exclusion, deprivation, etc. Rather than try and tackle the outcomes of these situations, it would be prudent to allocate funding at a universal level to try and address these crisis issues at the root cause.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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Public health approaches to public safety in the United States: An overview of results from GLEPHA's Envisaging the Future project

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ABSTRACT

In the summer of 2020, the Global Law Enforcement and Public Health Association (GLEPHA) launched a worldwide effort to identify and understand public safety approaches that leveraged the promise of public health frameworks and interventions. This article describes initial results from an effort to identify established and burgeoning programs applying public health approaches to meeting public safety needs in North America. It also includes an assessment of current challenges for sustainably implementing these models and ensuring equitable outcomes for all communities.

INTRODUCTION

In May 2020, the police murder of George Floyd sparked national and global outrage and drew attention to the fundamental mismatch between the public safety needs of communities and the skills, abilities, training, and resources of the police that serve them. Though Mr. Floyd's murder activated a cultural shift in understanding this incongruity, communities disproportionately impacted by enforcement systems have long identified the limits and harms of policing as it is currently designed.

In the United States, the most common model of public safety provision relies heavily on the police. People call an emergency line for help, and police almost always are dispatched to respond, regardless of the overt or underlying needs associated with the call. While calls for service span a broad range of issues (e.g., substance use disorders, a lost pet, acute mental health crises), most police academy training is focused on force and enforcement, with minimal attention to the raft of inherently social issues implicated in calls for help (Buehler, 2021). This means police often are dispatched to address problems for which they are ill-equipped and untrained (Bailey et al., 2021).

Not only does this fail to address community needs, it contributes to overcriminalization and can lead to the inappropriate or excessive use of force. The public safety response often relies on citations, arrests, and incarceration when treatment or other social services are what is needed most. While this mismatch between response and needs affects all of society, the costs fall disproportionately on marginalized communities and communities of colour—especially Black communities (Anderson et al., 2017; Hinton et al., 2018; United Nations, 2018).

The resulting failure to meaningfully solve community problems is exacerbated by a lack of coordination across public services, especially across public safety and public health systems. Individuals often cycle repetitively through these systems—from jails to emergency rooms and back again (Milgram et al., 2018). This results in a small number of individuals with unmet needs using an outsized proportion of public resources across systems (Baker et al., 2021; Milgram et al., 2018). For example, researchers in Camden, New Jersey, analyzed local hospital and arrest data to find that more than half of individuals arrested between 2010 and 2014 also made five or more visits to the emergency room during that same period. For many of these individuals, the presence of socio-behavioural challenges such as housing instability, substance use, or mental health issues co-occurred with a health condition or legal concern that may have been better managed in alternative settings.

But there is reason for hope. Attention to this problem is growing, and promising solutions are on the rise (Bailey et al., 2021; Lum et al., 2021). More and more, conversations about community public safety priorities often centre on social determinants of health: economic mobility, affordable housing, dependable transportation, and education. Rather

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than focusing on outcomes relevant to either a public health or public safety system, some jurisdictions are focusing on achieving community well-being through collective, coordinated efforts. This understanding, coupled with strident calls for police reform, has motivated the replication of existing models and innovation of new approaches across the continent.

In the summer of 2020, the Global Law Enforcement and Public Health Association (GLEPHA) launched a worldwide effort to identify and understand public safety approaches that leveraged the promise of public health frameworks and interventions. GLEPHA engaged research teams from regions around the world to undertake media and literature scans, conduct outreach to practitioner groups, and engage municipalities to identify current and emerging strategies. The following describes the initial results from an effort to identify, define, and categorize established and burgeoning programs applying public health approaches to meeting public safety needs in the United States. It also includes an assessment of current challenges for sustainably implementing these models and ensuring equitable outcomes for all communities. As jurisdictions continue to launch new initiatives that aim to solve public safety problems with public health strategies, and as researchers work to fill the considerable gap in evaluations of these programs, this article catalogues models currently implemented, describes promising strategies, and outlines limitations both in theory and practice.

INITIAL RESULTS

Public safety approaches that leverage public health frameworks and concepts in the United States generally fall into the following categories. Importantly, some jurisdictions are implementing multiple approaches simultaneously across categories.

Improved Police Response

Some jurisdictions are attempting to respond to the breadth of community needs by investing heavily in police to function as non-enforcement responders in some cases. This approach acknowledges that officers require better tools to respond appropriately to the community issues for which they are dispatched and may include increased training, such as improving police responses to individuals experiencing a mental or behavioural health crisis. Some departments also are enhancing their understanding of individual-level needs by establishing voluntary databases of individuals who are vulnerable, largely those living with specific mental health challenges.

Training

Likely the most established specialized training to improve law enforcement's ability to respond to individuals experiencing a mental or behavioural health crisis is Crisis Intervention Team (CIT) training (or the "Memphis Model," named for the department in which it originated). It has been implemented in over 2,700 sites across the country for over two decades (Pelfrey & Young, 2019; Hassell, 2020). This 40-hour, specialized curriculum is designed to improve law enforcement response to individuals living with mental illness and substance abuse disorders, with a particular focus on reducing the risk of serious injury or death. Crisis Intervention Team training is a widely replicated program, though departments frequently modify the model to fit their local needs (e.g., integrating it as a mandatory part of officer training vs. permitting officers to voluntarily self-select). It is supported somewhat in the scientific literature. Studies generally show positive officer-level outcomes (e.g., self-perception of a reduction in use of force), as well as an increase in pre-arrest diversion (Pelfrey & Young, 2019; Hassell, 2020). However, there is limited evidence supporting CIT's impact on measures such as arrests, officer or citizen injury, and officer use of force (Rogers et al., 2019).

Officer Notifications and Flagging Systems

In Fort Smith, Arkansas, the police department has established a vulnerable persons database to assist police officers in responding to mentally impaired and other at-risk individuals (Fort Smith Police Department, 2020). Participation is voluntary—individuals or their guardians submit a picture of the individual and a form detailing the individual's at-risk status and their address. When an officer runs an individual's background during an encounter in the field, the system will flag for vulnerable persons and prompt an officer to call a specialist. This allows officers to benefit from support from other experts and better respond to individuals' immediate needs. Early research indicates that such flagging systems may make arrests less likely. Similar databases exist in other jurisdictions, generally focusing on mental health conditions or developmental disabilities, such as individuals living with autism (Watson et al., 2019).

Co-Responder Models

Co-responder models couple a non-police practitioner, usually a social worker or a mental or behavioural health specialist, with a police responder. These models vary widely across jurisdictions, though they usually involve at least one law enforcement officer and one social worker or mental health professional jointly responding to incidents. Usually, these teams are mobile and ride together for a shift, during which they're either jointly dispatched to respond immediately to relevant incidents or are called in as backup after the initial police response. The social services provider may take the lead in engaging with the individual in crisis at the scene. The provider may also follow up to connect the individual to treatment or help them access other needed resources. Unlike alternative response models that operate without the presence of a police officer, co-responder teams may respond to incidents involving threats or the presence of a weapon. Some jurisdictions are also experimenting with virtual co-response models, where officers are given iPads to connect with behavioural health specialists for assessments and referrals in real time (Krider et al., 2020). Though they are being increasingly adopted by municipalities across the region, these models lack rigorous evaluation and require further research.

In-Person Co-Response

The Denver, Colorado, Police Department has operated its Co-Responder Program since 2016. The model pairs a behavioural health professional with an officer to respond directly to 911 calls for service that involves a mental health component. These calls may or may not include the presence of a weapon and are dispatched day and night, 7 days a week. The Colorado

Department of Human Services funds some 28 similarly designed co-responder programs throughout the state and, in a recent evaluation, found that 98% of the 25,900 calls for service managed by co-responder teams between 2020 and 2021 did not result in an arrest (Colorado Office of Behavioral Health, 2021).

Remote Co-Response

Harris County, Texas's tele-psychiatry program virtually connects individuals experiencing a mental health crisis with licensed professionals in the field (Harris County Sheriff's Office, n.d.). Deputies use iPads to connect individuals with clinicians in real time, 24 hours a day, 7 days a week. In addition to assisting with stabilization, these clinicians connect individuals with necessary follow-up services, such as counseling or access to treatment.

Alternative Response

Alternative response models replace a traditional police response with a non-enforcement practitioner response. These responders generally are social workers or behavioural/mental health clinicians or specialists, with a particular focus on stabilizing individuals in crisis. Usually, these responders monitor police radios and are dispatched in response to very specific call types clearly identified as involving mental or behavioural health needs that do not involve the presence of a weapon at the time of dispatch (Baker et al., 2021; Blais & Brisebois, 2021; Lum et al., 2021). These teams are also dispatched for issues related to substance use and homelessness. When a call for service meets pre-defined criteria, the non-police practitioner is dispatched as the primary response, and police are called for backup only if necessary. The responders stabilize the situation and connect the individual with necessary services when appropriate, including transport.

The most well-known and established alternative response model is Eugene, Oregon's Crisis Assistance Helping Out on the Streets (CAHOOTS), founded in 1989 (Beck, 2020). In CAHOOTS, an experienced crisis worker and a paramedic (usually a nurse or EMT) are dispatched to calls for service that have a strong behavioural health component and clearly do not involve a legal issue or an extreme threat of violence. CAHOOTS teams may also self-initiate contact with individuals who appear in need of services or may be directly requested by officers on the scene during an encounter. These first responders stabilize the situation and provide transport for non-emergency medical care if needed. Estimates of the number of the Eugene Police Department's overall call volume that the CAHOOTS team answered range from 5% to 17% (Eugene Police Department, 2020.; White Bird Clinic Eugene, 2020)

Another growing alternative response model involves embedding clinicians within 911 call centres. These social workers, nurses, and other specialized health professionals interact directly with callers to understand the acuity of their needs and triage residents to appropriate levels of care. The Right Care, Right Now Triage Line in Washington, D.C., transfers 911 callers with non-threatening medical issues to a nurse who can assess individuals virtually and connect them with community clinics and in-person care. In its 4 years of operation, Right Care, Right Now has processed some 47,000 911 calls and diverted 17,000 from an emergency room response (Segraves, 2022). The triage line is undergoing an evaluation through a randomized control trial to better understand how co-locating practitioners in 911 impacts emergency department usage.

Non-Enforcement Police-Led Outreach

The goal of these programs is to identify proactively vulnerable community members and connect them with social services. These efforts are police-led and usually are part of a broader crime prevention strategy. Their success depends on police officer access to and relationship with communities, and they generally involve robust partnerships with other public agencies and social services, who either conduct outreach alongside the police officer, are standing by to provide necessary services, or both. Some programs target specific social issues such as homelessness, while others provide generalist responses to community needs.

For example, the Long Beach Police Department in California established a Quality of Life Unit. It was founded in 2007 with the goal of reducing vagrancy-related crimes and calls for service associated with homelessness by proactively encountering unhoused persons and connecting them with resources (Long Beach Police Foundation, 2019). This unit includes police officers and mental health clinicians who conduct outreach to individuals experiencing homelessness. The team members connect individuals with housing, transportation, mental health services, and community support groups. Similarly, in Sarasota, the Police Department partners with other service entities to operate its Homeless Outreach Teams (HOT), which consist of case managers, officers, and a supervising sergeant. Homeless Outreach Teams conduct outreach to persons experiencing homelessness throughout the week, connecting individuals to essential social services with a focus on improving long-term outcomes (Sarasota Police Department, 2022). These models have not undergone rigorous evaluation to understand their impact on public safety.

Pre-Arrest Diversion/Deflection

In pre-arrest diversion (also known as police deflection), a police officer has the discretion to connect an individual to necessary treatment or services in lieu of arrest. The individual must meet pre-defined criteria, and this model usually is used only with non-violent, misdemeanor offenses. This spares the individual from having an arrest record, diverting them away from the criminal justice system and into services more likely to address their underlying and overt needs. Usually, participation in a pre-arrest diversion program is voluntary, and an individual may choose to go through the criminal justice system rather than receive services or treatment. If an individual is diverted but fails to comply with the terms of treatment, they may be arrested for their original offense as a result. These approaches are increasingly used to respond to the opioid epidemic and connect individuals with substance use disorders to treatment, but they are also used for individuals experiencing mental or behavioural health crises and people experiencing homelessness.

One of the most well-known and replicated diversion programs is the Law Enforcement Assisted Diversion (LEAD) program. This is a community-based program that focuses on treatment and services in lieu of arrest for individuals whose criminal activity is linked to an underlying mental health

or substance use issue. Low-level offenders are diverted to harm-reduction–based, individualized case management. The individual receives a variety of support services, often including transitional housing and drug treatment. The case manager coordinates with law enforcement and prosecution to ensure that criminal justice contacts with LEAD participants—including new criminal offenses—are coordinated with the service plan (Clifasefi et al., 2016).

Research on the unique value of LEAD is promising, especially for low-level drug and prostitution offenses. A recent evaluation of Seattle's LEAD program found that participation in LEAD was associated with a statistically significant reduction in criminal justice and legal system involvement. Specifically, LEAD participants had 1.4 fewer jail bookings and spent approximately 41 fewer days in jail per year. Participants also saw a decrease in legal costs, while comparison participants saw significant cost increases (Collins et al., 2019). Another evaluation found that participants in LEAD were significantly more likely to obtain employment and a legitimate income after their LEAD referral compared with the month prior to their referral, and participants were 89% more likely to obtain permanent housing during their follow-up engagement with the program (Clifasefi et al., 2016). Together, these findings indicate a reduction in the use of multiple public systems resulting from implementing the LEAD model—carceral, government aid, housing, legal, and public health.

LIMITATIONS AND CONSIDERATIONS

While these models of public safety are promising, and some program evaluations indicate great potential for improving public safety outcomes, additional research is needed. Minimal research has been conducted beyond simple outcome evaluations, and long-term, cross-system studies are necessary to better understand the different models' efficacy. It is presently unclear whether these programs sufficiently realign community need with response. In addition to more in-depth program evaluations, the following issues must be sufficiently addressed to support broadscale adoption.

Systemic Racism

The driving force behind current calls for police reform is the historic and pervasive systemic racism in criminal justice systems and resulting disparate impacts on communities of colour, especially Black communities. The same systemic racism exists in other public institutions, including public health. Simply shifting aspects of police response to public health systems or adding a public health lens to a public safety challenge will not solve the underlying racial inequity inherent in public systems.

Risk Determination

Many of the models above involve modifications to current dispatch and response models. Understanding the risk associated with a call for service is critical when determining whether a police response or an alternative response is needed. Both failing to send the police when they are needed and sending them when they are not carry inherent risks. Research on risk and dispatch is extremely limited (though preliminary research on CAHOOTS indicates that this type of risk determination is possible).[1] Jurisdictions should establish clear guidelines regarding when various response types should be sent. Otherwise, overly subjective decisions could perpetuate disparate impacts (e.g., where police response is dispatched to Black communities and other communities of colour, while white neighborhoods receive the alternative models) (Gillooly, 2020).

Time Bound of Response

One advantage of police response is that they can be dispatched around the clock. Many alternative response models only respond during certain times of day in certain neighborhoods or geographic regions, and not necessarily the times where those services are most needed. If an alternative model is truly to replace the police response, it must be staffed and available for dispatch at all hours, every day, everywhere. In addition, there are many community issues beyond mental/behavioural health, substance use, and homelessness that may be good candidates for alternative or co-response models, such as noise complaints, general disturbances or assaults. Funding fully staffed responders available 24 hours a day, 7 days a week, and uniquely equipped to respond to variable community needs is costly and could require an infusion of newly dedicated resources.

Practitioner Implications

Many discussions about alternative models—especially alternative response models—take for granted that practitioners such as mental health or behavioural health specialists are willing to assume responsibility for first response at all hours, and in conditions that carry inherent risks. Additionally, discussions ignore the fact that the quasi-social work aspects of policing may be what drives many practitioners to the field. If these activities are removed from the police profession, the nature of the profession changes consequentially in a way that may negatively impact the ability of agencies to recruit service-oriented individuals. If certain police responsibilities are reduced or eliminated, there must be consideration for what police could and should do with freed capacity and how those changes might positively or negatively impact public safety outcomes.

