Journal of
COMMUNITY SAFETY & WELL-BEING

For Now, Let's Just Thank … and Help … the Heroes

Norman E. Taylor*

How does one write a meaningful community safety and well-being editorial in the midst of a rapidly unfolding global pandemic of epic proportions, and as yet untold consequences?

The answer is, one does not. This is no time for editorial commentary. It is a time for courageous and knowledgeable public health and public policy response. We are truly blessed to have, throughout the world, well-educated public health, medical, and emergency response professionals who in many ways have been training their entire careers for this event.

Nonetheless, no amount of training, planning and modeling can ever be enough to fully anticipate and prepare, and new learning is occurring now at lightning speed across the global response system. Not every answer will be correct, and not every policy decision will be adequate to the challenge. A direction that seems correct on one day may be upended, updated, and re-directed on another.

At times like this, perfect is indeed the enemy of good.

The Journal simply wants to thank all of those working on the front lines for all the good they are doing, using the best of their knowledge and abilities, creating new evidence and experience to inform us all for the future, and working tirelessly at great risk and personal expense to themselves and their own families.

There is so much we all stand to learn on the other side of this. We will be ready to do our part in sharing in that learning. In the meantime, we can all follow their advice, draw upon their inspiration, and do whatever is necessary to keep each other safe and well.

CONFLICT OF INTEREST DISCLOSURE

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

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Dialogue Highlights from the LEPH2019 Panel on Police Mental Health and Well-Being

Katy Kamkar,* Grant Edwards,† Ian Hesketh,‡ Dale McFee,§ Konstantinos Papazoglou,# Paul Pedersen,¶ Katrina Sanders,|| Tom Stamatakis,** and Jeff Thompson††

This article is related directly to the Law Enforcement & Public Health (LEPH) Conference in Edinburgh, Scotland, October 2019.

EDITOR'S INTRODUCTION

Dr. Katy Kamkar, *Ph.D., C. Psych & LEPH Session Convenor*

It has been a sincere honour and true pleasure to be on the program committee, as well as session convener, for the International Law Enforcement and Public Health (LEPH) conference held in October 2019 in Edinburgh, Scotland. During the recent conference, I was fortunate to work with eight esteemed colleagues from Canada, the United States, the United Kingdom, and Australia, sharing international perspectives on Police Mental Health and Well-Being. Police Organizations everywhere, it seems, are increasingly working on reducing stigma and addressing common mental health conditions such as depression, anxiety, and post-traumatic stress disorder as part of mental health education, prevention, early identification, and intervention. To this date, workplace interventions continue to be primarily reactive rather than preventive. One of the many pathways to build and optimize prevention involves interventions at both individual and organizational levels—creating a healthy positive organizational culture and improving workplace mental health promotion by reducing workplace risk factors and identifying and building individual as well organizational strengths and protective factors.

Together with these colleagues, all of whom contributed to the preparation and delivery of our panel session in Edinburgh, we are pleased to share some highlights from the important dialogue that resulted. The following segments each provide guidance on building awareness of police mental health; both organizational and individual level factors; ways to reduce stigma (personal stigma, self-stigma, and workplace stigma); optimizing interventions; and taking holistic approaches to care. I begin this paper, as I did during our session, by offering some of my own thoughts about a proactive approach to health at organizational and individual levels, as well as a discussion on psychological health and safety implementation strategies to help reduce risk factors and promote individual and organizational resiliency. My co-authors then each share their own perspectives.

Police Mental Health and Well-Being—Psychological Health and Safety Strategies Addressing Moral Injury, Compassion Fatigue, and Burnout to Promote Individual and Organizational Resiliency

Police work does increase the risk of psychological work-related injuries. Police officers are exposed to a unique set of challenges in their day-to-day duties that can increase the risk of mental health concerns. Occupational burnout and exhaustion result in reduced motivation and care or passion for the work. For others, it can cause feelings of helplessness or powerlessness, resulting in emotional disengagement or numbness. Depression, anxiety, substance misuse, pain and physical injuries, and occupational stress injuries (OSI), which are persistent psychological difficulties resulting from operational or service-related duties are also common. Depression has been found to increase the risk of post-traumatic stress disorder (PTSD), anxiety disorders, and addiction. As well, PTSD has often been found to be accompanied by depression, and the two overlapping conditions further worsen overall functioning and quality of life and increase the risk of suicide. Thus, the promotion of good mental health and mental health education, prevention, and early intervention, as well as the promotion of a healthy and supportive organizational culture and work environments based on trust, support, and care, are essential to prevent complications resulting from concurrent issues. Ongoing work is needed to encourage a proactive approach to health. Workplace stigma remains prevalent, in addition to other barriers to care and recovery that deserve further attention and interventions, including moral injury, compassion fatigue, and burnout.

Although moral injury, compassion fatigue, and burnout are not mental health disorders, they represent significant mental health issues resulting from organizational and operational stressors, with long-lasting emotional and psychologi-

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cal impact. They are associated with psychological disorders as part of Operational Stress Injuries, impaired personal, social, and occupational functioning, exhaustion, reduced work performance and productivity, reduced personal and professional accomplishment, suicidal ideation, interpersonal conflict, prolonged recovery, difficulty resuming daily activities or returning to employment, and self-isolation. There needs to be further education and early intervention around the emotional, cognitive/psychological and behavioural symptoms related to moral injury, compassion fatigue, and burnout in order to adopt psychological health and safety implementation strategies to help reduce the risk and promote individual and organizational resilience.

THE INSTITUTION, LEADERSHIP, AND CULTURE—THE MAJOR IMPEDIMENT TO BETTER HEALTH & WELL-BEING IN POLICE AND FIRST RESPONDERS

Grant Edwards, *Head of Aspect Frontline; Australian Federal Police Commander (Retired)*

Despite the best efforts of many to raise awareness, provide support, and promote well-being things aren't changing in any great way. In order for change to happen, a far-reaching institutional and leadership change program is required. Perhaps the biggest impediment to gaining traction for any mental health program is culture—a culture based on stoicism, that is the endurance of pain or hardship without a display of feelings and without complaint, separating yourself from feelings and emotions to get the job done. This culture breeds distrust, cynicism, and scepticism—all honed as a survival mechanism, physically, emotionally, and psychologically.

Australian Federal Police Commander Grant Edwards discussed a) the importance of understanding first-responder culture and, moreover, the variety of sub-cultural elements that impact and affect institutions and their members and how to use these to effect mental health change; b) the need to holistically address the issue of mental health cultural reform from four angles: underdeveloped human capital, weak and confused vocational capability, major leadership deficiencies, and dysfunctional institution practices; and c) the call to develop, plan, and engage a program for staff focusing on trust, commitment, overt actions, and communication to normalize the language of mental health within the workplace and institution; d) the need to reshape the law enforcement institution to be more accommodating and understanding of the impact mental health is having on the profession; and e) the importance of sharing a framework that can help law enforcement agencies, big and small, to implement subtle institutional and cultural change to build trust in staff, normalize the language of mental health in the workplace, and commence a strategy towards better employee wellness. Commander Grant Edwards also shared his personal lived experience of being diagnosed with Post Traumatic Stress Injury and the impact that had on his career as a senior officer in the Australian Federal Police. He has been working on sharing a framework that can assist law enforcement agencies of all sizes on how best to implement institutional and cultural change to build trust in staff, normalize the language of mental health in the workplace, and begin a strategy to better employee wellness.

THE THIN BLUE LINE IS OK: DELIVERING A NATIONAL WELLBEING SERVICE IN UK POLICING

Dr. Ian Hesketh, *FCMI (CMgr), FRSA, MSET (QTLS), Wellbeing Lead UK College of Policing and SRO – National Police Wellbeing Service UK (Oscar Kilo)*

In 2013, the National Police Chiefs Council (NPCC) Wellbeing and Engagement working group was established in the United Kingdom. Within this initiative, significant research was undertaken to understand the well-being landscape across policing, culminating in a well-being roadmap. This enabled UK policing to better understand the issues that challenge the police force in relation to employee well-being. Further, it identified and acknowledged a significant unmet need. A requirement for a whole systems approach to embed prevention into the system was recognized. In 2017, Oscar Kilo (OK) and the Blue Light Wellbeing Framework (BLWF) were launched.

Shortly after, on 11 July 2017 the UK Home Secretary announced that a grant of £7.5 million from the Police Transformation Fund (PTF) was being made available to the College of Policing. This grant would be provided over three years and used to address welfare provision within Policing across England and Wales.

A review of policing, known as Front Line Review, was carried out. This review proposed moving from a "blame" culture to one of "learning from failure" and highlighted a number of important implications for forces' ability to learn from mistakes and for their long-term success. Dr. Les Graham, from Durham University, who reported to the review, noted that when there is an ability to view failure as a source of feedback for improvement in daily work and to create recognition of the need for change, negative consequences that arise from future failure will be reduced. He further commented that work systems, processes, and policies can be improved through discussion, analysis, and information-sharing on failure and near misses, and innovation and proactive improvement behaviour would be encouraged.

To support the findings from the review and the earlier roadmap research, the National Police Wellbeing Service launched eight "live" services that are now available to all 43 forces in England and Wales:

1. **Leadership for Well-Being:** developing executive leaders and line managers who can lead and manage their organisations in a way that facilitates well-being, and improves performance
2. **Individual Resilience:** building individual resilience of officers and staff by developing their understanding and use of positive psychology, and other techniques, to enhance personal well-being and improve their ability to support others
3. **Peer Support for Well-Being:** delivering a national peer support model and network in order to provide the best care and support to officers and staff
4. **Psychological Risk Management:** high-risk roles screened for potential psychological trauma, and well-being screening available for all
5. **Trauma Management:** providing a police-specific post-incident support and disaster management model of care for officers and staff that provides

clear strategic and tactical direction specific to well-being when dealing with major incidents – known as Emergency Services Intervention Programme (ESTIP)
6. **Well-Being at Work:** Occupational Health support and liaison; post-HMICFRS inspection peer support
7. **Mobile Well-Being Outreach Service:** providing access to well-being services at the place of work, in order to increase the opportunity to access well-being services
8. **Physical Well-Being:** Including fitness mentoring and initiatives with Police Sport UK and the University of Lincoln

To complement the live services on offer, a number of toolkits and resources have been developed. A program of marketing and workforce engagement has also been developed. The key messaging focused on the following:

1. **Standard of Excellence** – OK is a visible sign that your police force has made a commitment to your well-being.
2. **Education** – OK provides information and guidance about well-being.
3. **Guidance** – OK delivers practical support to help forces build their well-being offer.
4. **Promotion** is achieved by displaying the OK badge as a symbol of commitment after embedding the frameworks and using the resources and materials to enhance well-being.
5. **Practical support** – OK is not a tick box exercise; it is a bold commitment to well-being.
6. **Evidence-based practices** that are cost-effective are modelled.

The final aspect, evidence-based practice (EBP), is based on the work of Prof Rob Briner at University of Bath's Centre for Evidence-Based Management. It proposes, the conscious, explicit and judicious use of the best available evidence for decision-making, drawn from four sources:

1. Practitioner experience, expertise and judgement
2. The local social and organizational context
3. The best available research findings
4. Those affected by the decision

The National Police Wellbeing Service has proven popular with officers and staff from all UK forces and is heavily used. The Oscar Kilo web portal has all the information *www.oscarkilo.org.uk*.

MENTAL WELLNESS FOR OUR MEMBERS ON TWO STREAMS

Dale McFee, *Chief of Police, Edmonton Police Service, Alberta, Canada*

Having spent 34 years in policing, including 9.5 years as Chief of Police in Prince Albert, Saskatchewan; 6.5 years as Deputy Minister of Corrections and Policing in Edmonton, Alberta, and now currently serving as Chief of Police, also in Edmonton, I must say that my position on Mental Health and Well-Being has grown significantly, largely due to the multiple perspectives that I have held.

The Edmonton Police Service has a progressive personnel-focused program that is divided into two streams:

- a short-term program to deal with serious incidents;
- a long-term program designed for re-integration/return to work.

While these are effective and crucially important pieces that have been successful in protecting our officers' well-being, we are now looking to go further.

It is not enough to just look internally at maintaining the health of our officers. With social issues growing in our communities and with trauma present in many of the people to whom police respond, we must also create treatment and partnerships in order to realize maximum impact in keeping our officers safe. This is a net sum program, and we must ensure that we are dealing with this issue at both ends of the spectrum.

As my colleagues, with a considerable amount of experience, have clearly stated in this chapter and articulated in volumes of prior literature, building resilience is critical early on in our people's careers. We are currently studying the best way to entrench trauma-informed practise in our training regime. There is without a doubt a need to have supports for police personnel to deal with the impacts of trauma on their mental health and well-being.

Extensive research has been done, but what has not happened fast enough is implementation and action! As this article is being written, news headlines make mention of another officer in a major police service within our country who has died by suicide. This again reminds us that we might not have all the answers, but that it is time to start implementing what we know. We don't need all the answers to start. We must continually be researching, implementing, and evaluating because this is about our people, and the status quo is not an option.

COMPASSION FATIGUE IN THE UNIQUE NATURE OF POLICE WORK

Dr. Konstantinos Papazoglou, *Ph.D., Postdoctoral Scholar, Yale School of Medicine*

Officers routinely face critical incidents that can involve violent offenders, hostage negotiations, intense crime scenes, and irate civilians (Cross & Ashley, 2004; Karlsson & Christianson, 2003). In addition, police officers often provide care and support for victims of crimes (Rudofossi, 2009). For instance, police officers were the first responders at the mass shooting in Newtown, Connecticut, providing, among other things, support for wounded children until medical help arrived (Draznin, 2013). Gilmartin (2002), a veteran police officer and police well-being author, coined the phrase "the hypervigilance biological rollercoaster" (p. 91) to describe the extreme physiological states that officers experience while on-duty (e.g., hypervigilance to threat) and the inevitable physiological exhaustion after each shift (Gilmartin, 2002). These extreme physiological states, combined with organizational stressors and frequent exposure to public disapproval or condescension, are a particularly potent set of risk factors for compassion fatigue (Violanti & Gehrke, 2004; Gilmartin, 2002).

Over time, efforts to alleviate victims' suffering may come with a cost. Figley (1995) coined the term "compassion fatigue" to describe this "cost of caring for those who suffer" (p. 9). Compassion fatigue has multiple negative effects on caregiving professionals' well-being and occupational performance, including behavioural (e.g., irritation, hypervigilance), cognitive (e.g., concentration problems, depersonalization), and emotional (e.g., negativity, helplessness, and hopelessness) detriments (Bride et al., 2007; Figley, 2002). Ultimately, compassion fatigue may render officers susceptible to other serious mental health issues, such as anxiety and depression, as well as failure to perform as expected on the job (Conrad & Kellar-Guenther, 2006). Covey and colleagues (2013) found that police officers with symptoms of anxiety were more likely to shoot inappropriately in simulated critical incidents. On the other hand, some care providers experience "compassion satisfaction" (p. 108), which refers to feelings of increased motivation and satisfaction gained from helping those who suffer. Compassion satisfaction is associated with enhanced job commitment, performance, and quality of life (Stamm, 2002), and may buffer or prevent compassion fatigue.

Once compassion fatigue is present, emotions such as hostility or apathy may prevent feelings of compassion satisfaction, leading to a further lack of commitment to occupational duties. In principle, individuals with higher levels of compassion satisfaction may find more meaning in their jobs despite the emotional weight of caring for victims (Radey & Figley, 2007). This author's (Papazoglou, 2017) doctoral dissertation research (study #1) with officers from the United States and Canada, revealed that of the total participants (n=1,351), 23% reported high or extreme compassion fatigue and 31.7% reported high or extreme compassion satisfaction. As expected, compassion fatigue was also negatively correlated with compassion satisfaction. Similar results to these were found in study #2 of the same project, with officers recruited from the National Police of Finland (n=1,173) (Papazoglou, 2017). Further research into police traumatization is imperative, as the findings will support the development of evidence-based training curricula and workplace policy programs that will promote compassion satisfaction and reduce traumatization among police officers. The development of such programs would yield results that will benefit not only the officers' mental health and well-being, but also their families and the communities they serve.

MEMBER WELLNESS: AN INTERWOVEN SUITE OF SERVICES IS REQUIRED

Paul Pedersen, *M.P.A., DipEd, M.O.M., SBStJ, C.M.M.III, Chief of Police – Greater Sudbury Police Service; President – Ontario Association of Chiefs of Police 2019-2020*

Police work is a people business. Community safety is not brought about by buildings or equipment; it is brought about by dedicated people who are regularly being pulled in multiple directions often to an unrealistic standard of perfection.

At the Greater Sudbury Police Service, Ontario, we have a robust, interwoven, suite of services that includes: an employee assistance program (EAP), Peer Support, our Health & Wellness Committee, a Chaplaincy Program, Service Psychologists, Road to Mental Readiness Training, an Income Protection Program, a Peer Support Program Coordinator, a Critical Incident Team, and more. We also work in a province where presumptive legislation is in place to assist those suffering with PTSD to access services without some of the barriers that used to exist.

And yet, we struggle with staffing levels due to absenteeism, with morale problems, and with occupational stress that didn't seem to be present years ago. As Chiefs of Police, we are charged with running a public business that can only perform at its peak levels with sufficient staffing levels.

While legislation that enables access to treatment more efficiently is important, it is equally important that the treatment be effective and sufficiently efficient to return people to work to maintain workforce levels. Moreover, funding is required to support both the treatment and replacement staff during absences.

As leaders and change-agents, we must set the stage to reduce stigma and to change traditional autocratic, leader-focused styles to leadership that is understanding, accepting, supportive, and involved but that also holds to the tenets of individual and organizational accountability to professionalism and fiscal responsibility.

A BIOPSYCHOSOCIAL APPROACH TO MENTAL HEALTH AND WELL-BEING IN POLICE

Dr. Katrina Sanders, *MBBS FRACGP MPH, Chief Medical Officer, Australian Federal Police*

The prevalence of mental illness amongst law enforcement officers is increasing despite genuine intent by leaders, policy makers and practitioners to combat this public health epidemic. Police jurisdictions typically rely on psychological interventions such as psychological screening, mental health first aid training, investment in psychologists, and psychological education as a means to protect the mental health of the workforce. The over-reliance on purely psychological workplace initiatives demonstrates a lack of understanding of the biopsychosocial model of healthcare.

Historically, the practice of medicine involved diagnosis and treatment of the biological causation, with little attention given to psychological or social aspects of health that also contribute to ill-health. Good medicine has evolved over the last few decades to incorporate a biopsychosocial model of health. This model recognizes that there are multiple inputs to ill-health: biological, psychological, and social elements, all of which can cause adverse biological changes to the human body (Inerney, 2002).

This is highly relevant to police, who have higher rates of hypertension, dyslipidemia (disordered cholesterol profile), obesity, diabetes, and sedentary lifestyles than the average adult (Zimmerman, 2011). These risk factors combine to a reported incidence of cardiovascular disease in police at 31.4% versus 18.4% in the general population (Han, 2018). Exercise reduces the risk of cardiovascular risk in addition to improving mental health (Rosenbaum, 2014). Furthermore, approximately 40.4% of police report a sleep disorder, which directly impacts police officer health, safety, performance, and risk of burnout (Garbarino, 2019).

Police jurisdictions must adopt a biopsychosocial approach to health and well-being, as part of a holistic health program. Exercise, a balanced diet and quality sleep can improve

psychological health and overall well-being and should be considered as critical components of prevention programs and treatment plans in police with mental illness. Adopting a biopsychosocial model of health protection in police jurisdictions is good practice and good medicine.

TOWARDS IMPROVED WELLNESS OUTCOMES FOR OUR MEMBERS: RESOLVING THREE VITAL ISSUES

Tom Stamatakis, *President of the Canadian Police Association; President, International Council of Police Representative Associations*

With respect to police mental health, the following three yet-to-be resolved issues need to be addressed or considered so that we might change our culture in such a way as to truly become organizations that prioritize mental health and wellness.