Need for Downstream Resources

In order for these models to result in improved community outcomes, there must be a wide range of local resources available to meet community public health needs, such as mental and behavioural health services, housing, substance abuse treatment, and other support systems. Otherwise, the "revolving door" nature of the public safety and public health systems will continue.

Narrow Scope of Responses

Most of these solutions target mental/behavioural health, persons experiencing homelessness, and substance abuse. While these are serious societal problems that police are indeed often ill-equipped to handle, they represent a small portion of calls for service that result in a police response

[1] For example, in 2019, CAHOOTS practitioners responded to approximately 24,000 calls, and only required police backup in 311 instances (Beck et al., 2020).

and are therefore unlikely to significantly impact the role that police play in first response.

Gravitational Pull of the Status Quo

Support for some of these models seems to be declining in the face of increases in violent crime across the United States (Rosenfeld & Lopez, 2022). Communities that were previously focused on narrowing the police function and expanding the role of social services in public safety systems seem to be shifting focus back to previous models with a focus on force and enforcement (New York Times, 2021; Goodman, 2021). From New York City to Los Angeles and Baltimore, cities across the country opted to restore and/or increase funding to police departments in 2021. For example, Portland restored $5.2 million to its police budget after cutting $15 million in June 2020. Despite there being no documented causation between the "defund movement" and rising crime rates, this public perception is difficult to combat. It is important to note, however, that simply because jurisdictions are putting funds back into police departments and expanding support for things like officers on patrol, it does not necessarily mean that they simultaneously are disinvesting from alternatives.

CONCLUSION

Across the continent, jurisdictions are exploring and implementing novel approaches to public safety that recognize the value and relevance of public health approaches to improving community outcomes. Communities and the government agencies meant to serve them—including police—seem to agree that we simply ask the police to do too much, and much of what we ask goes beyond their skills and resources. Many alternative models designed to address this mismatch show great promise, and several well-established programs are being replicated widely. However, more research is critically needed, and significant social, logistical, and political challenges must be navigated for these programs to be maximally impactful.

CONFLICT OF INTEREST DISCLOSURES

The author declares that there are no conflicts of interest.

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Law enforcement and public health programs in Latin America: The role of collective learning

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ABSTRACT

Implementation of law enforcement and public health programs in Latin America has been challenging. From financial reasons to lack of political support, positively evaluated programs are terminated. In this context, we argue that collective learning is an innovative strategy that leads to stronger, well-organized, resilient groups of policy entrepreneurs who can advocate for better policies and programs.

Key Words Policy entrepreneurs; collective knowledge; civil society organizations; community policing; sex workers; harm reduction

INTRODUCTION

The Latin American context, with complex patterns of violence and high crime rates, requires new public safety solutions and policing alternatives in the region. Considering the lack of citizen trust in police forces' effectiveness (Malone & Dammert, 2020) and the increased militarization of law enforcement that drives human rights violations (Flores-Macias & Zarkin, 2021), a window of opportunity has opened up to implement law enforcement alternatives. These actions can be oriented to strengthen citizen participation in the design and implementation of security policies, particularly those that consider public health as a key element of successful policing.

However, it is worth mentioning that the lack of citizen trust in police is linked to the violent actions perpetrated against communities; we understand trust as an instinctive unquestioning belief in and reliance upon an entity, such as a public institution established to protect citizens (Cao, 2015). As such, an important source of confidence is affective: people are concerned with how they are treated by the police (Jackson et al., 2012), and citizen trust relies on the relationships people perceive they have with them (Stanko et al., 2012). If oppressive and violent actions are perpetrated against communities, the relationships will be perceived negatively and trust will be lacking.

To improve the rapport with police, some countries have implemented community-oriented policing practices inspired by strategies from other countries (Malone & Dammert, 2020). However, some aspects have made it difficult to reach their intended goals, for example: for some police institutions, the community is still perceived as an external actor and deprived of any significant role in accountability mechanisms, there is opposition to decentralization of power, and indicators of police performance remain the same (Dammert, 2019; Malone & Dammert, 2020).

Despite this, there is significant progress in the region: in Brazil, Chile, Colombia, Mexico, and Panama, community policing initiatives can be found—at local and national levels—that have developed prevention strategies and actions to get closer to communities and regain citizens' trust (Malone & Dammert, 2020). In recent years, there are examples of initiatives that seek to replace traditional policing responses to situations such as problematic use of drugs and alcohol, violence against women, and mental health outbreaks. One example is the Colibri Centers in Iztapalapa (Mexico City), an innovative program that aims to provide medical care to people who use drugs using a public health approach, giving them full information and tools for self and collective care (Castrejón & Pasarán García, 2020). Another example is the Women's Emergency Centers in Peru, which offer free, specialized public services providing comprehensive and multidisciplinary care for victims of violence against women and their family (Gobierno del Perú, 2021). The Centers provide legal guidance and representation, psychological counseling, and social assistance.

Alternative strategies of policing not only aim to change the relationships between communities and police officers but constitute a turning point to move from traditional and

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militarized policing models (Alvarado, 2019) to community-policing ones. We understand community policing as a strategy that relies on collaborative partnerships between the law enforcement agency and the individuals and organizations they serve (Community Oriented Policing Services, 2012). An outstanding example is Nezahualcóyotl's community policing, an innovative program in a Mexican municipality with historically high crime rates. The police reform that led to the consolidation of the new policing model helped overcome corrupt practices by driving an institutional reform and firing police officers unfit for duty (Alvarado, 2009).

In Latin America, the emergence of these alternatives is not a completed process, and in many countries we are seeing a transition to the militarization of public safety (Magaloni & Rodriguez, 2020). Most of them are pilots or projects in early stages in which design, evaluation, and reformulation are ongoing (Quintero Cordero, 2020). Apart from the common challenges of public health–oriented interventions, in some cases law enforcement and public health initiatives face strong political opposition that seeks to prevent its design, implementation, and continuation. This phenomenon can be seen through the cancelation of these initiatives when a different political party comes to power. In this context, the participation of communities is crucial. The existence of strong, well-informed, empowered groups that can act and react before policy changes are made that may impact the evolution of these alternatives and their results is key for project sustainability.

For these reasons, there is a need to promote and ensure the continuity of existing law enforcement and public health alternatives to tackle security problems in Latin America, instead of promoting militarized and repressive policing strategies. Thus, we propose strengthening civil society actors—through collective learning—as an innovative strategy in aligning the goals of public health and law enforcement to generate evidence-based successful public policy in the region.

Citizen Participation, Law Enforcement, and Public Health Policies

Citizen participation has three main objectives: (i) restoring citizens' trust in police by strengthening police–citizen relations, allowing joint work and actions; (ii) involving the police itself in the action-items developed by the communities; (iii) giving the residents the ability to play an active role in designing and implementing policing strategies (Quintero Cordero, 2020).

Correspondingly, there is a relationship between public trust in police officers and the effectiveness of community-oriented security strategies: "Public trust in the police is essential, for if citizens view their police as corrupt, inefficient, and/or abusive, they will be reluctant to turn to police for protection or to solve problems in their communities or homes" (Malone & Dammert, 2020, p. 419).

Promoting citizen participation is therefore crucial for enhancing trust between police institutions and communities, and accordingly, for the effectiveness of police actions. This is important because one of the key challenges that community-oriented strategies face is ownership (Malone & Dammert, 2020), since domestic actors engaged with the public policy process make it more difficult to discard the strategies when external conditions change. Citizen engagement is key for long-term sustainability of policing projects.

Policy Termination: A Permanent Risk for Programs with Good Results in Latin America

As mentioned previously, changes in the political landscape can lead to the cancelation of innovative programs that are in the early stages of evaluation. A poster child for this phenomenon can be found in Open Arms (*Braços Abertos*), a positively evaluated yet canceled multidisciplinary urban policy program in São Pablo (SP) (Brazil) (Evans, 2017). By the end of 2013, policy makers (SP mayor's office experts) and representatives from the local community of Crackolandia (a pejorative name for an urban area characterized by its high criminality and problematic drug use rates in downtown SP), held meetings and proposed a new strategy to address the street-based drug use phenomenon.

Rather than constantly evicting marginalized populations and applying heavy policing tactics, the City Administration designed a program based on three axes: housing, work and income, and health and social follow-up (Paiva & Garcia, 2021). One important aspect to emphasize is that the program was designed and implemented with the active participation of its target population, considering the demands of local tenants, represented by community leaders (Paiva & Garcia, 2021). It was an innovative approach designed to tackle a complex public problem taking into consideration the needs of the target population, always fostering a dialogue between the authorities and citizens.

The program demonstrated good preliminary results and was supported by a significant group of residents: 87.3% of its participants were receiving health care services, 87.9% reported diminished crack use, and 84.3% said they had reduced their use of other drugs (Teixera et al., 2018). In terms of beneficiary-State relations, a preliminary evaluation conducted in 2015 showed that beneficiaries had a very positive perception of the public servants involved in the program (Rui et al., 2016). Despite this evidence, the municipal election winner, João Doria Jr., who belonged to a different political party, ended the program in 2016 after it had been running for 3 years, cutting short what could have become an example for other countries in the region.

The Open Arms case is remarkable but not unique: law enforcement and public health programs in Latin America are commonly placed at the centre of political polarization and can become an instrument of confrontation in the political arena. It is common that these programs, despite having citizen support and early evidence of a positive impact on social and policing indicators, move back and forth depending on political shifts and, ultimately, the presence of political will.

In policy termination processes, there are *Oppositionists*, proponents of termination who dislike the policy and firmly stand against it because of their personal values and principles (Bardach, 1976). These kinds of groups do not intend to promote a substitute policy, they only want to end it. It is within this context that anti-termination coalitions can occur. When these groups are viewed as prospectively powerful, authorities avoid attempting policy termination (Bardach, 1976).

We argue that strong and well-organized civil society groups can be strategic coalitions that act in the context of policy termination processes to advocate for policies with good results and support from communities. This requires creating a network where local civil society groups can share

information, experiences, good practices, and challenges in a collective learning process.

Civil Society Groups as Policy Entrepreneurs: A Need to Create Stronger Networks in Latin America

Civil society organizations and community-based groups have played an important role in the emergence and evolution of important law enforcement and public health policies in Latin America. One successful example of this is RedTraSex, a transnational network of sex worker organizations in 15 countries (Mzilikazi, 2016). By identifying the common struggles sex workers face and using this knowledge to work together, these organizations nurture solidarity and enhance support from the local communities (Mzilikazi, 2016) to modify the policing environment that increases their daily risks.

RedTraSex members worked together to advocate for their human rights and confront situations that negatively impact their daily lives such as stigma, the risk posed by infectious diseases such as HIV and syphilis, discrimination, and violence perpetrated by law enforcement in the region (RedTraSex, 2017). Their members have designed, implemented, and analyzed the outcomes of a project oriented towards changing police behaviours and attitudes towards sex workers, through training with national and local police officers on human rights and sex work dynamics.

In some countries, such as Honduras, where sex workers can be victims of institutional violence, the organization, along with the police training attendees, elaborated a Police Protocol oriented towards guaranteeing their human rights protection. Considering the positive results of the Honduras project, the network set the goal of sensitizing at least 150 people in each country (RedTraSex, 2017). In Honduras, the sex workers worked closely with police officers in planning the training sessions. This led to important achievements: 16 sessions were run with the active participation of 240 police officers. This is important because despite prejudices and a history of aggression against sex workers, police officers could get first-hand knowledge of their reality and daily life experiences. The project has also faced some challenges, such as trying to empower and support sex workers who could teach these lessons to officers who have conducted violent actions against them.

RedTraSex is an example of an active and organized civil society effort that aligns policing, public health, and human rights goals. Within the network, participants constantly share information, organize events, maintain communication, conduct research and coordinate to demand the protection they deserve by law. By doing this, they present themselves as policy entrepreneurs who are alert to opportunities and act upon them (Petridou et al., 2015).

However, the existence of networks is not enough to guarantee the human rights protection of vulnerable individuals. It is necessary to maintain the collective dynamic and direct the networks' actions towards people whose agency is lost. This means that networks must be designed with an extensive connection with their environment, considering that collective initiatives may not emerge spontaneously and that some people may be left out of the community. Solidarity is needed as an enduring principle of law enforcement and public health collective networks. There is also the need to continue funding community organization efforts to foster the survival of these networks. Some countries, such as Mexico have unfortunately cancelled all federal funds for any type of civil society organization since 2018 (López Obrador, 2019).

Collective Learning as an Innovative Strategy to Design, Implement, and Advocate for Law Enforcement and Public Health Policies

Collective learning is defined as "a collective process, which may include acquiring information through diverse actions (e.g., trial and error), assessing or translating information, and disseminating knowledge or opportunities across individuals in a collective" (Heikkila & Gerlak, 2013, p. 486).

In the context of new policing and public health alternatives, collective learning may be useful in two ways: first, it can be a tool for sharing information between groups or communities within or across countries. This information can be related to good practices, challenges, and strategies related to their projects and programs and lessons learned from them. In Latin America, there is need and an opportunity since civil society groups that strive for changes in policing models are not linked and significant knowledge is therefore not shared.

Also, through collective learning, communities and groups can collect data and develop strategies to influence policy decisions regarding existing or new alternatives. Activists, community leaders, and citizens can become involved in communicative situations, in which they argue, propose, and assess new perspectives, modifying their cognitive structures (Forchtner et al., 2020). This is how communities can construct knowledge and use it in their favour. This is important because, as mentioned above, innovative models and approaches can be at the centre of political confrontations and are at permanent risk of being terminated despite positive impact evaluations. Fostering collective learning throughout the region could help make some of these potentially successful short-lived programs, or "shooting stars," sustainable across communities that face similar structural problems.

An important limitation of collective learning is stigmatization that vulnerable groups often face. When there are rooted patterns of invalidation of communities, collective learning processes are not possible because excluded groups cannot be recipients of any kind of information. In the context of resource-sharing networks, they are invisible; simply, they do not exist: "Stigmatization and its [effects] are themselves powerful forces that act against interaction and 'integration', enforce separation and hinder collective actions" (Creţan et al., 2022, p. 97). Therefore, stigmatization, exclusion, and discrimination are incompatible with the collective learning strategy we propose here. In other words, collective learning actions require significant efforts to overcome stigmatization and, at the same time, collective learning initiatives can insist on inclusion. The fight for collective building is tied to the fight for more inclusive societies.

CONCLUSION

In Latin America, the expansion of law enforcement and public health alternatives has faced lack of interest, as it goes against the current wave of militarization of the security forces and is therefore perceived as a threat by the authorities and policy-makers. Hence, there are certain risks that may impede such policies' success: 1) institutional corruption of

the police and lack of trust on the part of citizens; 2) abandonment of the policy due to changes in government or political authorities; and 3) absence of the dissemination of collective learning from successful programs.

In this article we argue that collective learning is an innovative strategy to strengthen civil society and local community actions advocating for law enforcement and public health programs and policies that are perceived positively. To understand the Latin American context, we concisely explained the dynamics of community-oriented security programs, including the challenges and situations that can lead to policy termination. Also, we reviewed specific cases to illustrate how positively evaluated programs can be terminated and how civil society organizations can actively look for alternatives to influence the status and evolution of certain programs.

We conclude that it is necessary to sensitize the authorities and civil society on the possible alternatives that citizens and interested groups can implement to avoid authoritarian, violent, and corrupt models, lack of knowledge, and the lack of trust of certain political authorities in this kind of strategy.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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Law enforcement and public health approaches in the Asia-Pacific region

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ABSTRACT

The Asia-Pacific region comprises a large number of countries, all with different policing systems and variations in the extent to which these agencies collaborate with multisectoral partners in response to public health–related issues, including harm reduction, gender-based violence, mental health, and COVID-19 pandemic responses. We reviewed 90 programs involving partnerships and cooperation between law enforcement and public health agencies across the region. From this review, we recommend that police agencies develop training and engage in collaborative engagement with a range of health and community stakeholders to evolve police officers' views towards a public health perspective in relation to policing activities. Furthermore, law enforcement and public health approaches should embrace technological advancement and innovation to promote both public safety and community health. As a specific example, different areas have employed different strategies to deal with the COVID-19 pandemic, mainly depending upon available resources and cultural and social factors. However, more collaboration between government agencies, the private sector, and NGOs is needed at national and local levels to effectively respond to the pandemic worldwide.