We have very little program evaluation to help us determine what kinds of treatments are effective and which are not, and we still have very little access to appropriate and qualified persons for assistance, particularly in more rural and remote areas. That said, access is a very real issue in urban centres as well.

There is currently a tremendous amount of emphasis on recruiting diversity, including more gender equity or balance, into our police services, yet very few services (in my estimation) have shown that they are able to build capacity in this regard. The messages and direction from the Police Boards, City Councils and more senior levels of government have likely contributed to the urgency and pressure around this particular initiative or priority. To be clear, no one disagrees that diversity and gender equity/balance should be prioritized; however, it is unrealistic to expect to turn what has historically been a predominantly homogenous male-dominated industry into something completely different overnight, particularly when our industry attrition rates are generally quite low. This is important because our organizational construct is based on this type of organizational make-up, in terms of both shifting and deployment, for instance. We have not created capacity to manage the needs or demands that come along with more ethnic, cultural, and religious diversity and we have definitely not built the capacity to manage the needs and demands that having more female officers create for an organization. Just one very important example of this is our maternity and paternity benefits and how much they lag behind what is available federally and in other sectors. In addition, we do not seem to "backfill" for maternity or paternity leaves, which has a negative impact organizationally in a number of ways, including on employees who have to cover or work harder to pick up the gap created by the vacancy, as well as for the person taking the leave, who potentially has to deal with the "stigma" attached to taking time off and leaving co-workers to pick up the slack. That is just one example. A related example is when a parent, most often our female members, needs an accommodation for childcare or for family reasons; we have not created a culture where this is widely accepted or where people feel these requests or accommodations are managed equitably. A further example is found in expectations for those on leave to manage work-related demands, including court, even though they are effectively off work on leave without pay.

Second, we talk about police personnel seeking assistance, "taking a knee" or a break, when necessary to manage their mental health and wellness. However, we have not built the capacity to allow for that. Generally speaking, most if not all services are under-resourced right across Canada. Most don't have the capacity to ensure members regularly take the breaks and time off they are contractually entitled to, let alone additional time off because of unexpected events or the cumulative effect of exposure to trauma—or just too much work. Our typical response to managing any crisis is to schedule mandatory overtime with little consideration for what impact that might have on an employee or the employee's family. It is easy to say that mental health is important, and it's great that we are having a conversation about it. However, there is little evidence that Police Services are able to provide opportunities for time off where the vacancy is backfilled so that the "stigma" issue can be better managed and so that the vacancy does not have an aggravating effect on those who continue to have to respond to calls or manage files. Furthermore, until we change how we reflect on these issues when we select people for assignments or promotion, we will not create the kind of environment that emphasizes positive mental health and overall wellness.

Finally, I can provide numerous examples, including where a mental health/PTSD/Operational Stress Injury (OSI) diagnosis has been made, where this is not at all taken into account when it comes to police misconduct and discipline. There is often very little consideration of any underlying issues when misconduct occurs, and I find this particularly troubling and disappointing when it involves long-term employees with many years of exemplary service. Rather than taking an approach that seeks to be supportive and corrective, the common approach appears to be one that emphasizes discipline and punishment. Often, investigations take far too long and include re-assigning a member, which is not only stigmatizing but also often removes the member from the place where they typically get the most support. One of the key recommendations that came out of the Oppal Commission of Inquiry into Policing in British Columbia in the 1990s was the need to normalize police labour relations and discipline. In a labour context, all of the case law, research, and best practices around misconduct including discipline is that the response needs to be progressive, proportionate, and timely in order to be effective. These are concepts that are either nonexistent in or foreign to policing. As part of prioritizing employee mental health and wellness, any misconduct involving a sudden change in behaviour, where there has not previously been any misconduct, should trigger a response that seeks to look beyond the misconduct.

THE LAW ENFORCEMENT PSYCHOLOGICAL AUTOPSY: UNDERSTANDING SUICIDE IN POLICING

Jeff Thompson, *PhD, Adjunct Associate Research Scientist, Columbia University Medical Center*

According to the Blue HELP, more law enforcement officers in the United States have died by suicide than been killed in the line of duty in the last three consecutive years. In order to prevent suicide, law enforcement outreach and prevention efforts must be developed by understanding, to the extent

possible, why it happens. An effective and scientific way to understand why officers die by suicide on a case-by-case basis is by conducting a psychological autopsy.

The psychological autopsy (PA), which was created in the 1950s, is a scientific, investigative procedure designed to explore what happened in a person's life that resulted in their death by suicide. A Law Enforcement Psychological Autopsy (LE-PA) has been developed to meet the specific needs of the law enforcement community.

More often than not, a death by suicide is the result of numerous factors. Further, a common feeling expressed by a suicidal person is having a deep sense of helplessness and hopelessness. They feel as if no one is able to help them and things will never get better. The emotional, psychological, and physical pain becomes unbearable, resulting in the person feeling that there is only one option to get rid of that pain (also referred to as psychache): taking their own life.

The LE-PA cannot change what has happened, but it can provide a greater understanding of why it happened. The LE-PA seeks to answer the following questions for an individual officer's death by suicide: why suicide, why the particular method was used, why that particular day, and what, if anything, could have been done to prevent it.

CONFLICT OF INTEREST DISCLOSURES

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REFERENCES

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*, 155–163.

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect, 30*(10), 1071–1080.

Covey, T. J., Shucard, J. L., Violanti, J. M., Lee, J., & Shucard, D. W. (2013). The effects of exposure to traumatic stressors on inhibitory control in police officers: a dense electrode array study using a Go/NoGo continuous performance task. *International Journal of Psychophysiology, 87*(3), 363–375.

Cross, L. C., & Ashley, L. (2004). Police trauma and addiction: coping with the dangers of the job. *FBI Law Enforcement Bulletin, 73*(10), 24–32.

Draznin, H. (2013, December 6). Report supports police report time to Newtown shooting. *CNN Justice*. Retrieved from: http://www.cnn.com/2013/12/06/justice/newtown-police-response-school-shooting/

Figley, C. R. (1995). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Bruner/Mazel.

Figley, C. R. (2002). *Coping with secondary traumatic stress disorder in those who treat the traumatized*. London, UK: Brunner-Routledge.

Garbarino, G. P. (2019). Sleep quality among police officers: implications and insights from a systematic review and meta-analysis of the literature. *International Journal of Environmental Research and Public Health, 16*(5), pii: E885.

Gilmartin, K. M. (2002). *Emotional survival for law enforcement: A guide for officers and their families*. Tucson, AZ: E-S Press.

Han, M., Park, S., Park, J. H., Hwang, S. S., & Kim, I. (2018). Do police officers and firefighters have a higher risk of disease than other public officers? A 13-year nationwide cohort study in South Korea. *BMJ Open*, 1–7.

Inerney, M. (2002). What is a good doctor and how can we make one? *BMJ, 324*, 1537.

Karlsson, I., & Christianson, S-A. (2003). The phenomenology of traumatic experiences in police work. *Policing: An International Journal of Police Strategies & Management, 26*, 419–438.

Papazoglou, K. (2017). The examination of different pathways leading towards police traumatization: exploring the role of moral injury and personality in police compassion fatigue. *Dissertation Abstracts International, 77*.

Radey, M., & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35*, 207–214.

Rosenbaum, T. S. (2014). Physical activity interventions for people with mental illness: a systematic review and meta-analysis. *Journal of Clinical Psychiatry*, 964–974.

Rudofossi, D. (2009). *A Cop Doc's Guide to Public Safety Complex Trauma Syndrome: Using Five Police Personality Styles (Death, Value, and Meaning)*. Amityville, NY: Baywood Publishing Company.

Stamm, B. M. (2002). Measuring compassion satisfaction as well as fatigue: developmental history of the compassion satisfaction and fatigue test. In Figley, C.R. (Ed.) *Treating Compassion Fatigue* (pp. 107–119). New York, NY: Brunner-Routledge.

Violanti, J. M., & Gerhke, A. (2004). Police trauma encounters: precursors of compassion fatigue. *International Journal of Emergency Mental Health, 6*(2), 75–80.

Zimmerman, F. (2011). Cardiovascular disease and risk factors in law enforcement personnel: a comprehensive review. *Cardiology in Review*, 159–166.

ORIGINAL RESEARCH

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Impact of The HEROES Project on First Responders' Well-Being

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ABSTRACT

First responders experience a myriad of stressors (e.g., operational, organizational, personal) over the course of their career. An abundance of empirical evidence shows that the impact of those stressors on first responders' health, well-being, and performance can be detrimental. Nevertheless, previous research has mainly focused on the role of a specific technique (e.g., mindfulness, breathing exercises, psychoeducation) towards the promotion of well-being among first responders. This allows us to explore the role of a single technique in supporting first responders. However, given the complexity of stressors experienced by this population, it appears that a synergistic role of multileveled intervention is imperative to promote lasting improvement in first responders' well-being. To this end, The HEROES Project, an eight-week online training program, was developed to address the aforementioned gap in the literature. The HEROES Project incorporates lessons that aim to build a cluster of skills that together promote first responders' wellbeing. In the present study, a sample of first responders ($n = 124$) from the US Midwest were recruited and completed The HEROES Project. They were assessed before and after completion of the program, and then follow-up measurements were obtained for two years following the baseline assessment. Results showed that participants with higher distress and lower psychological resources before the training benefited most from The HEROES Project, but that the training significantly improved psychological capital and reduced stress, depression, anxiety, and trauma symptoms for all participants. Clinical and training implications as well as future research directions are discussed.

Key Words First responders; well-being; health; performance; resilience; police training.

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INTRODUCTION

This paper describes the results of a pilot study of a six-lesson, eight-week online wellbeing program for first responders. There is no argument that law enforcement personnel and firefighters experience numerous occupational and organizational stressors, which can jeopardize their health and well-being (e.g., Carpenter et al., 2015; Tuttle, Blumberg, & Papazoglou, 2019). The threats to well-being affect first responders physically, mentally, emotionally, socially, and spiritually (e.g., Papazoglou & Blumberg, 2020). Perhaps most alarmingly, in one sample of police officers, over 12% reported a likelihood of attempting suicide at some point in the future (Thoen, Dodson, Manzo, Piña-Watson, & Trejos-Castillo, 2019). Although suicide represents the most extreme outcome, most first responders experience a range of other well-being-related effects (Mumford, Taylor, & Kubu, 2015). Clearly, first responders' well-being is crucial for their own and the public's safety (Creighton & Blumberg, 2016).

Specific efforts to improve first responders' well-being have produced generally positive results. For example, social support was found to reduce a sample of firefighters' occupational stress levels and their suicidal ideation (Carpenter et al., 2015). Likewise, police officers who felt support from their agency reported greater well-being and less stress (Thoen et al., 2019). Resilience training improved a sample of female police officers' psychological well-being and reduced their occupational stress levels (Chitra & Karunanidhi, 2018). Firefighters' mindfulness was associated with better health outcomes and psychological functioning (Smith et al., 2011). However, questions have been raised about the extent to which employees will use available well-being services (Biebel, 2010; Kuehl, Mabry, Elliot, Kuehl, & Favorite, 2013) and what sorts of incentives might be necessary to increase employees' use of an online well-being program (Hibbard & Greene, 2014).

An important question is whether or not the effects of a well-being program will last. One study (Christopher et al.,

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2018) demonstrated the very positive impact of mindfulness training to increase resilience among a sample of law enforcement officers. The program showed significant improvement in a variety of health and behavioral outcomes for participants who took part in the training over a control group, but those improvements were not maintained at a three-month follow-up assessment (Christopher et al., 2018). Similarly, in a recent large study of non–first responders, a workplace well-being program was effective for improving exercise and weight management for participants over the control group members, but "did not generate differences in clinical measures of health, health care spending or utilization, or employment outcomes after 18 months" (Song & Baicker, 2019, p. 1498).

A possible problem with the longevity of positive effects of many well-being programs is their singular training focus. Many of the above-mentioned studies taught mindfulness, resilience, tactical breathing, or techniques to improve fitness and nutrition. These efforts may be enhanced when there is a concurrent sense of support from the organization, but the benefits may be fleeting when those who followed the program are not sufficiently motivated to continue to practice what was initially taught. This raises questions about the method of delivery of training, the extent to which the organization reinforces the training after it occurs, and, even, whether training or coaching is better for sustaining results (e.g., van Buuren & Edelenbos, 2013). Therefore, a critical factor associated with maintaining the effects of a well-being training program may be to expand the singular training focus.

Rather than focusing on one or two key well-being skills, it may be more important for efforts designed to enhance health and well-being to emphasize first responders' broader psychological skills (e.g., Blumberg & Papazoglou, 2018; Blumberg, Schlosser, Papazoglou, Creighton, & Kaye, 2019). Instead of learning a specific technique, the goal is to develop the skills that promote and maintain healthy functioning in many domains (i.e., physical, mental, emotional, social, spiritual, occupational, and financial). According to the California Commission on Peace Officer Standards and Training (2014), for example, "very effective" police performance involves maintaining competence in many psychological areas, including social competence, teamwork, adaptability/flexibility, conscientiousness/dependability, impulse control, decision-making/judgment, emotional regulation/stress tolerance, assertiveness/persuasiveness, and integrity/ethics (p. 51). Therefore, once first responders' well-being is operationalized, one recognizes the importance of focusing on a variety of competencies when designing a training tool intended to have long-term benefits.

The HEROES Project

One such broad-based training program is The HEROES Project (Thornton, Blumberg, Papazoglou, & Giromini, 2020). The HEROES Project is a six-lesson online course taken over eight weeks "that combines the therapeutic tools of clinical and organizational psychology and provides first responders access to a self-driven well-being program" (p. 155). The theme for each of the six lessons corresponds to the letters in the title: Hope, Efficacy, Resilience, Optimism, Empathy, and Socialization. These skills are rooted in the theory of psychological capital (PsyCap), which recognizes that healthy employees are "an indispensable asset" in every organization (Luthans & Youssef, 2004, p. 143). The HEROES course uses active-learning techniques and provides participants with practical, job-related well-being strategies:

> Participants start a project in lesson one and continue it throughout the training. They are then encouraged after conclusion of the training to regularly update it over the course of their careers. Each training activity adds an essential element to the project, challenging trainees to apply lessons to their own lives. The training is self-paced. Trainees are able to take as much time as they want to critically evaluate and apply the learning outcomes. Each lesson includes a video lecture delivered by the project author [the present paper's fourth author] with downloadable lecture notes focused on learning outcomes. Trainees are virtually introduced to Mitch Kazjer, a police officer who survived being shot on the job, and are provided with short video clips throughout the training, wherein he details his journey to resilience. Additional resources such as podcasts, books, and articles that are particularly relevant to the development of resilience are made available to the trainees as adjuncts to the lesson materials. At the conclusion of the training program, first responders receive a certificate of achievement. (p. 157)

The Present Study

The present study was initiated to obtain results from participants who volunteered to complete The HEROES Project. The empirical question was: How are first responders impacted by completing the course? Specifically, because of the recognized incidence among first responders of stress and trauma reactions and anxiety and depression symptoms, and, conversely, the known benefits of positive psychological capital, these were the variables assessed. Secondarily, and, perhaps most importantly when it comes to first responders' health and well-being, did the benefits of the training last? The goal was to identify whether this self-paced, off-duty program provided first responders with the tools to stay healthy despite some of the more toxic stressors of their jobs. Thus, data was collected at five separate times up to two years after completion of the program. The study received approval from the Institutional Review Board of the fourth author's prior university.

METHODS

Participants

Volunteers were recruited from the police and fire departments of a medium-sized city in the Midwestern United States. In all, 124 participants (116 males and 8 females) completed the training program. Most participants completed all assessment components of the study (100% at T2; 93% at T3; 90% at T4; and, 89% at T5). Although the sample consisted of 55 police officers (44%) and 69 firefighters (56%), no differences were found between the two groups, so all analyses reflect the combined group of "first responders." The age breakdown of participants was: 18–29 = 9; 30–44 = 60; 45–59 = 52; 60+ = 3. Years of service of the participants was: 0–5 = 8; 6–10 = 22; 11–15 = 22; 16–20 = 30; 21–25 = 18; 26+ = 24. To determine whether two additional factors other than completion of the course had an influence

on the outcome measures, participants were also asked about the frequency of their physical activity outside of work and if they "lived an active life of faith."

Measures

Participants were asked to complete three self-report instruments related, respectively, to their: 1) psychological capital (i.e., well-being); 2) experience of post-traumatic stress symptoms; and, 3) levels of depression, anxiety, and stress.

PCQ-24. The Psychological Capital Questionnaire 24 (Luthans, Avolio, Avey, & Norman, 2007) is a 24-item self-report instrument that measures dimensions, which the authors refer to as positive PsyCap. Specifically, the PCQ assesses the extent to which participants feel self-efficacy, hope, optimism, and resilience on a five-point Likert scale from strongly disagree to strongly agree. The authors reported a Cronbach's alpha coefficient score of 0.91 for the scale.

PCL-5-Civilian Version. The DSM V PTSD Checklist – Civilian Version is a 20-item self-report checklist designed to evaluate symptomology of post-traumatic stress disorder (PTSD). The civilian version is used to evaluate responses to traumatic situations encountered in the course of civilian life. Using a five-point Likert scale, respondents indicate the degree of impact a traumatic event has had on their emotional state. Originally created by Weathers, Huska, and Keane (Weathers, Litz, Herman, Huska, & Keane, 1991; 1993), the scale was updated by the National Center for PTSD in 2014.

DASS-21. The Depression, Anxiety, Stress Scale (DASS-21) is a 21-item self-report instrument that measures the severity or frequency of feelings of depression, anxiety, and stress in a non-clinical sample (Lovibond & Lovibond, 1995). It has been used in over 7,000 studies involving police and firefighters (Thoreau Walden University Discovery Service).

PROCEDURES

Participants completed the three measures at Time 1 (prior to beginning the training), at the conclusion of the eight-week program (Time 2), and again at one year after the initial assessment (Time 3). Additionally, participants completed only the PCL and PCQ at 18 months (Time 4) and again two years after the initial assessment (Time 5). The measures were delivered via the Survey Monkey platform to each participant's personal e-mail address at each data collection point. However, due to a technical glitch on Survey Monkey, the distribution of the DASS to participants at T4 was corrupted, so that measure was not administered then or at T5. Between T1 and T2, each participant completed the online psychological skills development course, details of which can be found in a recent book chapter (Thornton et al., 2020)

RESULTS

The goal of the current study was to evaluate the impact of The HEROES Project on scores of psychological trauma, depression, anxiety, stress, and well-being. We performed a series of repeated-measures ANOVAs investigating whether the scores of *PCL-5*, *DASS* (depression, anxiety, and stress), and *PCQ* (hope, optimism, self-efficacy, and resilience) varied across time. To deepen our understanding of the phenomenon, we explored the extent to which the effectiveness of the training could be moderated by factors such as age of the trainee, baseline levels of distress, and PsyCap, etc. Therefore, a series of mixed ANOVAs were computed.

Impact of Training on Psychological Distress and PsyCap

Table I presents descriptive statistics and Cronbach's alphas for all key measures under investigation. A first consideration that deserves mentioning is that *PCL-5*, *DASS Depression*, *DASS Anxiety*, *DASS Stress*, and *PCQ Total* produced Cronbach's alpha values ≥ .68 in almost all cases, with the sole exception of *DASS Anxiety*, which produced a value of .49 at T3. Conversely, each of the four subscales of the *PCQ* produced unsatisfactory alpha values (i.e., < .70; Nunnally, 1978) in at least one the five data points. Accordingly, the following analyses on *PCQ* scores focused on the total score only, and disregarded the subscale scores.

TABLE I Cronbach's alphas and descriptive statistics.