Key Words Policing system, harm reduction, public safety.

POLICING SYSTEMS IN THE ASIA-PACIFIC

The Asia-Pacific region is large and populous, comprising many different countries in which policing systems vary considerably. Our review found two major interwoven categories of influence on policing systems in the region: religious and colonial. The influence of religions and social philosophies on society has shaped policing cultures as patriarchal, hierarchical, and authoritarian, while police agencies affected by colonialism are often central para-military units solely focusing on crime control and social order (Brodeur, 2010; Cao & Cullen, 2001). Such policing approaches in many countries in Asia and the Pacific, then, have origins in the pursuit of centralization and public order rather than in cooperation with other agencies in terms of health promotion or disease control. In some jurisdictions, police are perceived to be distant from the people but willing to serve the government to help it exercise its political power. As a consequence, there is a lack of public trust in the police, which leads to difficulties in addressing public health issues (Punch & James, 2017).

Nevertheless, policing systems have been developed in many countries in the current century in which community policing approaches have been adopted to provide more modern police services. For example, the decentralization of police forces and the development of the Koban and Chuzaisho systems in Japan put focus on community policing and responding to the needs and concerns of people in terms of public safety and security (National Police Academy of Japan, 2005). Consequently, police agencies can be effective first responders in a range of situations relating to public health, such as accidents, epidemics, and disasters in the community when they have close relationships with the community. Access to information about risks or concerns can contribute to police taking preventive measures or increasing awareness of their role in reducing harms created by some policing practices. Nowadays, law enforcement agencies in many countries are more willing to cooperate with the community and other organisations to enhance public safety and well-being.

POLICING AND PUBLIC HEALTH

According to principles of new public management, partnerships between government, non-governmental agencies, and civil society organisations are required to enhance the efficiency of public services in the form of inter-agency cooperation (Punch, 2019). The partnership between law enforcement

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and public health agencies is particularly crucial in terms of crime and disease prevention and support for victims and patients. For example, victim support services after the tsunami in 2004 which affected India, Indonesia, Malaysia, Myanmar, Sri Lanka, Thailand, Bangladesh, and Japan were provided jointly by law enforcement and public health agencies from both domestic and international institutions, assisting with first aid, body search and recovery, victim identification, biohazard prevention, and infrastructure reconstruction (Punch, 2019). In addition to catastrophic responses, cooperation between police and public health practitioners can take various forms, such as traffic accident prevention, referrals to treatment for substance misuse and psychological disorders, behavioural rehabilitation, and so on.

This article presents the review of nearly 90 law enforcement and public health–related programs in the Asia-Pacific region, covering countries in East and Northeast Asia, South and Southwest Asia, Southeast Asia, and Oceania. We focus on four major issues which countries in the region are currently experiencing: harm reduction approaches to substance misuse, gender-based violence, mental ill-health, and the COVID-19 pandemic. Our main purpose is to examine the extent of police involvement in such programs and their approaches to addressing public health issues. A key finding is that localised law enforcement units in some countries have adapted well to the needs of their local communities. As a result, these police have become more willing to cooperate with other agencies and increasingly use alternative non-police responses to deal with social and public health issues. A further crucial finding, however, is the challenge of scaling up and sustaining good practices in relation to law enforcement and public health partnerships across entire agencies.

CASE STUDIES

Our first focus is the role of law enforcement and public health agencies in harm reduction. From our review of 30 programs in the regions, it appears that most countries use non-police responses led by non-governmental and civil society organizations to minimize the risk of harm from substance misuse and injection-associated HIV transmission. Key approaches to harm reduction include methadone treatment, needle and syringe exchange, and community healthcare services. For instance, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centre for Supporting Community Development Initiatives (SCDI) in Hanoi, Vietnam, have launched a harm reduction program for people who use drugs (PWUD) and people living with HIV (PLWH). This is a community-based program focusing on coordination between former drug users, law enforcement agencies, and other agencies, namely the Ministry of Health, Ministry of Labour, Invalids, and Social Affairs, and medical, legal, and social services in the community. Luong et al. (2015) indicated that inter-agency collaboration is achieved through informal community-based organizations that help reduce harmful impacts of drug use through counselling, treatment, and detoxification. This reduces the risk of HIV transmission in the community because injection-drug use is the main population affected by HIV infection in Vietnam (Lee & Docrat, 2021). In addition, this program potentially mitigates the rate of relapse and crime associated with drug use and dependency. Similar harm reduction programs exist in most Asian countries; however, we found problems impeding the success of such programs, including legal issues and dilemmas for law enforcement. For example, the provision of methadone for drug users is illegal in many countries in the region; therefore, law enforcement agencies are reluctant to either strictly enforce the law or help drug users in the program (Luong et al., 2019).

Secondly, 15 programs addressing gender-based violence were reviewed, including in Bangladesh, India, the Maldives, Pakistan, Nepal, and Sri Lanka. The majority of them (13) employed alternative non-police response approaches led by non-governmental organizations to deal with the issue, which can be divided into two categories: 1) prevention-oriented, focusing on men/offenders; and 2) victim assistance–oriented, focusing on victim support. Police and other law enforcement agencies have little participation in such programs. For example, the Men's Action to Stop Violence Against Women (MASVAW) in Uttar Pradesh, India, is an alliance of men and organizations working on gender issues committed to reacting to and reducing incidences of violence against women. Through cultural and advocacy campaigns, MASVAW raises awareness and recruits new network members who will work for institutional changes in gender relations to promote gender-equitable attitudes and confront conventional beliefs about masculinity and power over women (MenEngage Alliance, 2014). Even though the program is mainly conducted by civil society and youth in local communities, it was found that MASVAW activists could indirectly put pressure on police to engage in addressing gender-based violence via the media (Edström et al., 2015). On the other hand, a police-led program called Rabta ('Connection') in Pakistan focuses on police training to cultivate an attitudinal change in responding to issues of gender-based violence and vulnerable groups. The Rabta police training and reform program has been awarded best practice in the UN Women's Virtual Knowledge Centre. Its focus is on building the capacity of police officers regarding gender, human rights, communication skills, and how to address criminal cases associated with victims of gender-based violence via a police training curriculum designed in collaboration with the National Police Academy and other sectors, such as NGOs, media, academia, and civil society (Sadiq, 2020). Nevertheless, the scope of such programs was quite limited to specific areas and the culture and traditions may have overshadowed gender-based violence issues. To illustrate, it was reported that despite MASVAW, some parents were resistant to their sons treating women as equals because it is unacceptable in society. According to Edström et al. (2015), some Indian male activists are criticized or even mocked by their parents and relatives and told that they would not receive shared ownership of family property.

The third example of partnerships and cooperation focuses on mental health programs, with our review of 19 programs in Australia, Cambodia, China, Hong Kong, India, Indonesia, Singapore, South Korea, Taiwan, Thailand, and Vietnam. All were related to suicide prevention, with three programs addressing police suicide prevention in particular. Most of them were led by governmental health agencies, except for three programs carried out by police. An example of a police suicide prevention program is the BlueHub project in Australia, in which a centre of excellence for police

mental health treatment and support was established to enhance evidence-based interventions by specifically trained physicians for police and other emergency service workers who suffer from mental illness after critical incidents, such as post-traumatic stress disorder (PTSD) (Roberts, 2021). Another interesting program is a police-led psychological autopsy project for suicide prevention in South Korea. It was established in 2015 in collaboration with the Ministry of Health and Welfare to analyze victim demographics, suicide methods, and main causes of suicide by an investigation tool, K-PAC (Korea Psychological Autopsy Checklist) through police investigation records, and to identify better suicide prevention measures. The project sought to examine factors involved in suicides to help reduce the suicide mortality rate in South Korea (Na et al., 2019). However, there remains a lack of programs led by law enforcement agencies, and more mental health training for police is required to mitigate the effect of crisis situations.

In response to the COVID-19 pandemic, our review of 20 programs from Australia, Bangladesh, China, Hong Kong, India, New Zealand, Pakistan, Singapore, the Philippines, South Korea, Taiwan, Thailand, and Vietnam found that all were government-based responses mostly led by law enforcement agencies. Since the COVID-19 pandemic affected public health across the globe, it was vital that governments take immediate action, including through law enforcement, to combat the health crisis and keep their citizens safe. Law enforcement agencies in each country used various innovative means for pandemic management and control, from community-based responses and media interventions to technology-based responses. In some community-based responses, local police worked closely with public health professionals and people in the community. For example, a home visit program in Thailand demonstrated close coordination between police, public health officials, social workers, and village health volunteers to knock on the doors of all households to give advice on COVID-19 prevention, symptoms, and self-observation and to distribute face masks and alcohol-based gel to people in each local community, while warning them about the legal consequences of breaking the lockdown law or public health orders (Kanchanakit & Taveegate, 2020). Similar community policing approaches were instituted in other countries in the region, such as the Philippines and India. In India, police distributed face masks in Ujjain (Mangla & Kapoor, 2020) and community education on COVID-19 prevention and law enforcement regulations along with support from neighbourhood watch groups in Delhi (Mishra, 2020); police even dressed up as Yamraj, the God of Death, to remind people of the perils of lockdown violation in Uttar Pradesh (Kmaneck, 2020).

In addition to community-based responses, media coverage played a crucial role in COVID-19 news and information dissemination. Social media platforms are especially important for public health and law enforcement agencies to spread awareness and provide reliable and trustworthy information about COVID-19 prevention and vaccinations. All of the countries in the region employed both mainstream media and online social media to broadcast infographics, videos, animations, and various types of digital media about COVID-19 prevention practices and the legal consequences of violations of the law during the pandemic. Interestingly, the New Zealand police broadcast a creative series of "self-isolation for beginners" videos to encourage people to stay at home. Most importantly, a wide range of innovative technologies were harnessed by law enforcement and public health agencies to fight the COVID-19 pandemic. Most of the countries used mobile tracking technologies to monitor their citizens, especially when lockdown or home quarantine measures are strictly executed. For instance, Delhi police tracked the location of people under quarantine via mobile phones. Similarly, the Singaporean government sent text messages to contact people under quarantine to click on a link to prove they were at home. Thailand also required inbound foreign travellers to download and register with the ThailandPlus application to monitor self-quarantine. Similar mobile applications were also used in many countries, such as China, Hong Kong, Pakistan, South Korea, Taiwan, Vietnam, and so forth, and some are continuing. Interestingly, Taiwan implemented an effective action against COVID-19 that enforces quarantine and self-isolation using a system called "electronic fence" to track individuals' mobile phones and determine their current location. The system would alert police and local authorities if those under home quarantine moved away from their address or turned off their phones for more than 15 minutes (Gupta et al., 2021). Hong Kong also traced its people under quarantine using wristbands (Liu & Bennett, 2020). Another interesting strategy was found in Seoul, South Korea, where mobile phone and financial transaction data were used to trace nightclub visitors and to identify and tackle COVID-19 cluster transmissions (Kim et al., 2020).

Robotics and artificial intelligence (AI)-based technologies were also employed for surveillance and monitoring activities during the pandemic. For example, drone-based systems were used in many cities in India and China to monitor COVID-19 hotspots and gather data for health-care analysis via thermal imaging and wearable sensors (Kumar et al., 2021). Singapore deployed "Robodogs" named SPOT (remote-controlled, four-legged robots) in a central park to warn people. SPOT also broadcast messages reminding visitors of social distancing measures. It was also fitted with cameras and analytics tools to estimate the number of people in the park and predict superspreading hotspots for COVID-19 (Bouffanais & Lim, 2020). Nevertheless, the virus continues to be readily transmitted and its emerging variants are massively increasing. Therefore, coordination between law enforcement and public health agencies should be strengthened with the use of innovative technologies to curb the spread of the COVID-19 pandemic as soon as possible.

RECOMMENDATIONS

According to the findings, it was found that law enforcement could play a better role in the prevention or control of substance misuse, gender-based violence, mental illness, and the COVID-19 pandemic. Our thematic analysis of the reviewed programs derived from the four issues demonstrated that there are two types of responses that law enforcement and public health agencies in the Asia-Pacific region could improve to enhance the efficiency of disease and crime prevention and control, including police responses and alternative approaches.

Firstly, police responses consist of three categories: education and training, increasing public participation, and

leveraging new technologies for use by police and communities. Improvements in police education and training are vital since they can enhance knowledge, attitudes, and the professional judgement of newly recruited police officers so they can be more focused on coordination and cooperation with other institutions, especially public health agencies (Poothakool, 2016). In terms of harm reduction approaches to substance misuse, the police curriculum should shape trainees' attitudes to work with harm reduction interventions according to public health strategies rather than merely supporting criminalization and charging PWUD (Luong et al., 2019). In other words, people who use drugs problematically should be perceived as patients who need treatment, care, and support rather than as criminals who need to be incarcerated. For gender-based violence, a greater focus on policies and structural changes that promote gender equality and localized engagement of police involvement in responses to gender-based violence in different communities is needed. Police training on attitudes, codes of conduct and protocols, and the recruitment of female police officers can also be more systematically implemented and promoted to increase understanding of gender-based issues and develop better skills to deal with these criminal cases more appropriately and professionally (McMullin-Messier & McMullin, 2020). Similarly, training in the areas of crisis intervention and communication and healthcare and safety measures for police could enhance the police's ability to address mental illness and COVID-19 prevention. Such training would also equip them with knowledge and skills about how to work with public health practitioners to cope with people with health issues in the community and prevent them from exacerbating any existing illnesses.

Secondly, more public engagement is required for police responses at all levels. Law enforcement and policing systems across the region need to be more decentralized. The principles of community-based policing should be implemented to develop an understanding of the nature of community and evidence-based responses to public health situations (Punch, 2019). Public engagement requires all sectors, including government and non-governmental agencies and civil society, to work together as a team to address the issues and respond to the needs of people in the community.

Lastly, innovative technologies should be devised and used to enhance the effectiveness of public health-related programs to make them sustainable and promote better quality of life and well-being for the public. For instance, Australia developed and adopted a telemedicine strategy to provide health-care services to drug users for harm reduction during the COVID-19 pandemic (Perri et al., 2021), but police play no role in the program because the data is not to be shared with law enforcement. There are important reasons not to involve law enforcement agencies in aspects of public health responses, such as privacy implications and data being misused and negatively affecting user uptake of, or engagement with, such technologies. However, some cooperation between public health and law enforcement agencies in the development and assessment of technologies can contribute to re-shaping "what success looks like" to law enforcement agencies and provide feedback loops regarding strategies to reduce harm that avoid criminalization in order to maintain public safety and enhance preventive measures for both crime and disease.

LIMITATIONS IN PRACTICE

While research results demonstrate that law enforcement and public health agencies should develop community-oriented approaches to respond to public health issues, there may be certain limitations due to the current situation in the Asia Pacific region. First, it is clear that policing systems in some countries are still significantly dependent on politics, making it less possible to practically decentralize police forces to communities. Second, partnerships between police, public health, and community sectors in some parts of the region are difficult due to the lack of trust in law enforcement. Third, the availability of resources for cooperation may be insufficient, particularly in developing and underdeveloped countries. The institution of diversion programs, for instance, will be difficult where there are inadequate services to divert people from the criminal justice system. Lack of resources, especially on the public health side, makes it difficult to explore technology-based approaches to address the issues. Finally, resources and education for practitioners are currently scant. Therefore, further research is required to explore more effective approaches for each country and develop guidelines for law enforcement and public health practitioners to assist them in health-care promotion and crime prevention in the region.