	T1 (*N* = 124)			T2 (*N* = 124)			T3 (*N* = 116)			T4 (*N* = 112)			T5 (*N* = 110)		
	α	M	SD	α	M	SD	α	M	SD	α	M	SD	α	M	SD
PCL-5	.96	16.8	14.7	.90	6.9	6.8	.84	5.0	4.5	.77	4.4	3.6	.71	4.1	3.1
DASS Depression	.90	9.2	9.3	.80	4.0	5.3	.74	2.6	3.6	—	—	—	—	—	—
DASS Anxiety	.79	5.1	6.1	.69	2.1	3.4	.49	1.4	2.2	—	—	—	—	—	—
DASS Stress	.86	13.5	9.5	.73	6.0	5.8	.68	4.1	4.1	—	—	—	—	—	—
PsyCap Hope	.97	23.7	9.6	.79	28.8	3.2	.41	32.0	1.8	.35	32.4	1.4	.64	33.4	1.8
PsyCap Optimism	.97	23.4	9.7	.71	31.6	2.6	.26	32.3	1.6	.37	32.6	1.5	.16	32.4	1.4
PsyCap Self-Efficacy	.97	23.8	9.2	.86	30.9	3.5	.66	32.4	2.0	.64	32.6	1.8	.49	33.5	1.7
PsyCap Resilience	.97	23.5	9.1	.82	31.7	3.0	.41	32.4	1.7	.52	32.7	1.6	.70	33.6	1.8
PsyCap Total	.99	94.4	36.7	.93	123.0	10.9	.71	129.1	4.9	.76	130.2	4.6	.80	132.9	5.2

DASS = depression, anxiety, and stress scale; PsyCap = psychological capital.

Noteworthy, Cronbach's alphas tended to decrease when going from T1 to T5. A possible explanation for this finding is that the variability of the scores (i.e., SD values) tended to decrease as well, when going from T1 to T5. Indeed, because Cronbach's alphas reflect the correlations among all possible split-halves of a given scale and since co-variation cannot occur without some variation, it is likely that alpha decreased from T1 to T5 simply because the scores tended to become more homogeneous from T1 to T5. Figures 1 and 2 show that the scores of *PCL-5*, *DASS Depression*, *DASS Anxiety*, *DASS Stress*, and *PCQ Total* became increasingly homogeneous with the passage of time.

Influence of Demographic and Behavioral Variables

We next tested whether age (< 45 vs. ≥ 45), experience in the profession (0–10 years vs. 11–20 years vs. 21+ years), faith (yes vs. no), or physical activity (0–3 times per week vs. 4+ times per week) had an impact on the effectiveness of the training. We tested a series of mixed ANOVAs, with *Time* as our within-subject factor (considering *PCL-5*, *DASS Depression*, *DASS Anxiety*, *DASS Stress*, and *PCQ Total* scores), and each of the demographic and behavioral variables described above, entered one at a time, as our between-subject factors. Of the 20 interaction effects under investigation, none resulted in statistical significance after applying Bonferroni correction.

Influence of Psychological Distress and Resources at the Baseline

Lastly, we investigated whether the baseline levels of psychological distress (i.e., *PCL-5* and *DASS* scores) and resources (i.e., *PCQ* scores) were impacted by the effectiveness of the training. As a proxy marker of the levels of psychological distress at baseline, we calculated the *z* average of the T1 scores of *PCL-5*, *DASS Depression*, *DASS Anxiety*, and *DASS Stress* (which correlated with each other at $r \geq .63$, $p < .01$). Individuals with a *z* score greater than zero were considered to be at a high level of distress, and individuals with a z score lower than zero were considered to be at a low level of distress. For the psychological resources, individuals with a T1 score on *PCQ Total* greater than the median (i.e., *PCQ Total* = 115) were considered to have good psychological resources while individuals with a T1 *PCQ Total* score lower than the median were considered to have poor psychological resources.

For the *PCL-5* scores, a mixed 2 (between-subjects factor, baseline level of distress: low vs. high) by 2 (between-subjects factor, baseline level of resources: poor vs. good) by 5 (within-subjects factor, time: T1 vs. T2 vs. T3 vs. T4 vs. T5) ANOVA revealed a statistically significant interaction between time and baseline level of distress, $F(4, 424) = 86.4$, $p < .01$ (Table II). No other interaction factors were statistically significant, $p \geq .12$. As shown in Figure 3, the training had a greater, positive impact on individuals who had higher levels of distress at baseline. The size of the difference from T1 to T5 in *PCL-5*

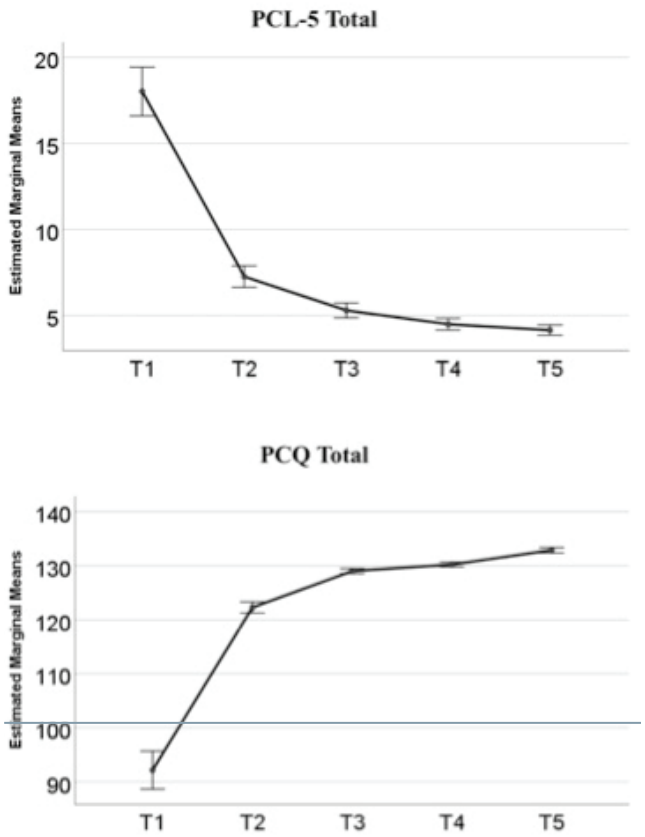

FIGURE 1 Graphical representation of PCL-5 and PCQ Total Scores. Error bars represent the standard error of the mean. PCQ = Psychological Capital Questionnaire.

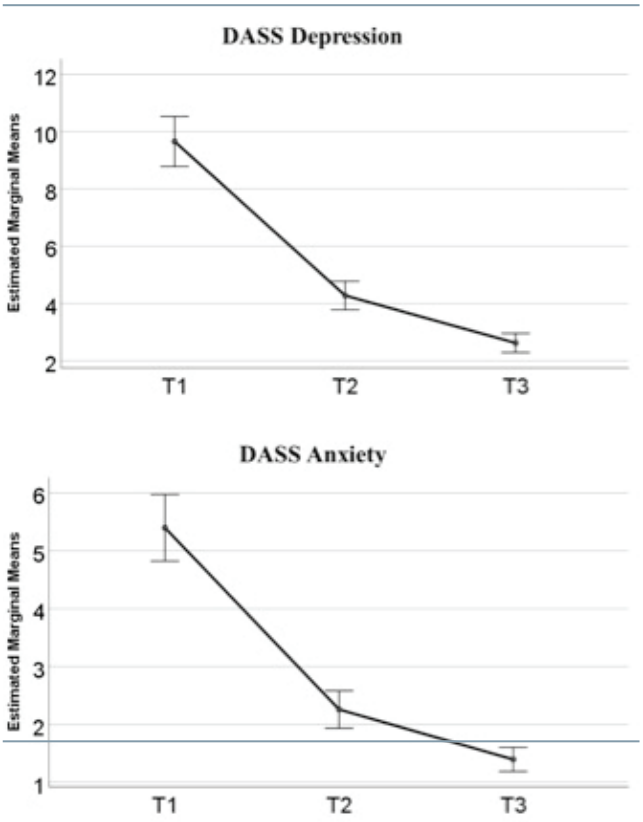

FIGURE 2 Graphical Representation of *DASS* Scores. Error bars represent the standard error of the mean. DASS = depression, anxiety, and stress scale.

TABLE II Results of repeated-measures ANOVAs.

	Main effect	Pairwise Comparisons	Cohen's *d* Effect Size			
			T1 vs. T2	T1 vs. T3	T1 vs. T4	T1 vs. T5
PCL-5	$F(4,436) = 132.8$, $p < .01$	All p's < .01	.86	1.07	1.13	1.16
DASS Depression	$F(2,230) = 134.0$, $p < .01$	All p's < .01	.69	.92	—	—
DASS Anxiety	$F(2,230) = 81.6$, $p < .01$	All p's < .01	.61	.80	—	—
DASS Stress	$F(2,230) = 237.4$, $p < .01$	All p's < .01	.95	1.27	—	—
PCQ Total	$F(4,436) = 133.6$, $p < .01$	All p's < .01	1.06	1.30	1.34	1.43

DASS = depression, anxiety, and stress scale; PCQ = Psychological Capital Questionnaire.

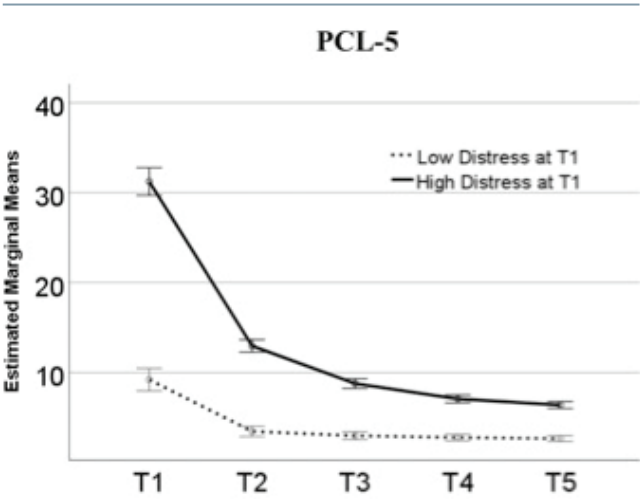

FIGURE 3 Graphical Representation of PCL-5 Scores. Error bars represent the standard error of the mean.

scores for individuals with a high distress level at baseline consisted of a remarkably large Cohen's *d* value of 2.33. A similar pattern was observed when inspecting the impact of baseline levels of distress and resources on *DASS* and *PCQ* scores. It should be noted also that baseline level psychological resources influenced the extent to which the training increased the scores of *PCQ Total*. More specifically, the higher the distress and the lower the psychological resources were at T1, the greater was the impact of the training on the participants' psychological resources.