CONCLUSION

Although it might be impossible to describe the overall majority of law enforcement and public health approaches in the world's largest and most diverse region, Asia-Pacific, this article has presented four public health–related dimensions in which both sectors are playing a role together: harm reduction, gender-based violence, mental health, and the COVID-19 pandemic response. Since most of the reviewed programs are led by non-police agencies, it is essential that police be more active to take the lead on crime and disease prevention as well as improvements in the quality of life. We propose that police focus more on training to adapt their attitude towards the relationship between crime and public health. In addition, the community policing approach should be adopted to improve participation in the community. Meanwhile, modern technologies should be used in law enforcement and public health activities to effectively help solve the problems.

We found that there are some challenges to the implementation of our recommendations with respect to the collaboration between law enforcement and public health at national and local levels. Further research—especially at national and local levels, given the diversity of contexts—is therefore required to specifically tailor the best and most suitable law enforcement and public health collaborative approaches for each country in the region to foster partnerships and achieve the goals of public safety and public health.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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Law enforcement and public health collaborations and partnerships in Africa

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ABSTRACT

Though not high-profile, collaborations and partnerships between law enforcement agencies (LEAs) and public health organizations do exist across Africa. Law enforcement and public health (LEPH) partnerships are common in responding to epidemics, such as sexually transmissible infections (STIs), tuberculosis, and malaria, and pandemics, such as HIV/AIDS and COVID-19. Some collaborations are in response to gender-based violence (GBV), particular socio-economic problems and challenges, counterinsurgency and terrorism (when it happens within civilian spaces), to address issues of rape, disease, and death. Such approaches are led by local and national governments, law enforcement agencies (LEAs), civil society organizations (CSOs), regional economic bodies, and United Nations agencies. Success and sustainability are achieved mostly were partnerships have long histories of working together, especially among those with established common goals aimed at local, national, and global health outcomes. However, antagonism also exists between CSOs and LEAs, with CSOs placing blame on LEAs for harms caused, and LEAs perceiving CSOs as enemies of the state. The situation arises because of their work with, and advocacy for, the rights around culturally or politically taboo or sensitive matters, such as sex work or homosexuality. Often, partnerships have either not been formed, or, where they have formed but have failed to achieve consensus and joint results, have collapsed. This paper does not pretend to fully represent the pan-African experience, as local variations and conditions are myriad and complex. But it does ultimately observe that partnerships among law enforcement and public health hold promise for improving community outcomes, and much more will need to be done at all levels to achieve effective, humane, and sustained cooperative responses to difficult public health issues in the African context.

Key Words Policing; key populations; rule of law; abortion; vulnerable groups.

INTRODUCTION

Governments strive to govern societies in an orderly and organized manner; laws and regulations guide this organization. Governments have an imperative and a role to enforce the law, and they hold state power to implement this mandate. The idea is that violators of these rules and norms are punished and rehabilitated. The agencies engaged in enforcing the laws (law enforcement agencies, LEAs) act to maintain public order and safety by preventing, detecting, and investigating criminal breaches of these laws. This article will focus on LEAs that deal with citizens and others suspected of having violated a law through a range of actions, including apprehension and detention. National police institutions—police services, forces, or agencies—are LEAs acting on behalf of state parties.

Law enforcement faces a number of challenges deriving from the specific geographical, political, and cultural context, and the impact of global, regional, and national issues. This article will focus on law enforcement and public health collaborations and partnerships in the African region, with particular focus on national police institutions. The objective of the article is to describe and discuss examples of collaborations and partnerships in some parts of Africa, focusing on what is working well and why it is working well. The article highlights and examines some problems and challenges to LEPH collaborations within the African region, and outlines and discusses some proposed solutions.

POLICING IN AFRICA

We found that collaborations between civil society organizations (CSOs) and national police institutions exist in some parts of Africa. In the jurisdictions we reviewed for this article, this is especially the case where countries have

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transitioned from colonial or apartheid states, in which LEAs, especially police, were used to crush political opposition or control community mindsets. Many African jurisdictions learned lessons from this transition from colonial to sovereign states. Colonial laws have progressively—but by no means completely—changed over the years: they have posed serious challenges to the role and nature of democratic policing after states gained independence from their colonisers. As such, some African countries have experienced terrorism, insurgency, serious violent crimes, and citizen uprisings. This situation has in large part been due to deteriorations in the political and socioeconomic environment.

ENFORCING THE LAW IN CONFLICT SETTINGS

Police institutions across Africa face challenges when enforcing the law because of existing hostile social and political environments. Some countries are also experiencing wars, insurgency, and serious violent crimes. The mandate of police and their accountability in war zones has been questionable, especially where military solutions are deployed against terrorism. Police and other law enforcement officers have often become perpetrators of abuse and human rights violations. Complex situations arise when counterinsurgency or responses to terrorism happen within civilian spaces. Police in some cases are under military command while they are expected to investigate and hold terrorist suspects to the rule of law. Further, some African countries have inherited colonial-era laws criminalizing, for instance, same-sex relationships, sex work, and drug use. In most countries where these laws are enforced, police actions have been detrimental to public health. Police actions make these groups shy away from seeking health and criminal justice services for fear of being arrested themselves and detained by law enforcers. As a result, some communities, for example lesbian, gay, bisexual, trans, and intersex (LGBTI) individuals, sex workers (SW), and people who use drugs (PWUD), have been made socially and economically disadvantaged, and vulnerable (Scheibe et al., 2016).

POLICING ISSUES AND VULNERABLE GROUPS

For some time now, HIV infection has no longer been a death sentence; globally, HIV is largely controlled among the general population. People have access to medications, and the majority of people living with HIV who are on anti-retroviral therapy have undetectable viral loads in their blood. Despite these gains, however, some communities and populations have been left out of the response because of adverse policies and legal environments. Many countries in Africa have enacted HIV criminalization laws, with women more likely to be prosecuted than men because of widespread antenatal HIV testing. Many countries introduced very broad HIV-specific legislation in past decades, but several have since been decriminalizing HIV transmission issues (Barré-Sinoussi et al., 2018).

In 32 African countries (out of a total of about 55), homosexuality or consensual sex among same-sex adults is criminalized, with penalties up to life imprisonment and death (https://antigaylaws.org/regional/africa/); most African countries criminalize prostitution (Scorgie et al., 2013), and all criminalize the use of some drugs. Members of LGBTI communities are scared to seek early mental health, STI, and HIV services due to fear of disclosing their same-sex behaviours or sexual orientation and exposing themselves to the risk of being arrested. Law enforcement officers often demand unprotected sex from sex workers to release them when they are arrested under loitering or petty crimes (Scorgie et al., 2013; Women's Legal Centre et al., 2012). Police in some cases confiscate clean needles that government health departments and CSOs have distributed, undermining global and national HIV/STI prevention efforts. Policies and laws are not aligned to general provision of health and human rights services for vulnerable groups.

Police attitudes and practices towards vulnerable groups come from the community and are governed by these policies and laws; this has several implications for society at large, as well as for the communities themselves. Community relationships, social cohesion, and human rights are influenced by the nature of these interactions. Ultimately, the nature and quality of interactions between police and vulnerable communities can reinforce or reduce cycles of violence and can increase or decrease the risk of HIV infection and transmission. Police actions can also promote or prevent access to health, HIV prevention, and treatment services for vulnerable groups, their families, and the entire community. Police directly serve the general public when they act to discover criminal activities and when investigating crimes and apprehending offenders, but major and frequent irregularities have been reported when police arrest offenders, put them in custody, or detain them. Some of these reported issues related to members of LGBTI, SW, and PWUD communities include the following (Scheibe & Müller, 2016):

- Mishandling of suspects during arrest:
  - Mishandling of sex workers by police, including fondling or inappropriately conducting body searches;
  - Body searches of trans persons often done by a police officer not of the preferred gender.
- Disproportionate use of force:
  - Use of excessive force when arresting PWUD.
- Unlawful arrests:
  - Use of loitering or petty offence laws to arrest SWs who, in some cases, are put in the back of a police van and driven around for no reason other than to punish them;
  - Denial of access to the criminal justice system services for SWs, as their cases are not investigated;
  - Use of condoms by police as evidence to arrest female sex workers at hot spots or in the streets;
  - Targeting of SWs by police under specific operations, for example Operation Chipo Chiroorwa by Zimbabwe Republic Police;
  - Unlawful arrests of members of the general public —LGBTI, SWs, and PWUD—that are costly to police institutions (for example South African Police Service spent ZAR34 million (about USD2.26 million) in 2016) (South African Police Services, 2017)
- Police corruption:
  - Demand that SWs pay a bribe in order to avoid arrest or to be released from police custody.
- Rape and sexual harassment:

- Rape by police officers of SWs who are then released without charge;
- Unlawful body searches conducted by police which dehumanize SWs;
- Fondling of trans persons by police officers during body searches, and rape of trans persons in police custody.

POLICING, TERRORISM, AND COUNTERINSURGENCY

In this review, we refer specifically to Somalia, South Sudan, Eritrea, Central African Republic, Western Sahara, Democratic Republic of Congo, and Mali.

In some African countries, implementation of the rule of law (RoL) is a critical challenge on emerging from war or civil conflict. Police from other jurisdictions have partnered through United Nations (UN) peace building missions to assist in the development of RoL frameworks in such countries, to help them learn to collaborate and engage with military and civilian components in developing strategies towards strengthening RoL. Police peace building and strengthening missions and operations have been instrumental in developing national police capacities. Support for host countries has included protecting civilians under imminent threat and assisting them with security sector reform, and in some cases supporting the disarmament, demobilization, and reintegration of ex-combatants. Such a process was exemplified within the Southern Africa Development Community (SADC) during terrorism and insurgencies in Mozambique. Other examples are found in the Economic Community of West African States (ECOWAS) responding to the Boko Haram in Nigeria, the Economic Community of Central African States (ECCAS) responding to the Revolutionary United Front (RUF) in Sierra Leone, and the Common Market for Eastern and Southern Africa (COMESA) responding to insurgencies of the Lord's Resistance Army (LRA) in Uganda and Al-Shabaab in Kenya and Somalia.

Further in this role of implementing RoL programs, police have addressed issues of sexual abuse, sexual and gender-based violence (GBV), and violence against children and vulnerable persons in ensuring the State was stable and secure. Policing around GBV has been key in ensuring most police institutions prioritize GBV as a serious offense. Partnerships and collaborations with CSOs, community-based organizations (CBOs), and communities do exist as well in addressing such matters. For example, police institutions in the Southern African Regional Police Chiefs Co-operation Organisation (SARPCCO) have all set up specific branches or departments dealing with GBV to offer specialized services in addressing GBV prevention and assistance to and protection of survivors (Katumba, 2020).

Law Enforcement and Public Health Case Studies

Case studies were documented through literature review, network referrals, and further conducting interviews to gather more data to show that collaborations and partnerships do exist in some parts of Africa. A summary is provided in Appendix 1. These collaborations and partnerships, for example the South African Police Service (SAPS) and CSOs (COC Nederland, Aidsfonds, the Triangle Project, Sisonke, TB/HIV Care, the South African Network of People Who Use Drugs, and the African Policing Civilian Oversight Forum) in South Africa and the Netherlands partnered to develop the Dignity, Diversity and Policing (DDP) training program. The program brings in key populations as experts to co-facilitate the training sessions with SAPS officers. Results show improved police officer strategies in responding appropriately to issues of sexuality, drug use, and GBV, among others. SAPS officers reported that DDP, a training program on public health and human rights for all improved their knowledge, attitudes, and practices when arresting and detaining suspects, especially LGBTI individuals, SWs, and PWUD.

Further, another collaboration with PWUD in Durban, South Africa, highlighted that police had become advocates for harm reduction during the COVID-19 lockdown in Durban, thereby shifting the dominant narrative that law enforcers are abusers and human rights violators (Marks et al., 2020). In these partnerships, law enforcement officers reported having improved in managing challenging situations, for example, in situations of suspects resisting arrest or engaging in verbal abuse, as well as in handling overdoses and withdrawals by PWUD while in police custody. In general, law enforcement officers who had received training demonstrated increased knowledge and an improvement in their attitudes and practices towards key populations or vulnerable groups.

There are more examples of programs that are working well to build better law enforcement and public health collaborations and partnerships. The republic of Mozambique Police Services has also responded to GBV and other forms of violence, particularly relating to sex workers, drug users, and the LGBTI community, including with an emergency response system set up to deal with violence against sex workers. The gender desk set up by the Mozambique police allows key populations or vulnerable groups to receive enhanced services. In Kenya and Zimbabwe, there are documented cases of programs responding to stigma, discrimination, and violence perpetrated by police where police and sex workers hold meetings to share information and knowledge on improving policing sex workers.

Liberia and Sierra Leone have CSOs coming together with the security sector to respond to policing and human rights of marginalized groups, especially sex workers and men who have sex with other men. According to Ipas, in Ghana, Nigeria, Uganda and Zambia, CSOs and CBOs work on educating police officers on human rights and raise awareness, especially on issues relating to the treatment of women and girls. This work is in connection with accessing abortion services, which is extremely difficult because of criminalization. Police can behave very brutally, so that girls and women do not have access to safe health-care providers for abortions because of the fear of being reported to the police.

The Government of Zimbabwe was also active, especially the Zimbabwe Republic Police, in addressing issues relating to COVID-19. It was reported that police officers working in the medical field were deployed to general hospitals and provided clinical services during the COVID-19 pandemic in 2020 and 2021. Lastly, according to United Nations reports, there have been collaborations addressing issues of GBV, rape, and disease in areas of conflict and violence, for example in Central African Republic, Democratic Republic of the Congo, Eritrea, Mali, Somalia, and Sudan. During the past 20 years,

police officers have been involved in peace-building missions and the response to issues addressing RoL and in building a RoL framework in those countries. The cases shared are not conclusive or a full representation of Africa as a region, but these are some of the very good examples of collaborations and partnerships. The partnerships enhance law enforcement and public health initiatives to ensure communities are safe and can access public health services.

ONGOING CHALLENGES AND ESSENTIAL OPPORTUNITIES EMERGING IN LAW ENFORCEMENT AND PUBLIC HEALTH COLLABORATIONS AND PARTNERSHIPS

Daily police operations, actions, and practices of arrest, police custody, and pre-trial detention can have severe consequences for public health. Negative attitudes held and practices used by police have made women and girls, SWs, PWUD, and LGBTI individuals vulnerable or susceptible to trauma, mental health challenges, HIV, AIDS, and STIs. The actions of police officers affect the way these groups seek health services and support from the criminal justice system. These groups are afraid and fear arrest or abuse either when reporting cases at a police station or seeking health services. Criminalization of public health and normal behavioural issues, such as abortion, drug use, same-sex sexual behaviours, and prostitution, sets the scene for driving those involved in these behaviours underground; discriminatory policing compounds the impact. These situations make it difficult for members of such communities to make the decision to seek health services. As a result, their communities are disproportionally affected by mental health issues, complications after abortion, HIV, AIDS, hepatitis, and other STIs. The situation is often made worse by punitive measures governments take instead of appropriately resolving the health and socio-economic hardships these groups suffer. To offer sustainable solutions, CSOs and CBOs have had to continuously approach their governments and police institutions and advocate for possible collaborations and partnerships to rectify the public health problems.

The initiation, implementation, and maintenance of good relationships within police collaborations and partnerships are fraught with challenges and issues, many of which have been documented. CSOs and CBOs are often perceived by police and other authorities as enemies of the state because they deal with sensitive societal and community issues and advocate for marginalized and criminalized populations. These issues are regarded as taboo, perceived to promote immoral behaviours, or characterized as "the Western agenda." When Western countries or Western-based agencies have voiced or been seen to be supporting human rights values of certain groups, such as homosexual and sex workers' health and rights, local CSOs and CBOs have suffered the backlash.

Police organizations are rigid, bureaucratic, and protocol-driven, and dealing with their processes can be lengthy and time-consuming, making it difficult for non-state parties to cope financially and meet project timelines. As a result, CSOs and CBOs often give up attempting to follow process, they lose funding, projects are not completed, and outcomes are not realized. Further, CSOs and CBOs often lack convincing needs-based research with which to advocate, to get them on the agenda, with the result that they are not taken seriously by law enforcement agencies. Non-state parties often have insufficient knowledge of the processes, protocols, and structure of law enforcement, especially police processes and cultures, to be able to navigate them. Above all, CSOs and CBOs lack the financial and human resources to initiate and implement projects and maintain relationships within the collaborations and partnerships.