DISCUSSION

The results from the present study were very robust. After completing the program, participants reported significantly reduced stress, depression, anxiety, and trauma symptoms and significantly higher levels of psychological capital. These results were even greater for participants whose pre-program scores reflected greater psychological distress and lower psychological resources. It could be said that The HEROES Project worked best for those first responders who needed it the most.

Of great significance was that the impact of the psychological skills training program endured through the two-year assessment point. Moreover, there was some indication that participants continued to improve past the conclusion of the program. It appears that the skills developed during the eight-week training were used long after participants ended the program. Thus, rather than learning a specific skill, The HEROES Project instilled psychological skills and methods to practice those skills in a manner that led to sustained psychological well-being. This was independent of participants' ages, years in their profession, level of physical activity, and extent of faith activities.

The HEROES Project reinforces the theory that efforts to improve first responder well-being should emphasize broad-based psychological skill development. To maintain well-being, first responders require a diverse skill set, because threats to their well-being are multidimensional (e.g., Kwiatkowski & Robison, 2020; Thornton, 2020). Therefore, well-being programs should expand to address the many areas that pose a risk to first responders' health and well-being.

Limitations

The present study has some limitations and, as mentioned, was a rather narrow preliminary study. The sample size was small, geographically constrained, contained an underrepresented number of female participants, and did not collect information about the ethnic or racial background of the participants. All of these factors may limit the generalizability of the findings. Although the present sample contained participants of various ages and years of experience, it cannot be ignored that there may have been a self-selection effect whereby those who volunteered were more likely to benefit from the training than those who did not choose to participate. Finally, although unlikely, the possible impact of practice effects cannot be overlooked. However, the time between administration of the measures and the continued improvement of participants' scores can provide some confidence that a practice effect was not responsible for the scores that were obtained.

Future Directions

The efficacy of The HEROES Project remains to be tested more rigorously. A significantly larger number of participants from broad geographical areas should be assessed. The program should be taken by more females as well as by first responders of all cultural backgrounds to further determine the impact of this training on various demographic groups. It may be advisable to employ a variety of assessment measures to avoid practice effects.

Nevertheless, as a pilot study, the present findings offer some encouragement that The HEROES Project may be an important option to boost first responders' well-being. It is significant that the present results demonstrated that the program benefited participants who were relatively healthy and that it had an even better impact on first responders who were not functioning as well before the training. This indicates that The HEROES Project could serve both as an adjunct to clinical interventions and as a preventive tool for first responders who have not yet begun to experience the most deleterious effects of their job. Nevertheless, while more research is necessary before making any definitive conclusions, the present findings provide a promising start.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that there are no conflicts of interest.

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REFERENCES

Biebel, C. J. (2010). Analysis of variables affecting participant success within a law enforcement wellbeing program. *Dissertation Abstracts International: Section B: The Sciences and Engineering*. ProQuest Information & Learning.

Blumberg, D. M., & Papazoglou, K. (2018, July). Arming police officers with psychological survival strategies. *The ePolice Chief*, 12–13 https://www.policechiefmagazine.org/osc-psych-survival-strategies/.

Blumberg, D., Schlosser, M. D., Papazoglou, K., Creighton, S., & Kaye, C. C. (2019). New directions in police academy training: A call to action. *International Journal of Environmental Research and Public Health*, *16*(24), 4941. https://doi.org/10.3390/ijerph16244941

California Commission on Peace Officer Standards and Training. (2014). *Peace officer psychological screening manual*. California Commission on Peace Officer Standards and Training (2014). *Peace Officer Psychological Screening Manual*. Sacramento, CA: California POST.

Carpenter, G. S. J., Carpenter, T. P., Kimbrel, N. A., Flynn, E. J., Pennington, M. L., Cammarata, C., … Gulliver, S. B. (2015). Social support, stress, and suicidal ideation in professional firefighters. *American Journal of Health Behavior*, *39*(2), 191–196. https://doi.org/10.5993/AJHB.39.2.5

Chitra, T., & Karunanidhi, S. (2018). The impact of resilience training on occupational stress, resilience, job satisfaction, and psychological well-being of female police officers. *Journal of Police and Criminal Psychology*. https://doi.org/10.1007/s11896-018-9294-9

Christopher, M. S., Hunsinger, M., Goerling, L. R. J., Bowen, S., Rogers, B. S., Gross, C. R., … Pruessner, J. C. (2018). Mindfulness-based resilience training to reduce health risk, stress reactivity, and aggression among law enforcement officers: A feasibility and preliminary efficacy trial. *Psychiatry Research*, *264*, 104–115. https://doi.org/10.1016/j.psychres.2018.03.059

Creighton, S., & Blumberg, D. M. (2016). Officer wellbeing is fundamental to officer safety: The San Diego Model. In *Police Executive Research Forum, Critical Issues in Policing Series: Guiding Principles in Use of Force*. Washington, DC.

Hibbard, J. H., & Greene, J. (2014). The impact of an incentive on the use of an online self-directed wellness and self-management program. *Journal of Medical Internet Research*, *16*(10), e217. https://doi.org/10.2196/jmir.3239

Kuehl, H., Mabry, L., Elliot, D. L., Kuehl, K. S., & Favorite, K. C. (2013). Factors in adoption of a fire department wellbeing program: Champ-and-chief model. *Journal of Occupational and Environmental Medicine*, *55*(4), 424–429.

Kwiatkowski, C. C., & Robison, A. J. (2020). Internal threats to police wellbeing. In K. Papazoglou & D. M. Blumberg (Eds.), *POWER: Police officer wellbeing, ethics, & resilience* (pp. 29–36). Cambridge, MA: Academic Press.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*(3), 335–343. https://doi.org/10.1016/0005-7967(94)00075-U

Luthans, F., Avolio, B. J., Avey, J. B., & Norman, S. M. (2007). Positive psychological capital: Measurement and relationship with performance and satisfaction. *Personnel Psychology*, *60*(3), 541–572. https://doi.org/10.1111/j.1744-6570.2007.00083.x

Luthans, F., & Youssef, C. M. (2004). Human, social, and now positive psychological capital management: Investing in people for competitive advantage. *Organizational Dynamics*, *33*(2), 143–160. https://doi.org/10.1016/j.orgdyn.2004.01.003

Mumford, E. A., Taylor, B. G., & Kubu, B. (2015). Law enforcement officer safety and wellness. *Police Quarterly*, *18*(2), 111–133. https://doi.org/10.1177/1098611114559037

Nunnally, J. C. (1978). Phychometric theory. In *Psychometric theory*. New York, NY: McGraw-Hill.

Papazoglou, K., & Blumberg, D. M. (Eds.). (2020). *Power: Police officer wellbeing, ethics, & resilience*. Cambridge, MA: Academic Press.

Smith, B. W., Ortiz, J. A., Steffen, L. E., Tooley, E. M., Wiggins, K. T., Yeater, E. A., … Bernard, M. L. (2011). Mindfulness is associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems in urban firefighters. *Journal of Consulting and Clinical Psychology*, *79*(5), 613–617. https://doi.org/10.1037/a0025189

Song, Z., & Baicker, K. (2019). Effect of a workplace wellness program on employee health and economic outcomes. *JAMA*, *321*(15), 1491. https://doi.org/10.1001/jama.2019.3307

Thoen, M. A., Dodson, L. E., Manzo, G., Piña-Watson, B., & Trejos-Castillo, E. (2019). Agency-offered and officer-utilized suicide prevention and wellness programs: A national study. *Psychological Services*. https://doi.org/10.1037/ser0000355

Thornton, A. R. (2020). Police officer wellbeing. In K. Papazoglou & D. M. Blumberg (Eds.), *Power: Police officer wellbeing, ethics, & resilience* (pp. 7–27). Cambridge, MA: Academic Press.

Thornton, A. R., Blumberg, D. M., Papazoglou, K., & Giromini, L. (2020). The HEROES Project: Building mental resilience in first responders. In C. Bowers, D. Beidel, & M. Marks (Eds.), *Mental Health*

Intervention and Treatment of First Responders and Emergency Workers (pp. 154–168). https://doi.org/10.4018/978-1-5225-9803-9.ch009

Tuttle, B. M., Blumberg, D. M., & Papazoglou, K. (2019). Critical challenges to police officer wellness. In H. Pontell (Ed.), *Oxford research encyclopedia of criminology and criminal justice*. https://doi.org/10.1093/acrefore/9780190264079.013.538

van Buuren, A., & Edelenbos, J. (2013). Organizational competence development in two public agencies in the Netherlands. *Public Personnel Management, 42*(3), 385–402. https://doi.org/10.1177/0091026013495771

Weathers, F. W., Litz, B. T., Herman, D., Huska, J., & Keane, T. (1991). PTSD CheckList – Civilian Version (PCL-C). In *National Center for PTSD*. Boston, MA.

Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. *Annual Convention of the International Society for Traumatic Stress Studies*. San Antonio, TX.

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A look in the back yard: Mitigating home-grown extremism in Canada

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ABSTRACT

Canada has the capability to provide a significant security blanket with which to protect Canadian citizens from the effects of terrorism. I will discuss the scholarly work in the area of extremism and associated ideologies. Contemporary issues of environmentalism, race and gender, and government legitimacy will be examined with respect to how they contribute to growing extremist segments of Canadian society. Findings support the argument that, as society grows in its liberal approaches, extreme ideologies from those on the fringes may begin to grow in order to counter the influence of opposing views and social policy. This article closes with a discussion of how the growth of extremism may be mitigated through attention to history and societal development, asserting control over the Internet, strengthening the criminal justice system, and education.

Key Words Homegrown terrorism; extremism; mitigation; conservatism; liberalism; social agents.

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INTRODUCTION

Terrorism is not strictly an imported commodity. We generate our own culpability through homegrown social challenges that increase the potential for radicalization, through political developments (both traditional and contemporary), and as a result of growing global social problems that are transcending borders and cultures. The social conditions giving rise to extremism, both from the right and the left, are growing in Canada. While the current situation may not indicate an imminent revolution, it forms the very conditions that have created extreme social and political ideologies in the past (Public Safety Canada, 2018; Parent & Ellis, 2016; Berger, 2016; Kohler, 2016; Crawford & Pilanski, 2014; Levitas, 2002). As Canadian society continues to grow in its openness, and social and political activism grows to cross all boundaries and borders, managing information in terms of veracity and content continues to challenge our social institutions.

The federal government names terrorism and extremism as a major priority in Canada (Public Safety Canada, 2018). Canadian homegrown extremism must be considered a social problem at the very roots of society and we must empower Canadian society to address the matters that lead to the development of behaviours fuelled by dogma and extreme narratives. The increasing prevalence of blind faith in Internet commentators and social engineers, and the very little veracity of online narratives regarding volatile issues such as the rise in nationalism, immigration and refugees, ethnic pride, and environmentalism all potentially contribute to the increase in extremism or, at the very least, in the dissatisfaction of society and in fear of these issues. This article's focus will be on identifying the role grassroots social growth plays in the development of extremism, with the aim of mitigating the growth of terrorism.

DOGMATIC ISSUES IN CANADIAN EXTREMISM

According to Crawford and Pilanski (2014), both Liberals and Conservatives are motivated to afford more rights to groups and individuals with whom they agree. Equally, according to Sabbagh (2005), individuals "occupying different social positions favour different justice principles because these principles enhance a self-interested pattern of instrumental benefits" (p. 119). It stands to reason, however, that egalitarianism is very much a foundation for social and political life, in that power is a central theme in social and political dynamics. The pursuit of equality is simply a power struggle. I find Crawford and Pilanski's focus on intolerance to be another significant factor in the dissent between Liberal and Conservative ideologies with respect to the manner in which society manages ideological approaches to conflict. They focus on the determination of liberalism and conservatism as more of a valid perspective. According to Crawford and Pilanski:

> both political liberalism and conservatism predict intolerance of politically opposing targets and that such

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> intolerance is explained by perceived threat from these targets. Moreover, both liberals and conservatives were biased in their intolerance judgments, with conservatives expressing more intolerance of left-wing than comparable right-wing targets and liberals expressing more intolerance of right-wing than comparable left-wing targets. (2014, p. 847)

Their research advances that, with respect to political issues and the way political expression is undertaken, both Liberal and Conservative factions are intolerant of those with whom they disagree, and that intolerance was justified by how threatening those political opponents were perceived. As such partisanship continues to grow in the population, we could see a ripe breeding ground for an increase in Canadian extremism, both from the right and from the left.

Environmentalism and climate change is one of the most significant issues in contemporary global life and politics in the 21st century, and is becoming the basis of militancy and extreme behaviour. A contemporary example of this phenomenon can be seen in the recent North American tour by Greta Thunberg and the newest forms of neo-environmental narratives of the contemporary global climate change dialogue. The vitriolic behaviour on both sides that resulted from the visit made it clear that both the Conservative and Liberal ideological sides experienced perceived threats and believed important values each held were under attack. This perception of attack, from either side, further supports the idea that fear is growing, and the associated behaviours have the potential to enhance the growth of extreme thoughts and behaviours to the degree of radicalization and thus be the path to terrorist action, especially when local economic factors are considered. The climate change movement has solidly demonstrated the sheer emotionalism and interconnectedness between issues of economics and climate change. One of the most powerful worries for most is the fear for their ability to make a living. For example, Albertans felt threatened by Thunberg's environmental message, which went straight to the heart of the livelihoods of many Alberta residents. The strong emotions expressed by Thunberg, such as anger and frustration, elicited the very justification needed by the conservative population to grow and show the type of intolerance researched by Crawford and Pilanski. As climate change increases in relevance and, with it, social desperation, I would posit that the future will hold ever increasing measures taken by advocates. We have seen examples of extreme environmentalism in Canada, such as the Wiebo Ludwig conflict in the 1990s with the oil producers in Alberta. In 2013, Public Safety Canada considered eco-terrorism to be a leading domestic threat and that environmentalists could be a major hazard to the public (Yang, Su, & Carson, 2014).

It is of interest that, in Public Safety Canada's 2018 report on terrorism in Canada, there is no mention of eco-terrorism in the assessment of contemporary terrorism threats. Parent & Ellis (2016) posit that extremist groups are characterized by loose, heterogeneous groups and individuals that claim to believe in deep-seated grievances that typically include anti-government sentiments (involving individual sovereignty, anti-globalization/anti-immigration), racism, fascism, race supremacy (including white supremacy, anti-Semitism, and anti-Muslimism), misogyny-based values, and sexual-/gender-based values. Further, they have found that right-wing extremists do not fall specifically into cohesive groups, as they can be religious or secularly organized, and there is frequently conflict from within these groups. I believe that these groups that espouse a broader, more general, condemnation of social and political issues can further fuel the others. Parent and Ellis open the door for this issue to be considered a single-issue extremist matter.

Research has shown a connection between dogmatism and rigid adherence to political intolerance (Levitas, 2002; Crawford & Pilanski, 2014). With respect to right-wing ideology, white supremacy, anti-immigrant, and anti-Islamic sentiments have been given a forum, from both growth on the Internet and a growing liberalization of the ruling political power, to contribute to in mushrooming conflict between ethnic groups and those who are fearful of a multitude of perceived social ills. Public Safety Canada defines right-wing extremism as follows:

> traditionally driven by hatred and fear, and includes a range of individuals, groups, often in online communities, that back a wide range of issues and grievances, including, but not limited to: anti-government and anti-law enforcement sentiment, advocacy of white nationalism and racial separation, anti-Semitism and Islamophobia, anti-immigration, male supremacy (misogyny) and homophobia. The threat of violence from any individuals, including those holding extreme right-wing views, may manifest in terrorist activity or other forms of criminal violence. However, while racism, bigotry, and misogyny may undermine the fabric of Canadian society, ultimately, they do not usually result in criminal behaviour or threats to national security. (2018, para. 25)

However, political/social extremism is growing in its violence, evidenced by groups such as the misogynist movement of involuntary celibates (Incels) and the anti-government sovereign citizens. According to Louie:

> when a term like Incel is created and used in online forums, it allows all of these isolated and alienated people to unite and for once feel a sense of connection, acceptance, and understanding, which in turn allows them to share their sense of shame and self-condemnation. But it also allows for a perfect storm of not only self-hatred but vitriol, rage, and a desire to inflict harm on others whereby victims can also experience firsthand the grief and suffering that Incels feel they've had to endure for a lifetime. (2018, para. 12)

The Incel movement is described as, "by ideals of male supremacy, believing that men are the victims of oppressive feminism that has destroyed society and thwarted their perceived entitlement to women's bodies" (Dixon, Harkins, & Wegerhoff, 2019, p. 681). By nature of the supremacy ideology, Incels fall within the category of extremism. The growth of this very specific movement may have resulted from the movement that saw the increase of women's rights from the 1960s to the 1980s. The rise of the power afforded to women and the associated programs and policies to forward that

goal is interpreted as a perceived removal of power from men. Widespread Internet communication between individuals about contemporary sexual politics can then bring those with grievances together to share information and to develop a sense that there are others with similar issues. Additionally, such communication allows for the dissemination of information, false or otherwise, that fuels the cause.

The Sovereign Citizen movement is yet another example of this backlash to a growing and changing society. This is an interesting movement, not only because it is identified as a terrorist group in the United States, but also because it shares both left- and right-wing ideologies. Although the Sovereign Citizen movement began in the United States, the dogmatic foundations remain the same in Canada. What is concerning about this movement is its dissemination of dogma over the Internet, spawning self-professed gurus who sell legal filing kits and guidelines (Berger, 2016). This use of the internet to spread ideology and to exploit the disenfranchised is similar to the spread of extreme thought, such as the previously discussed Incels. However, these tactics, when used by such self-professed gurus, are more akin to the radicalization tactics seen in Islamic extremism than in the Incel movement.

GROWTH IMPLICATIONS

Historically, the development of most, if not all, terrorist groups has roots in unbalanced power dynamics, typically socioeconomic and political power. Race and cultural differences, and the associated political implications, have played a significant role in the growth of extremist groups, such as the FLQ and militant indigenous groups, and more currently the growth of Islamic-inspired terrorism. In addition, contemporary liberal-leaning groups are beginning to gain social momentum, such as the gender-/sex-based movements (e.g., LGBTQ+ and Incels), as well as environmentalism and climate change. These historical and contemporary movements produce lessons, or the potential to foresee growing extremism. Society tends to forget the impact of significant events and usually has difficulty drawing lessons from the past once the movement has been quelled or is no longer popular. However, we can see the ebb and flow with respect to social movements, and history certainly demonstrates that past social conflicts continue to re-emerge, couched in contemporary issues.

Growing dissatisfaction with contemporary government continues to fuel both right- and left-wing extremism, and the growth of homegrown responses. Specific internal matters continue to erode faith in the capabilities of the government to keep Canadians safe from both internal and external threats. Global conflicts contribute to Canada's own challenges, such as increased race relations, refugeeism and immigration, as well as dissatisfaction with the way in which Canada's governments are dealing with economic downturn, and how the government is legislating social issues, touching on gender/sexual roles, the environment, religion and spirituality.

Immigration has consistently increased in Canada (Statistics Canada, 2018). As a result, Canadian society has already seen an increase in race-related extreme ideological narratives, both generally with respect to closing borders to refugees and specifically with growing Islamophobic sentiments. If the research is accurate, Canada will continue to see social discord in terms of race and will also begin to see the displacement of racial tensions (and associated cultural and political tensions) from the homelands of new Canadians.

MITIGATION

Canada, both politically and socially, must continue to look to the past to counter the conditions that contribute to homegrown extremism. While the Canadian government works on mitigation of the growth of such groups through the development and exercise of legislation and the criminal justice system (Public Safety Canada, 2018), socialization agents must take a stronger role in education and addressing these conditions at a grassroots level in local communities: schools, religious institutions, local law enforcement, community social groups, and mental health institutions.