The SAPS's DDP training program needs assessment provides good examples (COC Netherlands & SAPS, 2017). Police acknowledged limited understanding of sexual orientation and gender identity within the service. SAPS also acknowledged stigmatizing attitudes and practices towards LGBTI people. The rights of SWs were not recognized. Most police understood that sex work was done primarily for financial reasons and associated sex work with crime, particularly theft and organized crime syndicates. Sex workers were often arrested to reach targets. Further, police recognized drug use as a priority concern in South Africa. Police had very little understanding of the risks of drugs and drug treatment. The term "harm reduction" and related programs were not known. Police officers acknowledged stigmatizing attitudes towards PWUD and recognized that their moral views and personal opinions influenced their attitudes towards PWUD and other key populations. Training was seen as important to improve relationships and collaborations with LGBTI people, both within SAPS and with the wider LGBTI community. Training was also identified as necessary to help implement existing protocols around handling transgender people.

Following the training, police conduct when searching and arresting PWUD and SWs improved. It was reported that police no longer confiscated condoms from SWs and, to some extent, understand harm reduction programs. Some trained police officers became ambassadors and champions for programs that advocate for vulnerable groups. This partnership has continued to work.

OBSERVATIONS AND CONCLUSIONS

Public health–based and human rights–based approaches are highly recommended in reforming police institutions in Africa. Prioritization of the protection of human rights is a major concern, and these partnerships and collaborations between police and CSOs have proved to be critical in advocating for such. The partnerships and collaborations are recommended to ensure that national police institutions hold themselves and other law enforcement agencies accountable. The partnerships are working towards reducing the likelihood of police becoming platforms for further abuse and human rights violations as their role is not to harm but to serve, protect, and ensure safety.

This report is limited to the few police collaborations presented and to the knowledge of the researchers' networks. Collaborations and partnerships do exist and need to be supported, and many more established, as there are many challenges. While not generalizable, the issues and challenges highlighted are common to many jurisdictions and continue to reflect the early adoption of a broadened mission for law enforcement, one more tied to the essential outcomes of community safety and well-being. Early lessons in Africa show

promise, as they have in other settings globally. Continued research and application will help such practices evolve. But for these changes to truly take hold and have lasting success and impact, greater dialogue about the broadest public health aims, and the cross-over with the many roles of policing that can contribute in such partnerships, must continue to occur at the highest levels of public policy.

CONFLICT OF INTEREST DISCLOSURES

The author declares that there are no conflicts of interest.

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APPENDIX 1: Case studies of LEPH partnerships and collaborations within Africa

ID	Country	Name of program	Theme	Program description and outcomes
1	South Africa, Durban	The Durban Moment	Harm reduction	In Durban, South Africa, police advocated for harm reduction during the COVID-19 lockdown in Durban, thereby shifting the dominant narrative that police officers are abusers.
2	Mozambique, 11 provinces	Hands Off!	Violence, GBV	In Mozambique, law enforcement officers were one of the major perpetrators of violence against SWs. After years of lobbying, Pathfinder, an international NGO, and SW-led network Tiyane Vavassate got SWs and police officers to work together directly.
3	Kenya, Kisumu	Keeping Alive Societies' Hope (KASH) – From Abuse to Protection: Building Understanding Between Police Officers and Sex Workers	Gender, violence, sexual orientation, gender identity & expression	Police sensitization on human rights of marginalized groups (SW & MSM)
4	Liberia & Sierra Leone	LEGAL & SoSNoL	Gender/, violence, SOGIE, COVID-19	Educating police officers on human rights and raising awareness on COVID-19 among police officers as an emergency response
5	Ghana, Nigeria, Uganda, & Zambia	Ipas – Police as partners in improving abortion access	Gender, abortion	Training police to be allies in advocating and helping rather than hindering women's access to abortion care. Training police officers on abortion law and the right of women to access services.
6	South Africa	South African Police Service (SAPS) Dignity, Diversity and Policing program	Violence, SOGIE, Gender	Training South African police to incorporate human rights principles relating to drug use, violence, gender identity and expression, and sexual orientation.
7	Zimbabwe	Space for Marginalized Groups in Diversity. Zimbabwe Trust's sensitization of police officers in Masvingo Zimbabwe	Violence, gender, sex work	In 2020 during the first phase of the COVID-19 lockdown, 30 sex workers were chased away from the compound where they had lived for over 30 years. The Zimbabwe Republic Police (ZRP) Dispol Masvingo Central appreciated the dialogue and admitted they needed sensitization on the subject matter. Since then, SWs have been allocated a slot in the ZRP quarterly meetings to provide sensitization talks on issues relating to sex work, SWs, and marginalized groups. Court lenience has also been observed, where restrictions have been reduced and sex workers and other minority groups allowed to access courts with the GBV survivors. Case handling has also improved because of a proper case tracking and tracing.
8	Zimbabwe	Provision of clinical services by Zimbabwe Republic Police at government hospitals and clinics during COVID lockdown	COVID-19	During the COVID-19 lockdowns in 2020 and 2021, Zimbabwe law enforcement agencies, including the ZRP, were engaged in providing clinical services at general hospitals and clinics. Health care workers from the security sector were deployed to provide this service.
9	Africa (Somalia, Sudan, Eritrea, Central African Republic, Western Sahara, Democratic Republic of Congo, Mali)	The Development of peace operations in Africa, and its police components	Gender, conflict, violence, sexual abuse	Police have assisted in the development of RoL frameworks in countries emerging from conflict. Police collaborated and engaged with military and civilian components in developing strategies towards strengthening RoL. The police peace-building missions and operations cover developing national police capacity within the host country; supporting protection of civilians under imminent threat; assisting security sector reform; supporting the disarmament, demobilization, and reintegration of ex-combatants. Addressing issues of sexual abuse, sexual and gender-based violence, and violence against children and vulnerable persons has also been key as part of critical components of a stable and secure state.

GBV = gender-based violence; SW = sex worker; NGO = non-government organization; MSM = men who have sex with men; SOGIE = sexual orientation, gender identity and expression; RoL = rule of law.

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Snapshots from Kyrgyzstan: Promising early partnerships in community safety and well-being

Erkinbek Iriskulbekov* and Ilimbek Sadykov*

In 2021, Kyrgyzstan celebrated the 30th anniversary of its independence. It was on August 31, 1991, that the "Legendary National Parliament" adopted the Declaration of Kyrgyz state Independence. During the previous 55 years, Kyrgyzstan was part of the Union of Soviet Socialist Republics (USSR). After gaining its sovereignty, Kyrgyzstan continued to use the Soviet infrastructure to manage its affairs, and its system of work was still based on the Soviet model. Much remains that was inherited from the Soviet period.

The system of governance in the Soviet Union, which had been established for many years, continues to be used 30 years later. Of course, since their independence, Kyrgyzstan and other post-Soviet Union countries have made reforms in several areas (including the police system). Some of these reforms adapted to the new conditions, but others failed, a significant proportion of the population not being ready to embrace reform. Nonetheless, the work of law enforcement agencies and public health in Kyrgyzstan has undergone periodical changes, and several new approaches have been integrated. These two structures are independent departments in the same chain, and the collaboration between them is carried out within the spirit of achieving their common goals and objectives, which are mainly declared in the strategic country documents and laws.

One of the more visible examples of the joint work of law enforcement agencies and public health is the initiative aimed at preventing the use of illegal drugs and the introduction of new models for drug users. These efforts are based on the elimination of repressive drug policies. Thus, in 1999, the first needle exchange program appeared in Kyrgyzstan, successfully launched in two large cities—Bishkek (the capital) and Osh (the biggest city in the south). Program goals included: 1) reducing the risk of transmission of HIV and other infections from sharing needles, syringes, or contaminated drug preparation equipment among injecting drug users (IDUs); 2) better integrating IDUs into mainstream society and ensuring their equal rights and opportunities; 3) improving the criminal situation in the country. The program was implemented in collaboration with the Ministry of Health, the Ministry of Justice, and the Ministry of the Interior. Early in the new millennium (2000–2001), Kyrgyzstan became the only country in Central Asia and among the Commonwealth of Independent States (CIS)[1] to establish the needle exchange program in prisons.

The second program, which has proven to be a prominent and positive initiative, is the methadone substitution maintenance therapy (MMT) program. The MMT program was first introduced in Kyrgyzstan in 2002 and managed as a pilot project in two cities, Bishkek (led by the Republican Narcology Center) and Osh (led by the Osh Interregional Narcology Center). The maintenance therapy goals were to stop or reduce the use of illicit opioids, reduce the harm and health risks from a particular use (for example, the risk of diseases from sharing needles), and reduce the social consequences of drug addiction in general. Subsequently, the MMT program expanded geographically to cover all the large regions of Kyrgyzstan. Additional service provision points (sites) for the legal use of methadone were opened, and the program was also introduced in the country's penitentiary institutions (pre-trial detention centres and prisons). The modest role of law enforcement agencies, which continued to pursue the goal of preventing illegal drug use, was to refer drug users to needle exchange programs and MMT and, at the same time, not to interfere with the sites' activities. Of interest, in later years, representatives from neighbouring countries have visited Kyrgyzstan to study these initiatives.

With the involvement of public health experts and activists, regular training sessions were conducted for law enforcement officers. These events were focused on the need for partnership between public health and police, and the need for further support of HIV-prevention and harm-reduction programs. Regulatory documents were developed jointly with the Ministry of Health and the Ministry of the Interior to implement these programs at the legislative level. Today, the joint work of law enforcement agencies and public health has allowed these programs to continue to be provided in Kyrgyzstan.

The most recent example of partnership work between law enforcement agencies and public health arose due to the COVID-19 situation in Kyrgyzstan. From March 25 to May 10, 2020, a state of emergency was declared in certain territories

[1] Excluding the countries of Moldova and Belarus.

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of Kyrgyzstan, known locally as "the lockdown." To ensure compliance, commandant's offices were created in which the leading role was given to the Ministry of the Interior. The general epidemiological situation and the welfare of the population remained under the coordination of the Ministry of Health.

The COVID-19 pandemic made 2020 a difficult period not only for Kyrgyzstan but for nations all over the world. Kyrgyzstan's public health system was not able to manage the situation with its own resources. Law enforcement agencies were entrusted with the mission of supporting the maintenance of order and ensuring control of the imposed restrictive measures for the population. The Presidential Decree of March 24, 2020, determined the framework for temporary restrictions on the rights and freedoms of citizens, and further elaboration of restrictive measures was entrusted to the commandant's offices. The joint coordinated work of public health and law enforcement agencies prevented a massive spread of COVID-19 during the period of restrictive measures. For example, IDUs received methadone therapy and other services with no interruption, and community paralegals continued to mobilize humanitarian aid for marginalized populations.

During the lockdowns, the Office of the Mayor in Bishkek created special multidisciplinary mobile teams which included representatives from law enforcement agencies and medical establishments, a social worker, and a psychologist. Jointly, this team carried out visits to homes where domestic violence had been reported to have taken place and provided emergency aid to the victims. Jointly with medical workers, law enforcement agencies carried out patrols and introduced preventive educational work among the population to mitigate the spread of COVID-19. During the first wave of COVID-19, the Kyrgyz health-care system experienced a significant shortage of medicines, including oxygen concentrates, as well as beds for hospitalizing seriously ill patients. It was medical workers who received the initial onslaught of complaints from disgruntled relatives of patients.

Without the help of law enforcement agencies, the COVID situation may not have been stabilized, and the consequences to public health and for health-care professionals would likely have been more serious. This recent experience adds to the early promise of such partnerships in Kyrgyzstan and will hopefully add support to their continuing forward momentum in more stable times ahead.

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Responding to persons in mental health crisis: A cross-country comparative study of professionals' perspectives on psychiatric ambulance and street triage models

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ABSTRACT

People with mental illness can experience mental health crises (MHCs) that manifest in behaviours risky for the affected persons and for others, often resulting in unwanted police encounters and detention. Mobile crisis teams employing the psychiatric ambulance model (PAM) have shown positive effects when responding to MHCs, including diverting patients from police custody. However, the literature contains few reports about PAM. The emerging model of street triage (ST) is more frequently used and better researched. This study explored and compared facilitators and barriers of PAM and ST from the perspective of professionals from different countries. We conducted 12 semi-structured interviews with key PAM stakeholders in Sweden and the Netherlands and ST stakeholders in England, then performed comparative thematic analysis. Participants believed that PAM and ST led to better care for persons in MHC, reducing stigma and use of force. The main facilitators for Swedish participants were that PAM is a specialty with highly experienced and autonomous staff. For Dutch participants, the more generalized medium-care ambulance led to success. Street triage enhanced overall safety and interagency collaboration. A common barrier was the lack of (emergency) treatment options and funding to meet the high demand for mental health care. Future research should explore collaboration between mobile crisis teams and community care to improve MHC response, and the perspectives of persons with mental illness on mental health emergency response models. Careful assessment is recommended to determine which mental health emergency response model best suits a specific local or national context.

Key Words Psychiatric emergency; mental illness; mobile crisis teams; mental health emergency response; psychiatric nurses; co-response; police; community care.

INTRODUCTION

People with mental illness have a high potential for experiencing a mental health crisis (MHC) and, as in any health emergency, quick and effective action is important to avoid deterioration of health, injury, or death (Brister, 2018). An MHC is "any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community" (Brister, 2018, p. 5).

Deinstitutionalization coupled with a lack of mental health (MH) resources have made the police increasingly responsible for MHC responses, which can be complex (Bradbury et al., 2016; Jacob et al., 2014; Lamb & Bachrach, 2001; Wachholz & Mullaly, 1993). Policy-makers and funders globally have failed to prioritize care and treatment for people suffering from mental illness (Becker & Kleinman, 2013; Vigo et al., 2016; World Health Organization, 2019). Without alternatives to police involvement, persons in MHC often end up in jails, prisons, general hospitals, or forensic institutions, with longstanding negative psychological effects on the person (Bradbury et al., 2016).

To ameliorate MHC response and divert cases from the police, mobile crisis teams (MCTs) can provide professional emergency MH assessment and care outside of institutions (Geller et al., 1995; Hogan & Goldman, 2021). These teams

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differ greatly in organization, composition, and structure between and within countries but are widely accepted as an effective approach to MHCs (Carpenter et al., 2013; Hogan & Goldman, 2021; Jacob et al., 2014; Landeen et al., 2004; Muehsam, 2019). Models include police-based Crisis Intervention Teams (CIT), MH (community) outreach teams, co-response teams with MH professionals and law enforcement and/or paramedics, and responses handled by voluntary sector personnel teamed up with MH professionals (Nonko, 2020; Eugene Police Department, n.d.).

One MCT is the psychiatric ambulance model (PAM) that has operated in Australia, India, England, Denmark, Norway, Sweden, and the Netherlands (Faddy et al., 2017; Chandrashekar et al., 2009; Trainer, 2020; Nordentoft et al., 2002; Bouveng et al., 2017; Kuiper, 2012). There is no set description of PAM available in the literature, but we found it typically consists of a (modified) ambulance vehicle staffed by a paramedic and one or two (psychiatric) nurses or a psychiatrist, responding to MH emergency calls. Though PAM has been presented in the media as a successful emergency MH response (Kjølberg, 2018; Pandika, 2014), few studies have examined this model. Findings show that PAM may reduce violence and distress for both persons in MHC and their families (Chandrashekar et al., 2009; Lindström et al., 2020), police involvement (Kuiper, 2012), and admissions to the (psychiatric) emergency department (PED/ED) (Bouveng et al., 2017; Faddy et al., 2017; Nordentoft et al., 2002), and indirect costs (Carlborg et al., 2020). In this study, our focus was on two countries with comparable health and law enforcement systems, Sweden and the Netherlands, which both run a PAM.[1]

A more common MCT is the street triage (ST) model, as seen in the United Kingdom (UK), Canada, Australia and the United States (Puntis et al., 2018; Kirst et al., 2015; Lancaster, 2016). Street triage usually consists of a police officer and a psychiatric nurse, either together in one vehicle or co-responding from a control room (Puntis et al., 2018). Street triage improves outcomes for persons in MHC and reduces inappropriate use of involuntary inpatient care (Lancaster, 2016). Our study focuses on ST models in England, a former European country with health and law enforcement systems comparable with those of Sweden and the Netherlands.

Crisis response in MH is still a developing area of practice, with little in the way of firmly defined response models and many research gaps. While both PAM and ST have been presented internationally as "successful" response models, greater knowledge is needed about professional experiences with PAM and ST in order to achieve better care for persons in MHC worldwide. Therefore, the aim of this study was to explore professionals' perspectives on facilitators and barriers of PAM and ST, comparing three different countries: Sweden, the Netherlands, and England. The results will help practitioners and commissioners determine which particular MHC response model is most likely to be of benefit considering the context.

[1] Sweden has a PAM organized as described above, typically with two PAM vehicles (Bouveng et al., 2017). The Netherlands had a PAM like Sweden's, with 2 vehicles, called the "psycholance," for about 4 years, but changed it to a medium-care ambulance normally used for planned care, with 50 vehicles, in 2018. This has a focus on psychiatry, staffed by an ambulance driver and a medium-care ambulance nurse (ZonMw, 2018).

METHODS

A qualitative interview design was chosen, as this study focuses on the perspectives of people (Gray, 2018). To enhance reliability, the same qualitative design as Bailey et al. (2018) was used. These authors conducted semi-structured interviews with key program stakeholders, looking at barriers and facilitators to implementing an urban co-response model, a specific type of MCT.

Based on a literature review and orienting conversations with professionals, we identified stakeholders: police officers, (psychiatric) nurses, paramedics, psychiatrists, medical doctors and directors, program managers and public health managers. Participants were included if they 1) were closely involved in a PAM or ST project (i.e., had knowledge of the use, people, network, MHCs and organization), 2) were able to communicate in English or Dutch, 3) were available for online interviews between March and May 2021, and 4) consented to participation.

Purposive convenience sampling was performed where stakeholders from the researchers' networks were approached via e-mail, and the snowball method was used to identify additional participants. This led to recruitment of ten PAM stakeholders from two large cities in Sweden and the Netherlands of roughly the same size, and two ST stakeholders from England, one from a large rural area and one from a large urban area. Three pilot interviews were conducted, two of which were included in the dataset for analysis (one pilot interview did not touch on the topic of ST). The final sample included 12 key stakeholders ($n = 12$), comprised of 7 men and 5 women with an average working experience of 19.5 years (range: 8 to 35 years) (see Table I).

TABLE I Sample characteristics.

Participant number (P)	Profession	Country	Gender	Experience in working years
1	Public health manager	The Netherlands	M	*
2	Police officer	The Netherlands	F	29
3	Psychiatric nurse	The Netherlands	F	19
4	Psychiatrist	The Netherlands	M	10
5	Medical director	The Netherlands	M	35
6	Medical doctor	Sweden	M	21
7	Psychiatric nurse	Sweden	F	8
8	Paramedic	Sweden	M	27
9	Psychiatrist	Sweden	M	11
10	Police officer	Sweden	F	15
11	Police officer	England	F	24
12	Police officer	England	M	15

*Not reported

Individual semi-structured interviews were administered using an interview guide (see Appendix 1) based on concepts from the literature review, the interview guide used by Bailey et al. (2018), the proceedings of the Law Enforcement and Public Health conference (LEPH, 2021), and the Crisis Intervention System (CIS) model (Ordonez et al., 2007). Interviews (45–60 minutes) were performed by the lead researcher (IdeJ), in either English or Dutch, and were audio-recorded.

Audio recordings were transcribed verbatim, then carefully read and reflected upon. A summary was sent to each participant for member validation. IdeJ performed inductive thematic analysis (Gray, 2018) using MAXQDA 2020 (Berlin: VERBI GmbH). Line-by-line open coding was performed separately for each transcript, followed by axial and selective coding. Inspired by Bailey et al. (2018), directed content analysis was performed, allocating emergent themes to two broad categories—"barriers" and "facilitators"—for both PAM and ST. Comparative analysis was then used (Guest et al., 2011). The lead researcher discussed coding results and interpretation at various moments with other members of the team.

Ethics

The research proposal was reviewed by the Research Ethics Review Committee of the Faculty of Social Sciences of Vrije Universiteit Amsterdam (VU, 2021). A data management plan ensured secure storage and processing of data. All participants signed informed consent forms online. No financial incentives were provided.

RESULTS

Our research revealed that the "right" PAM/ST configuration was heavily context-dependent, but also that both were perceived as successful approaches to MHC response. Exploration of stakeholder perspectives resulted in five major themes, each with one or more sub-theme(s) that contained both facilitators and barriers (see Table II). Almost all barriers and facilitators identified fell within these five themes: role division, stigma attached to MH conditions, capacity of teams and health-care systems, funding for PAM/ST, and skills of PAM/ST practitioners. In the following sections, these themes and the sub-themes that participants highlighted as most important are described. In a different context, of course, sub-themes not emphasised by these participants might have greater importance.

Role Division

In all countries, the participants stated that PAM/ST was needed because the assessment and transport of persons in MHC is a health-care task, not a police task. Moreover, the police are not trained in MH and may unjustly detain persons in MHC. The PAM/ST can divert MHCs from the police and detention to the care they need: "So instead of, as a criminal to the station, you go as a patient to a health-care facility" (P5). However, participants remarked that regular

TABLE II Facilitators and barriers of PAM and ST per theme.

Themes	Facilitators	Barriers
Role division	MH is a health-care task.[abc] PAM/ST divert MHCs from police and detention.[abc] ST police officers provide safety for all stakeholders involved in MHC response.[c] PAM/ST have a high level of autonomy.[bc] PAM performs high quality assessments and interventions.[b] PAM/ST can often stabilize MHCs in home environments.[bc] Access to medical/MH records allows PAM and ST to provide better care.[bc]	Police often detain persons in MHC and are not well educated in MH.[abc] Police often aggravate crisis situations and cause violence.[ac] Police did not want to deal with persons in MHC anymore.[a] Not all PAM staff are properly trained to perform interventions or autonomously make decisions.[a] PAM staff do not have access to medical/MH records.[a]
Stigma	PAM/ST destigmatize and normalize MHC response.[abc]	Much stigma remains around persons in MHC, also among health-care professionals.[abc] Police cars/uniforms are stigmatizing.[abc]
Capacity	Medium-care ambulances increase capacity.[a] PED is large and located next to somatic ED.[b] ST enhances interagency collaboration.[c]	PAM is often dispatched to the "wrong" calls by dispatch centre.[b] PAM is often unavailable and needs to expand.[b] Lack of capacity in (P)EDs, crisis intervention teams, and long-term treatment facilities.[abc] EDs are unsuited for persons in MHC.[abc]
Funding	Permanent regional funding brings sustainability.[abc] ST have buy-ins from NHS and police.[c]	Funding does not keep up with demand for MH care.[abc]
Skills	Highly skilled and experienced psychiatric nurses combined with paramedics.[b] PAM staff are good at dealing with MHC and learn on the job.[a] ST caters for collaboration and mutual understanding between nurses and police.[c]	PAM staff need more clinical psychiatric training and sometimes lack interest in MH.[a] Police and regular ambulance service lack MH skills and education.[abc]

[a]In the Netherlands. [b]In Sweden. [c]In England.

PAM = psychiatric ambulance model; ST = street triage; MH = mental health; MHC = mental health crisis; PED = psychiatric emergency department; ED = emergency department; NHS = National Health Service (UK).

ambulances were also not well equipped to care for persons in MHC. Therefore, MH services have developed the psychiatric ambulance and ST models.

Although MHC response becomes primarily a healthcare task in both models, all participants agreed that dealing with persons in MHC nonetheless remained inherent to police work: the police are often first to arrive, and they have a monopoly on the use of force. Therefore, when the Dutch police announced they would no longer deal with persons in MHC (NCRV, 2016), this was considered unrealistic and undesirable by the Dutch participants, who emphasized the importance of collaboration between police and MH services. The English participants found that police assistance was even a condition for their ST service: "the police bring the value of safety of everybody […] that opens up a whole new area of people that [the crisis team] are going out to" (P11). While some Dutch and English participants claimed that police often aggravate the situation and that there are still too many deaths and injuries during arrests, this was not the case for Swedish participants.

Swedish participants attributed their PAM's success to its staff's autonomy and ability to perform highly qualified assessments and interventions:

> "PAM have a very good way of doing their assessments, which is treating in a way […] you can get a quick crisis intervention, onsite, at home and then maybe stay home. Instead of spending your night in a hospital" (P9).

The same beneficial practices were described by English participants regarding ST. All Swedish and English participants said their most important decision-making tool is access to both medical and MH records. Dutch PAM staff did not have access to these records, and some Dutch participants felt that not all PAM staff are properly trained to perform interventions at home, or to decide autonomously to leave a person at home. One Dutch respondent noted being skeptical about ST, because without the ability to stabilise persons in MHC at home and connect them with ongoing community services, it would lead to ambulance transport anyway.

Stigma

Mental health crises and mental illness are highly stigmatized among the public, police, and authorities, mostly due to a lack of knowledge about MH, according to most participants. A nurse explained: "Psychiatry of course takes a back seat, it's very scary, people can't understand it because it's very difficult to work with protocols in psychiatry" (P3). According to others, the fact that all personnel is trained in MH, meant there is no stigma among them. Destigmatizing and "normalizing" health care for persons in MHC was often mentioned by participants as an important reason for transport by ambulance: "When someone is put in a police van, you look at your neighbour differently than when the person has been taken away by ambulance" (P5). This was also experienced by one ST officer, who said they stopped wearing police uniforms and started using regular cars for their ST program, leading to greater success.

Capacity

Another way to "normalize" transport of persons in MHC in the Netherlands was to organize PAM with medium-care ambulances, instead of the earlier "psycholance".[1] Medium-care ambulances facilitate more capacity, significantly faster arrival times, more efficient consults, and greater likelihood of proper care. According to most Swedish participants, PAM is often unavailable, attending 40% of calls received. This is unavoidable due to city size, said one Swedish participant, but is also not an issue as long as the dispatch centre follows the right criteria (severe MHCs with high or medium priority). A Swedish nurse explained: "We have strict alarm criteria, which is good, so that we do not get busy with easier jobs and miss jobs where emergency psychiatric measures are required" (P7). Nonetheless, most Swedish participants thought PAM needed to expand.

According to most participants, the biggest capacity issue actually starts after the transport of persons in MHC: a lack of capacity in the (psychiatric) emergency department (P)ED, crisis intervention teams, and long-term treatment facilities.

> "You need a follow-up service that can pick up that call or the care. People sometimes forget: you can have a very rapid response and great consultation, but when the next day the person is out in the streets again, then it is actually a drop in the ocean" (P4).

All Dutch and UK participants agreed that their PED does not have enough beds or staff for a city/area as big as theirs, often leading to diversion to unsuitable EDs. Most Swedish participants did not experience problems with (P)ED capacity because their PED is very large and situated next to the somatic ED, but one Swedish participant said their PED is still overburdened.

English participants said enhanced interagency collaboration in ST improves pathways for persons in MHC in a timely manner.

> "I was a human switchboard last night […] I was speaking to two or three different departments, putting together people's different views on what they could do, what they couldn't do, and eventually, what might have taken in excess of ten hours to fix, took two" (P12).

Interagency collaboration was also seen in the Netherlands, through weekly meetings with key crisis care stakeholders to evaluate cases of MHC. In England, ST played a crucial role in collaborative discharge planning.

> "It is often very important that police have an input for their [persons in MHC] safety and the ability to better manage them, once in the community. Good discharge plans will often result in lower levels of presenting to services in the community, reduced workload and a better quality of life for the patient" (P12).

Funding

While both Dutch and Swedish participants mentioned that other initiatives to deal with persons in MHC had ended when pilot funding dried up, both of their projects have received continued funding. A Swedish participant explained,

> "[In a] lot of these projects [to increase the quality of MH care in Sweden], when the project ended, they didn't have

> funding to continue. But even after the first year there was so much positive response […] so now it has been integrated into the region's ambulance services" (P6).

In Sweden, patient organizations were essential, lobbying politicians to get PAM funded. In the Netherlands, changing from clinic nurses to medium-care ambulance nurses reduced costs and improved efficiency. 'In England, buy-in from both the National Health Service (NHS) and police contributed to saving costs. These funding solutions made all participants hopeful about program sustainability. Still, all participants remarked that funding for MH care is not sufficient, and more investment in (acute) psychiatric care is needed. As one Swedish participant explained, "If you compare the funding of psychiatric health care with somatic health care, historically, and you compare them with the burden of disease in society, it's not aligned" (P6).

Skills and Experience

Participants from Sweden all attributed their success to PAM teams that included experienced psychiatric nurses from the PED and paramedics knowledgeable about the pre-hospital environment: "[A paramedic is] used to finding the addresses, to communicating with the police and other ambulances […], trained to make risk analyses and think about safety in apartments and bridges, train tracks…" (P8).

Although PAM staff in the Netherlands are usually not trained psychiatric nurses, most participants said they are good at dealing with MHCs and "learning on the job". Some Dutch participants mentioned PAM staff lacked an interest in MH and needed more clinical psychiatric training. According to most participants in all three countries, the police should receive more MH and practical skills training (e.g., de-escalation). The English participants emphasized the benefit of specialized ST officers with good MH knowledge to bring about collaboration and mutual understanding.

> "We speak both languages, we understand where the police officers are coming from, but we also understand […] what the nurses can do, and we can also bring ideas, you know. What can we do? How can we deal with this?" (P11).

DISCUSSION

This is the first qualitative comparative study of professionals' perspectives on two specific types of MCT: PAM and ST. We collected the experiences of key stakeholders from three different countries and found that, for both PAM and ST, there were more facilitators than barriers. This led to several interesting findings.

Ambiguity of Police Role

A common barrier in this study was found to be ambiguity about the police role in MHC response. On the one hand, there is resistance to police involvement because they are seen as lacking skills and stigmatizing; on the other hand, police are seen as adequate first responders who must safeguard the public. This ambiguity was confirmed by the literature (Bouveng et al., 2017; Puntis et al., 2018). Fry et al. (2002) indicate that, from a police perspective, ambiguity leads to confusion about their role in MHCs, a feeling of being unsupported when dealing with MHCs, and lack of collaboration with MH services. Our study indicates that early contact with an MCT improves the perception of support for police officers on-site. This is supported by Puntis et al. (2018), who add that it can decrease distress for persons in MHC and is less likely to lead to criminalization. Adding a police officer to the team, as in ST, may improve collaboration and recognition of all stakeholders involved.

Specialized Versus Generalized MCTs

The most surprising finding was the clear difference between facilitators for Sweden's specialized PAM, and the Netherlands' generalized PAM. Our findings show that what can be a facilitator for one model can be a barrier for another. In the Dutch context, the determining factor seemed to be cost-effectiveness in terms of efficient consults, more personnel, and better arrival times. In Sweden, it appeared to be the high quality of care, autonomy, and serving a specified target population that determined their model. PAM could have extra utility in countries without well-developed outreach services, especially if PAM staff have resources to stabilize patients at home. In order to choose the right model, Sellers et al. (2005) advocate careful needs assessment before implementing costly interventions with low probability for substantial improvement. Moreover, specialized services can make other services reluctant to work with persons in MHC and give them an opportunity to opt out, as was seen in our study in the Netherlands. This has also been observed in the Norwegian context, where there has been MH deskilling for regular ambulance staff and police (personal communication, Researcher and general practitioner from Norway, May 30, 2021). According to Sellers et al. (2005) "treatment as usual," meaning traditional MHC response without "specialized" police/MH professional partnerships, can be just as effective as specialized responses—but the relationship between police and local agencies must be addressed to improve care for persons in MHC. Future work should concentrate on these relationships. Regardless of the service form chosen, while our study shows potential for "on-the-job learning," it nonetheless stresses the importance of MH training for all emergency responders to improve uniformity and quality of MHC response (Boscarato et al., 2014), which requires support from policy-makers.

Funding and Development

An important facilitator for all three countries was funding. The Dutch PAM received continuing funding, despite earlier low efficiency (ZonMw, 2018). So did PAM in Sweden, though research showed there were no direct cost savings attributable to the PAM unit (Carlborg et al., 2020). This contrasts with the reported experience of projects stopping after pilot funding ran out. According to Carlborg et al. (2020), this is fairly common with health-care interventions, for they often bring large indirect cost savings due to their impacts on health.

However, we found growing attention to MH care plans and increased policy-maker awareness of the MH burden, also by the World Health Organization (2019). If harnessed, this momentum could drive further development and exploration

of MHC responses, including both costs and other benefits of various responses. An interdisciplinary research approach is required to deal with tensions between politics, health care, and funding.

Collaboration with Community Care

The common barrier of the lack of the "next step" for persons in MHC after PAM or ST response aligns with previous research. Although ST sped up the pathway and made it more efficient, better access to care did not always result, due to lack of follow-up care and case management (Dyer et al., 2015; Evangelista et al., 2016; Kirst et al., 2015). Moreover, inpatient care facilities, like the ED, may not be a good fit for persons in MHC, as was confirmed by the literature (Faddy et al., 2017; Heyland & Johnson, 2017; Lamb et al., 2002). An appropriate, less costly solution to support persons in MHC and avoid inpatient care was found by Heyland and Johnson (2017) and Harvey and Fielding (2003), who both advocate enhanced community care. Community care may both precede and follow MCT response, as this sector can play an important role in signalling MHCs as well as in supporting persons after stabilization. Community-based services can help to create safe home environments and prevent the onset of new MHCs: this aim was emphasized in the Norwegian context (personal communication, Researcher and general practitioner from Norway, May 30, 2021). In addition, community-based services, especially MHC response in the home environment, are more acceptable and less burdensome to both persons in MHC and their families than inpatient care (Irving et al., 2006; Lindström et al., 2020). These findings highlight the usefulness of exploring community-based services in relation to MCT, and also the preferences of persons in MHC, as noted by our research participants.

Strengths and Limitations

Pilot interviews helped to validate the interview guide, strengthening this study. The fact that the first author is a registered emergency-care nurse helped with relating to participants, probing, and "reading between the lines." All participants had extensive experience working with PAM or ST, ensuring that they could reflect thoughtfully and speak from their own experiences. Another strength was member validation, which helped researchers gain greater understanding of perceptions. Study limitations included lack of a theoretical model that covered all elements of exploring the facilitators and barriers of MCT models; the availability of only two stakeholders for ST, which provided limited perspectives on ST; and the difficulty of comparing different programs in different countries. The results of our analysis may therefore not be directly applicable to other contexts. The current study emphasizes that MCT choice depends highly on context and stakeholder perspectives regarding appropriate care for persons in MHC.

CONCLUSION

This research explored and compared professionals' perspectives on the facilitators and barriers of PAM and ST programs in three countries. We learned that, for Sweden, the greatest facilitators are being a specialized emergency response unit for a specific target population, staffed by highly skilled nurses. In the Netherlands, a more generalized model with dedicated staff and less specialized ambulance vehicles to serve more people is preferred. In England, including a MH skilled police officer in the ST model adds to overall safety and interagency collaboration. All MCT models encountered the barrier of insufficient post-transport treatment options. Community-based services could fill this gap in an affordable manner, and enhanced collaboration with both police and community services may improve the well-being of persons in MHC and their families. Our findings indicate that while both models were experienced as effective responses to MHC, neither can be seen as a one-size-fits-all solution. The psychiatric ambulance model, ST or a combined approach using aspects of both models needs to be carefully fitted to the context of the health system capacity, staff roles, and staff skillsets, while considering the impact of MH stigma and funding. This study has added to knowledge about PAM and ST and has highlighted factors that municipalities and countries can use to determine which emergency MH response model would best serve their population and what issues they need to address when adjusting these models to fit their context.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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APPENDIX 1: PAM/ST semi-structured interview protocol

1. First, could you describe in your own words why you think there was a need for PAM/ST compared to how it was before?
2. Who are the founders who got the program going? How do they get/keep political support for the program?
3. Do you think PAM/ST is working out as you had hoped or expected?
4. Have you come across anything that you were not expecting or were not fully prepared for?
5. What is within your profession understood by a MHC?
6. How is the person being assessed?
   PROBE: Are there tools?
7. Are referrals to PAM/ST from 112/999 in your opinion appropriate? Are referrals also coming in from the same dispatch centre?
8. How has the community been made aware of PAM/ST services? Are they being kept up to date about the developments of the PAM/ST program?
9. Could you describe what a "typical" PAM/ST dispatch process looks like so far?
   PROBE: Could you share some details about the last few calls that you can remember?
10. What typically happens to someone after an PAM/ST involvement? Does someone follow up?
    PROBE: What does this follow-up look like?
11. How would you describe the roles [responsibilities] of each person on the PAM/ST team?
12. What is your particular role?
13. What are particular skills/knowledge you need working with PAM/ST?
14. Who makes the decisions during a PAM/ST dispatch? Is there a certain protocol? Who coordinates the dispatch?
15. How is the cooperation with other agencies from your perspective? How do they share information?
16. How do the different organisations communicate with one another? Are you satisfied with how the communication goes?
    PROBE: Do you all use the same language during cooperation?
17. How are PAM/ST dispatches being evaluated? Do you keep documentation of this?
    PROBE: Is the evaluation shared with others?
18. What is the main legislation you deal with in your country when it comes to dealing with persons in MHC?
19. Are all the necessary treatment options in place? What is missing?
20. What are the specific resources that PAM/ST needs to be successful?
21. What have you found working particularly well during PAM/ST responses?
22. What has gotten in the way of the PAM program since it started? Are there any difficulties?
23. What do you think the main benefit is for a person in MHC who gets a response from the PAM/ST versus a traditional police/ambulance response?
24. Do you believe there is a level of stigma among coworkers or other agencies towards persons in MHC?
    PROBE: How do you think this may affect their experiences?
25. Do you think that PAM/ST responses reduce the number of injuries/violence to officers, persons in MHC, mental health staff and public?
26. How sustainable do you believe this model is?
27. For anyone wanting to implement a similar model, what would you say the key components of a successful PAM/ST are?
28. Is there anything else you would want future implementers of PAM/ST programs to know that we did not touch upon?

PAM = psychiatric ambulance model; ST = street triage; MHC = mental health crisis.

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Police-mediated legal and social assistance to people who use drugs in two districts in Hanoi, Vietnam

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ABSTRACT

The Police Mediated Legal and Social Assistance pilot program was piloted in two districts in Hanoi, Vietnam, between 2018 and 2020. It aimed to strengthen the collaboration between law enforcement and the health and labour sectors and to strengthen the capacity of community services to divert people who use drugs from compulsory residential treatment and support them in accessing medical, social, and legal services in their communities. A total of 204 drug users were referred to treatment and support services by the pilot. Of them, 97 (47%) were referred to methadone clinics and 90 (44%) to recovery support programs, including home-based detoxification and voluntary rehabilitation at state-owned centres. Clients were also assisted in accessing ancillary treatment as needed, such as HIV, tuberculosis, hepatitis, mental health, vocational training, legal aid, and social support. Data indicated a high level of satisfaction from all those involved in the pilot. This pilot is the first collaboration aiming to assist drug users, between law enforcement, community organizations, and the health and welfare sectors. It represents a major shift in the evolving drug policy of Vietnam.

Key Words Police mediated program; police assistance; collaboration; community-based treatment; voluntary addiction treatment.

POLICY ON DRUG PREVENTION AND TREATMENT – BACKGROUND

The Evolution of Vietnam's National Policy

Since the early 1990s, Vietnam's official view of illicit drugs has been that they are a "social evil" to be eradicated. Article 61 of the 1992 Constitution (Vietnamese National Assembly, 1992) declared drug addiction a "dangerous social disease." In response to this problem, the state established drug treatment facilities in 1993. They were "to provide compulsory treatment for drug addiction and certain dangerous social diseases" (Vietnamese Government, 1993).

The Penal Code in 1999 Article 199 (Vietnamese National Assembly, 1999) stated that "those who illegally use narcotics in any form, have been educated time and again and administratively handled through the measure of being sent to compulsory medical treatment establishments but continue to illegally use narcotics, shall be sentenced to between three months and two years of imprisonment and that those who relapse shall be sentenced to between two and five years of imprisonment."

The Ordinance on Handling of Administrative Violations Article 26 titled "Sending to medical treatment establishments" authorizes district-level People Committee presidents to make the decisions to send persons who used illicit drugs to medical treatment establishments (Vietnamese National Assembly, 2002). Also, Decree 94 added that the time limits for application of the measure of sending to medical treatment establishments shall range from one to two years for drug addicts (Vietnamese Government, 2009).

The subsequent law of 2012, the Law on Handling of Administrative Violations, demonstrated a significant change. Article 104 of this law changed drug use from a criminal offense to an "administrative violation." In Article 103, the law describes the procedures for the administrative police to record drug use in the community and also states that an addict who is recorded as using drugs for the third time may be sent to compulsory detoxification centres for 12 to 24 months (Vietnamese National Assembly, 2012).

Subsequently, Decree 111 provides further guidance for police chiefs in documenting the profiles of drug users

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in their communities, which is a part of the procedures for sending people to compulsory detoxification centres. This decree also specifies that the People's Committee will be notified to allow preparation for social reintegration for people who are released from the centres. The released residents remain registered and supervised by local authorities for at least 2 years after completing their compulsory detoxification (Vietnamese Government, 2013).

Treatment Options

In response to United Nations calls for the closure of the compulsory detoxification centres and increasing evidence about the ineffectiveness of the compulsory detoxification provided (Werb et al., 2016), drug use was removed from Vietnam's Penal Code. A revised policy, the "Renovation Plan on Drug Treatment" (2013), sought to further reduce the number of drug users detained in compulsory drug detoxification centres from 63% in 2013 to just 6% by 2020 (Kamarulzaman & McBrayer, 2015) and to increase support for community-based treatment and for developing voluntary options within the compulsory detoxification facilities. This represents a significant policy change.

In April 2014, the Secretariat of the Communist Party Central Committee called for an improvement in the quality of state compulsory detoxification centres, transforming them into treatment facilities using a variety of treatment models.

Data from MOLISA (Ministry of Labour, Invalids and Social Affairs) in April 2020 indicated that Vietnam has 97 public drug detoxification facilities, treating 34,982 patients, plus 16 additional approved voluntary drug detoxification facilities countrywide. So far, there are only 13 provinces and cities in Vietnam where family- and community-based detoxification exist (Hieu et al., 2021).

The HIV epidemic further shifted official perception of the drug problem, and the "harm-reduction" approach was gradually introduced. As a result, the Law on AIDS/HIV Prevention and Control was issued in 2006, emphasizing the "encouragement of the use of clean syringes and needles, treatment of addiction to opium-related substances with substitute substances, and other harm reduction intervention measures."

The first opioid substitution clinic which dispensed methadone was opened in 2008, with the first pilot clinics opening in Haiphong and Ho Chi Minh City in August 2008 and Hanoi in December 2009. By March 2017, Vietnam had 280 methadone clinics nationwide and plans to scale up the coverage of MMT (Methadone Maintenance Treatment) programs with a target of 80,000 people who use drugs (PWUD) (Le et al., 2020).

Although the Ministry of Health is mandated by the government to provide technical medical guidelines for the treatment of substance use disorders, the management, planning, and implementation of treatment in drug rehabilitation facilities and in the community are MOLISA's responsibility.

Roles of Police

Even though drug use is no longer criminalized in Vietnam, it is still considered a major public security issue. The 2021 Law on Drug Control has an updated chapter on the management of people who use illicit drugs, in which the police were assigned the responsibility of making the list of PWUD and managing them in the locality.

The Department of Administrative Management for Public Order (Administrative Police) under the Ministry of Public Security is the police force responsible for all aspects of administrative management of Vietnamese citizens by the police. This includes issuing identification papers, maintaining household address books and a national data system of citizens, and other administrative measures. This police force is responsible for monitoring and managing all the residents in each neighbourhood. Therefore, detection of PWUD and the compilation of dossiers to send them to compulsory detoxification centres also fell under the responsibility of the administrative police.

PILOT PROJECT: POLICE-MEDIATED ASSISTANCE TO PWUD

Pilot Overview

The pilot was implemented according to the plan of Hanoi's People Committee. The Centre for Supporting Community Development Initiatives (SCDI) was chosen as a partner of Hanoi city to implement the plan, and they worked closely with Hanoi's Department of Social Vices Prevention to support the establishment of the model.

The pilot targeted PWUD who were known to and monitored by the administrative police. For example, the target groups included those who tested positive for drugs on 3 occasions and those recently discharged because they had a high possibility of being sent to the compulsory detoxification centres.

The pilot took place in Hanoi (Long Bien district: Wards Ngoc Thuy, Bo De, and Ngoc Lam; Nam Tu Liem district: My Dinh 1, Cau Dien, and Xuan Phuong wards) and consisted of 2 phases: May 2018 to May 2019 (sensitization and preparation) and May 2019 to June 2020 (implementation and expansion).

Objectives of the Pilot

The pilot aimed to develop a community drug treatment network which will:

- Strengthen collaboration and coordination between the Departments of Public Security, MOLISA, and the Departments of Health in facilitating access to medical, social, and legal services to include collaboration at the local level.
- Mediate the existing process of automatically sending drug users (who tested positive for drugs on more than three occasions over a 3-month period) directly to compulsory detoxification, by referring the drug user to a coordinator who will assess the situation and help the client find the most appropriate treatment.
- Create opportunities for early access and treatment to both drug detoxification and comprehensive rehabilitation in the community, reducing social, legal, and health harms.
- Increase the number of drug users in treatment and detoxification, reduce the number of compulsory detoxifications, and increase the effectiveness of treatment
- Reduce the negative consequences of drug use by decreasing relapse and repeat offending and reducing the risk of HIV, Hepatitis B and C, and tuberculosis (TB).

Components of the Project

Training was offered by SCDI and included various topics, such as the science of addiction treatment, referral systems,

screening procedures and tools, treatment planning, counselling skills, case management, and data collection. Learning visits to other sites, including a visit to a hospital-based addiction treatment facility in Chiang Mai, Thailand, and another visit to community-based addiction treatment units in Khanh Hoa province, Vietnam, were also organized for the pilot's key participants.

Police officers were the most important change maker in the pilot compared with common practice everywhere else in Vietnam. They were the front-liners who detected and first came into contact with PWUD by monitoring their areas. Their original main task was to make dossiers to send PWUD to compulsory detoxification centres. In this pilot, their assigned task was changed to referring PWUD they had identified to the ward's coordinator for health, social, and legal support. This change was possible because the pilot had already been approved beforehand by Hanoi People's Committee. The police also kept constant communication with coordinators to follow up on clients' progress to update in their monitoring system.

Coordinators were the pivotal figures in this project. They were usually volunteers for social activities in the ward or "social affairs" staff members who had been assigned the additional task of coordinator by the ward authorities. Each of the 6 participating wards had one coordinator who was experienced in the drug field and might be acquainted with their clients. Their task was to assess clients, refer, support, and follow up, with referral to ancillary health, social, or legal services as needed. The coordinators worked closely with, and received support from, senior law enforcement personnel, administrative police, counsellors, and recovery coaches. Coordinators worked part-time for the pilot. On average, they spent 10 to 14 hours to support and follow 8 to 10 clients per month. The average case load was around 30 per ward.

The counsellors (two) were selected by the piloted districts based on the availability and suitability of human resources in the district personnel. One of them was a counsellor working at the district's health centre and the other one was a member of the social affairs staff. Their responsibility was to cooperate with the coordinators to provide counselling sessions with the clients and monitor the progress of their recovery.

Recovery coaches (two), one in each district, were trained and were recruited by SCDI to provide peer recovery support for the pilot's clients. They were ex-PWUD based in the districts implementing the pilot and considered community leaders who had been providing harm reduction services for PWUD in their areas for a long time.

Drug Use

A total of 204 PWUD, including 2 women, were referred to the pilot out of a total of 265 registered PWUD known to the authorities. There were 117 referrals from Long Bien district and 87 from Nam Tu Liem district (Table I).

In total, 160 (78%) completed the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) forms (Humeniuk et al., 2010) to provide information on their current drug use. According to the ASSIST assessment:

- 111 (54%) were heroin users and 49 (24%) were injectors.
- 37 (18%) used methamphetamine
- 79 (38%) used alcohol.
- 6 clients used cannabis, 4 – cocaine, 12 – minor sedatives, and 6 – hallucinogens.

TABLE I Drug users in Long Bien and Nam Tu Liem districts / 6 wards

	Long Bien	Nam Tu Liem	Total
Total number of people who use drugs registered in the 2 districts	479	186	665
Number of registered drug users in the target 6 wards	220	45	265
Total number of drug users referred to pilot by the police	117	87	204
Total number of clients who were assessed by a coordinator resulting in a treatment plan	69 (58%)	87 (100%)	156 (76%)

What Happened During the Pilot?

Referral to Drug Treatment

In Vietnam, in general, PWUD identified by the police are sent to compulsory rehabilitation centres. However, community-based treatment became a priority in the context of this pilot. During the pilot, clients and coordinators discussed all available options, including opioid substitution treatment, home-based detoxification, voluntary residential treatment, and psychiatric hospitals. Voluntary residential treatment is usually for 3 months, and clients opting for this program have to pay 30% of the cost while the rest is covered by the government.

In total, 28 (14%) and 12 (6%) clients left the pilot in Long Bien and Nam Tu Liem, respectively. The main reason for the dropout was because the clients moved out of the piloting wards.

Services Offered and Used During the Pilot

Most clients were offered additional services and referrals to health services. By the end of June 2020, the model reached a total of 204 clients. Table II summarizes the referrals provided.

- 204 clients were reached and provided with screening and brief interventions
- 97 clients were referred to HIV testing and prevention services
- 97 clients were referred to methadone treatment
- 6 clients were referred to mental health services
- 90 clients were referred to recovery support (including detoxification at home, or at rehabilitation centres for 20 days, 3 months, and 6 months)
- 62 clients were provided legal aid
- 4 clients were provided vocational training and employment opportunities
- 2 clients were offered other supports

In addition, during the COVID-19 pandemic, 33 poor clients taking part in the pilot received food packages to help them through difficult times. All the clients and staff of the pilot also received a total of 370 bottles of hand sanitizer and 1,450 face masks in response to the COVID-19 waves in Hanoi.

One year after implementation, in May 2020, an evaluation was conducted to collect qualitative and quantitative data from the pilot. In-depth interviews with 16 clients, coordinators, counsellors, police officers, and representatives of the ward's People's Committee were conducted to collect qualitative data. The quantitative data was collected by using questionnaire surveys with the pilot's clients. The evaluation planned to survey all the clients of the pilot. However, it was finally reduced to 75 clients due to the COVID-19 wave in Hanoi during the evaluation time.

Quantitative Investigation

Drug Use

A more detailed account of the lifetime drug use and treatment history was obtained for 75 clients:

- Heroin: 64 (85%) had a history of heroin use; 42 (56%) were injectors; 24 (33%) smoked; and 8 (11%) snorted heroin. The average age of first use was 25 (range 23–61). The average frequency of heroin use prior to the project was 20 times per month.
- Synthetic drugs: 21 (28%) had a history of synthetic drug use. The mean age of starting use was 31.
- Cannabis: 8 (11%) clients had used cannabis. The average age of first use was 22. No clients reported the use of ketamine or of any other type of drugs.
- Alcohol: 42 (57%) of the surveyed clients drank alcohol. The average age of starting use was 18.

Addiction Treatment

In all, 51 (68%) of clients underwent compulsory detoxification an average of 1.5 times (range 1–4 years) for a mean period of 3 years (range 1–6 years). The length of abstinence following compulsory detoxification ranged from 0 to 16 years (mean 3 years). However, the majority of clients relapsed in the first year after discharge.

TABLE II Summary of client referrals to treatment by district (May 2019–June 2020)

No.	Description	Total	Long Bien	Nam Tu Liem
Total referred to pilot by the police		204	117	87
1	Were screened and provided brief interventions by coordinators	204	117	87
2	Were comprehensively assessed and for whom a treatment plan was developed	156	69	87
3	Were consulted and referred to HIV testing and HIV prevention services	97	19	78
4	Were sent to a methadone treatment facility	97	14	83
5	Were referred for mental health treatment	6	4	2
6	Received recovery support	90	88	2
7	Received legal support services	62	16	46
8	Were counseled, transferred to vocational training and job creation support services	4	3	1
9	Received other counselling and referral activities according to the pilot	2	2	0

Service

The questionnaire survey with 75 clients of the pilot also reported types of services that clients received. A summary of referral patterns for 75 clients indicated that testing for HIV was offered to 85%, hepatitis B and C testing to 81%, and assistance for mental health issues to 68%; 23% of clients received post-treatment support from pilot staff (Table III).

Clients' Perceptions of the Pilot

Perception of Support from Coordinators and Counsellors

Perceptions of the help provided by both were overwhelmingly positive. The opportunity to discuss treatment options was appreciated, as was the inclusion of counsellors in the process (which occurred in Nam Tu Liem district). The majority of clients were appreciative of the help provided by the counsellors, 84% expressing appreciation that the counsellor explained treatment options and continued to monitor their progress (Tables IV, V).

Client's Perception of Law Enforcement: Administrative Police

Many clients (68%) said that they had had little contact with the police in the previous 12 months. However, 88% noted that they were less afraid of being noticed by the police, and 81% said that the police attitude to PWUD had changed in a positive direction (Table VI).

Assessment of the Quality of Services

Most clients highly rated the quality of services provided: 71% said it was "good" and 27% rated it "excellent." The majority (77%) reported that their basic needs had been largely met, and a further 16% said that "almost all" of their needs were met. Clients' overall evaluation of the model indicated that

TABLE III Summary of services offered and used during the pilot (*N*=75)

Testing for health problems	Total *n* (%)	Treatment provided during the pilot	Total *n* (%)
HIV testing	64 (85%)	HIV treatment	14 (19%)
TB testing	63 (84%)	TB treatment	6 (8%)
Hep. B, Hep. C.	61 (81%)	Hepatitis B	5 (7%)
Mental health screening	51 (68%)	Mental health treatment	8 (11%)
Other medical tests	50 (67%)	Other treatment (e.g., private facility)	5 (7%)
Support services used by clients:			
Social support after leaving detoxification centres			17 (23%)
Support from pilot staff & volunteers (coordinators, counsellors, recovery coaches, peer educators)			60 (80%)

Some clients received more than one service. TB = tuberculosis; Hep = hepatitis.

TABLE IV Clients' perceptions of support from coordinators (*N*=75)

Agree with the statement:	*n* (%)		*n* (%)
I have been given information about services needed to address my current problems including: my drug use, health issues, legal issues, social issues	64 (85%)	I was referred for voluntary treatment at State-owned detoxification centre	45 (60%)
My family and I are involved in making decisions about my treatment options	66 (88%)	I was referred to a counsellor or peer educator	57 (76%)
The coordinator stays informed about my treatment options	66 (88%)	I was referred to the district health centre (to do tests for TB, HIV, hepatitis and STI)	63 (84%)
The coordinator helps me to decide what to do next	64 (85%)	The coordinator visits me at least once a month	57 (76%)
I have completed the evaluation called ASSIST	55 (73%)	The coordinator actively monitors my participation in the services he recommends me.	65 (87%)
I have completed the evaluation called DASS	54 (72%)	The coordinator actively monitors my participation in the services he referred me to.	67 (89%)
I was introduced the substitution therapy methadone	53 (71%)	The coordinator helps me and my family during the social distancing due to COVID-19	59 (79%)

TB = tuberculosis; STI = sexually-transmitted infection; ASSIST = Alcohol, Smoking and Substance Involvement Screening Test; DASS = Depression, Anxiety and Stress Scale – 21 Items

TABLE V Clients' perceptions of support from counsellors (*N*=75)

Description	Agree with statement (Yes)	Disagree with statement (No)	No answer given
	n (%)	*n* (%)	*n* (%)
The counsellor explains addiction treatment options.	63 (84%)	0	12 (16%)
The counsellor helps me make the decision of which type of treatment should be involved.	56 (75%)	4 (5%)	15 (20%)
The counsellor provides me necessary information about methadone substitution therapy.	56 (75%)	3 (4%)	16 (21%)
The counsellor offers to assist me during my chosen treatment.	53 (71%)	8 (11%)	14 (18%)
The counsellor helps me deal with my family issues.	48 (64%)	13 (17%)	14(19%)
The counsellor continues to monitor my treatment adherence at the service they referred me to.	60 (80%)	2 (3%)	13 (17%)
The counsellor helps me during social distancing due to COVID-19.	50 (67%)	11 (15%)	14 (19%)
The counsellor regularly calls to ask me about my situation.	54 (72%)	8 (11%)	13 (17%)
The counsellor gave me the opportunity to talk about my issues.	59 (79%)	4 (5%)	12 (16%)
The counsellor introduced me to the people that can help me to find jobs.	42 (56%)	17(23%)	16 (21%)

TABLE VI Clients' perceptions of the police (*N*=75)

	n (%)
The local police have been very helpful to me over the past 12 months.	57 (76%)
The police (ward police) where I live are very strict with drug users.	14 (19%)
I have not felt any change in the behaviours of the police in the past 12 months.	44 (59%)
The police (ward police) have helped me to access services for my drug use problem.	57 (76%)
I have confidence in the coordinator but not in the police.	27 (36%)
In the past 12 months (since I started treatment), the police trusted me and did not ask about me and my family.	48 (64%)
Now I feel that the police really want to help me.	64 (85%)
When asked to do things by the police, I understand they are just doing their job.	65 (87%)
The police's attitude towards drug users has changed in a positive direction.	61 (81%)
I have had a little contact with the police over the past 12 months (excluding contacting through the coordinator).	51 (68%)
I am very afraid of being "set up" by the police	9 (12%)

TABLE VII Quality of the service

Description	Frequency (*n*)	(%)
Not good	0	0%
Average	1	1.37%
Good	52	71.23%
Excellent	20	27.4%

TABLE VIII Clients' needs met

Description	(*n*)	(%)
None of my needs have been met.	0	0%
Only a few of my needs have been met.	5	6.85%
Most of my needs have been met.	56	76.71%
Almost all of my needs have been met.	12	16.44%

43% were "satisfied" and 51% were "very satisfied." Only 3% said they were "relatively" or just "somewhat" satisfied (Table VII, VIII).

Qualitative Investigation

Interviews took place over 1 week in May 2010 in the offices of the People's Committees.

Interviews with Officials

The government officials included management from districts and wards, the People's Committees, Department of Labour, Invalids and Social Affairs, Department of Social Vices Prevention, and administrative police officers.

Law enforcement's senior management: All expressed full support for this new initiative, saying that it was "very feasible," "human and convincing," and they supported its expansion. They highlighted the need for more investment in the health, welfare, and legal infrastructure to support this model. They noted that most subjects of this initiative were PWUD already known to the authorities, and that new young users, many of whom were ATS (amphetamine-type stimulants) users, were not yet included. Opinions expressed included:

> "In my opinion, one year is not a long time but I can see many positive things of the model. If It is replicated in other areas, it will be very good."

> "After one year of project implementation, from the management as well as personal aspect, I highly appreciate it—especially in getting to know and understand the patients so that we can support them."

Administrative police officers: All administrative police officers provided positive feedback and were comfortable changing their modus operandi, working with the coordinators to provide treatment options. During the pilot, only those who re-used drugs and did not adhere to community treatment were referred directly to the compulsory centres. Those with no fixed address were also sent directly to these centres. Several officers remarked that some families insisted on the compulsory centres option, believing it to be the only helpful treatment. Some commented that the pilot reduced bureaucracy and lightened their workload. One said: "The pilot has added to our knowledge and awareness about drug issues and about potential services. We are satisfied to be able to help PWUD access a host of ancillary services to help them in their recovery and rehabilitation."

Interviews with Pilot Project Staff

Coordinators: In all 6 wards, there was unanimous praise for the pilot and acknowledgement that dealing with PWUD by encouraging trust and consultation is a good way forward. Coordinators noted that the referral process was unclear and unsystematic and acknowledged their lack of experience in assessing clients' needs and treatment options. Some sought the help of counsellors. Although the training was offered by SCDI, coordinators said that it was insufficient and did not fully prepare them for their tasks. They felt that more training was necessary.

Counsellors: Both observed that the project should have more professional counselling staff and mobilize community peer volunteers and peer educators. A larger pool of counselling/recovery staff was needed to support the PWUD included in the pilot. They reported a lack of clarity about their roles and that the assessment process was inadequate and not fully realized.

Interviews with 16 Clients

All clients were selected by the coordinators and asked to come to the People's Committee office to be interviewed. All were well known to the police and had a long association with law enforcement. Among them, 12 of the 16 had been in compulsory centres. Most were currently attending a methadone clinic. All were unaware of the pilot and did not recognize it as a new initiative. Some, but not all, had been formally assessed before inclusion in the pilot. All were long-term PWUD. Most were primarily heroin users but also using ATS. Only 2 were primarily ATS users, and both displayed delusional behaviours during the interview (neither was receiving specialized treatment). Some respondents were already methadone patients at intake but, during the pilot, were offered additional help to access ancillary services, as needed. Overall, the coordinator was viewed positively, but previous (and current) experiences with law enforcement led some PWUD to be suspicious of the coordinators.

Interviewees reported that police continued to act independently during the pilot, pursuing their obligation to test those suspected of using illegal drugs. These efforts often centred around the methadone clinics. Views on the police remained ambivalent. The police remained a regular presence in their lives. Some had help with obtaining health insurance and identification papers.

The overall impression from interviewing these clients was that the changes introduced by the pilot were not explained or recognized although clients may well have benefited from the new approach. Overall, they made no complaints and reported satisfaction with their current engagement with law enforcement and with health and community services.

DISCUSSION

This report showcases a new approach to the treatment of PWUD in Vietnam. It was implemented in just 6 wards in 2 districts in Hanoi. The pilot represents a major policy shift by promoting police-mediated legal and social assistance to PWUD whereas previously the role of the police was confined to recording, supervising, and apprehending people who violate the drug laws and sending them to compulsory treatment when they do.

The approach piloted here is spearheaded by law enforcement, supported by health and welfare services, and predicated upon the availability of alternative community-based

voluntary drug treatment. The pilot allowed PWUD and their families to consider the most appropriate treatment depending on their situation and, wherever possible, allowing PWUD to remain with their families and in their communities. Indeed, in one of the two districts, no one was referred to residential or compulsory treatment. Feedback and reflections on the pilot are crucial for the future development of drug policy in Vietnam. Reflections and comments from both the pilot implementers and the clients indicated significant satisfaction and approval of the approach and the expressed recommendation that this approach should be extended to other parts of Vietnam.

It is important to note, however, that for the approach to be successful, much needs to be done both in the community and among relevant professionals to increase the workforce and upgrade their understanding and skills to provide assistance and rehabilitation to PWUD. There was universal endorsement of the approach by all stakeholders, all of whom expressed the view that this approach should be extended to the rest of the country.

CONCLUSION

This pilot is a "work in progress," and much needs to be done to improve and systematize this approach. Beginning with an extension and improvement of training and capacity building, there is little doubt that the counselling services should be considerably increased and that the assessment procedures should be streamlined and improved. A systematic and clear approach to data gathering is essential if legislators are to be convinced about the efficacy of this approach. So too, efforts should be made to raise awareness in the community about drug use and drug services. It was clear that many PWUD and their families were unclear about the role and objectives of the methadone program, and the idea of "maintenance" was unclear and rejected. Future interventions should include better systems of data gathering and analysis, vigorous evaluation of the methodology and procedures, analysis of outcomes, and assessments of community sentiments about the approach.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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