A significant mitigation must come from gaining appropriate control over the uncontrolled proliferation of information disseminated over the Internet. Public Safety Canada warns that, in Canada, those people who are inspired to extremism use low sophistication and low resource tactics to commit their violent activity and are still capable of delivering the high casualty- and publicity-generating events. The Internet can be considered a low sophistication tool, as it is an easily acquired tool and is simple to use to further such causes. Further, these groups typically use online resources for recruitment, facilitation, and guidance. As society becomes increasingly isolated and its knowledge base formed more by the Internet, we must strive to create stronger opportunities to combat the false narratives typical of the spread of extremist thought and ideology. The Internet is not, by design, a tool of evil. It can also be the saviour with respect to education, a mitigation yet to be discussed. It has become a significant wayfinder for information and communication, both protective factors with respect to countering all sorts of threats to society. The problem is that the internet became weaponized. As with any weapon, we must build a safety response before that tool can be rendered controllable. Regardless of the inherent lag with legislation, Canada continues to play catch up with public safety matters involving the Internet.

Legal and justice enforcement systems in Canada must continue to adjust to the rapid transformation of public safety as it is affected adversely by the growth of homegrown extremism. Although the *Criminal Code of Canada* and the criminal justice system have continued to lag behind technological advances in crime and communication for the purposes of criminal activity, there are successes in prosecutions for offences committed involving the matters covered in this article (Yang, Su, & Carson, 2014; Public Safety Canada, 2018). However, the justice system remains bogged down in its own complexity, in civil libertarian disputes, and in constitutional arguments that prevent it from being a truly effective tool to counter growing extremism as it begins to transgress the law.

Granted, the Canadian justice system requires significant oversight to ensure the *Charter of Rights and Freedoms* is upheld, so that the system does not suffer disrepute; however, the system allows for the growth of hate-fuelled ideology due to its inability to address the matters contemporaneously and the fact that it operates at a speed that cannot keep pace with the sheer rapidity of the Internet. The current judicial system in Canada is also failing to counter the growing extremist

movements, issuing correctional sentences that are not in line with the severity of the crime because ideological criminal behaviours are not considered serious offences. It is concerning that some of these contemporary movements are being judged as low-level threats when compared with issues such as Islamic terrorism; in reality, they are just in their infancies. The purpose of this article is to explore how we may intervene in the growth of such movements, rather than wait until they are on par with the larger-scale, more global, threat actors.

Education is the single most significant tool in mitigating the growth of extremism. Dogma is a natural state of human ideology and will always be present. When considering the definitions and the typologies provided in this article, what is common to most forms of extremism is ignorance. As such, in order to mitigate the growth of extremist ideology, it is vital to educate the upcoming generations and bolster their abilities in critical thinking to counter the false narratives and to combat racism and misogyny, as well as strengthening social legitimacy to combat intolerance. We must strive to lessen society's emotionalism with respect to issues of great importance, and to empower the next generations to seek social justice through legitimate knowledge. Knowledge is a powerful tool to address social justice and can be the redress to political barriers and social ignorance. Canadian society is rife with socialization agents, be they schools, religious institutions, youth and community groups, or parents. There can be no valid excuse as to why children cannot be better inculcated with the ability to think for themselves following healthy discourse and the ability to conduct independent research. The use of socialization agents to radicalize has been demonstrated as being very effective with respect to extreme ideologies. The same methods can be used by social institutions to buttress knowledge and veracity to reduce the proliferation of extreme ideologies.

CONCLUSION

In this article, I have explored the scholarly work in the area of extremism and associated ideologies. I set out to examine the potential for homegrown extremism in Canada with respect to the contemporary issues of environmentalism, race and gender, and government legitimacy. In exploring Canada's experience with movements such as environmentalism, sexual/gender motivation, self-sovereigns, I am convinced that the conditions exist that could contribute to a growing extremist segment of Canadian society. I would argue that we must expand resources that support education, as the most significant aspects of extremism are ignorance and intolerance. Canadian society continues to grow in its exercise of freedoms of expression, and social and political activism grows to cross all boundaries and borders, continuing to challenge our social institutions.

CONFLICT OF INTEREST DISCLOSURES

The author declares that there are no conflicts of interest.

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REFERENCES

Berger, J. (2016). Without prejudice: What sovereign citizens believe. Program on Extremism. George Washington University. Retrieved from https://extremism.gwu.edu/sites/g/files/zaxdzs2191/f/downloads/JMB%20Sovereign%20Citizens.pdf

Crawford, J., & Pilanski, J. (2014). Political intolerance, right and left. *Political Psychology, 35*(6), 841–851.

Dixon, L., Harkins, L., & Wegerhoff, D. (2019). Incorporating sociocultural and situational factors into explanations of interpersonal violent crime. *Psychology, Crime & Law, 25*(6), 675–692. Retrieved from https://journals-scholarsportal-info.libproxy.wlu.ca/pdf/1068316x/v25i0006/675_isasfieoivc.xml

Koehler, D. (2016). Right-wing extremism and terrorism in Europe: Current developments and issues for the future. PRISM 6(2), 84–105

Levitas, D. (2002, July 22). The radical right after 9/11: The attacks hardened the resolve of immigrant bashers and anti-Semites. *The Nation, 275*(4), 19. Retrieved from https://link-gale-com.libproxy.wlu.ca/apps/doc/A88696750/AONE?u=wate18005&sid=AONE&xid=c9122e3c

Louie, S. (2018, April 25). The Incel movement: What are the sexual, social, recreational, and racial implications of Incels? *Psychology Today*. Retrieved from https://www.psychologytoday.com/ca/blog/minority-report/201804/the-incel-movement

Parent, R., & Ellis, J. (2016). The future of right-wing terrorism in Canada. The Canadian Network for Research on Terrorism, Security, and Society. Retrieved from https://www.tsas.ca/wp-content/uploads/2018/03/TSASWP16-12_Parent-Ellis.pdf

Public Safety Canada. (2018). 2018 public report on the terrorist threat to Canada. Retrieved from https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/pblc-rprt-trrrsm-thrt-cnd-2018/pblc-rprt-trrrsm-thrt-cnd-2018-en.pdf

Sabbagh, C. (2005). Environmentalism, right-wing extremism, and social justice beliefs among East German adolescents. *International Journal of Psychology, 40*(2), 118–131.

Statistics Canada. (2018). 150 years of immigration in Canada. Retrieved from https://www150.statcan.gc.ca/n1/pub/11-630-x/11-630-x2016006-eng.htm

Yang, S., Su, Y., & Carson, J. (2014). Eco-terrorism and the corresponding legislative efforts to intervene and prevent future attacks. Canadian Network for Research on Terrorism, Security and Society. Retrieved from https://www.tsas.ca/publications/eco-terrorism-and-the-corresponding-legislative-efforts-to-intervene-and-prevent-future-attacks/

ORIGINAL RESEARCH

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JUSTICE

Prison Health as Public Health in Ontario Corrections

Yoko Murphy* and Howard Sapers†

ABSTRACT

The majority of incarcerated individuals in Canada, and especially in Ontario provincial correctional institutions, are released into the community after a short duration in custody. Adult correctional populations have generally poor health, including a heightened prevalence of mental health and substance use disorders. There are legal and ethical obligations to address health care needs of incarcerated individuals, and also public health benefits from ensuring adequate, appropriate, and accessible health services to individuals in custody. The Independent Review of Ontario Corrections recommended the transformation of health care in Ontario provincial corrections in 2017, including transferring health service responsibilities to the Ministry of Health and Long-Term Care. The *Correctional Services and Reintegration Act, 2018,* would affirm the provincial government's obligation to provide patient-centred, equitable health care services for individuals in custody. We encourage the Government of Ontario to proclaim the *Act* and continue the momentum of recent reform efforts in Ontario.

Key Words Public health; prison health; Ontario; correctional institutions; correctional health care, Independent Review of Ontario Corrections.

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INTRODUCTION

The World Health Organization defines public health as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society" (Acheson, 1988; Marks, Hunter, & Alderslade, 2011). In Ontario, Canada, the Ministry of Health and Long-Term Care—the governing provincial body for health care services—operates under this vision and asserts a number of standards to protect and promote the health of Ontarians (Ministry of Health and Long-Term Care, 2018). Yet, the health of individuals in custody in Ontario provincial institutions is not managed the same way as that of other Ontarians. In 2016-2017, there were about 40,000 adults in custody on an average day in Canada; 64% of those were in provincial or territorial facilities (Malakieh, 2018). In Ontario's adult provincial institutions, 7,699 people were in custody on an average day in 2016-2017 (Malakieh, 2018). The vast majority of inmates in provincial institutions will be released within six months after admission to custody (Malakieh, 2018). Not only is there an ethical and legal responsibility to provide health care to these individuals (Ministry of Health and Long-Term Care, 2018), but it also would be in the public's interest and in line with public health principles to prevent disease and promote health among this high-needs and high-risk population, who will be returning to the community following a short duration in custody.

METHODS

The primary objective and scope of this paper was to present a narrative review of the health status, risks, and needs of adult correctional populations and strategies aimed to address those needs in Ontario provincial correctional institutions. Keywords (i.e., corrections, prison, inmates, public health, mental health, drug use) were used in searches conducted in key databases (e.g., PubMed, Medline) for relevant academic publications. In addition, government reports and published studies were scanned and reviewed for Canadian and Ontario-specific data on correctional populations. Data previously gathered from the Ministry of Community Safety and Correctional Services (MCSCS) for the Independent Review of Ontario Corrections' 2017 *Corrections in Ontario: Directions for Reform* report was used for information pertaining to governing policies within MCSCS in the Government of Ontario. Information pertaining to the recent efforts towards reform by MCSCS is based on public announcements, legislation, and the firsthand knowledge gathered by the Independent Review of Ontario Corrections.

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RESULTS

Legal Regulations and Responsibilities

The management of people charged with criminal offences in Canada falls under two jurisdictions—federal and provincial or territorial. The Correctional Service of Canada manages the federal correctional institutions across the country that administer custodial sentences of two or more years (Correctional Service Canada, 2016). Provincial and territorial corrections are managed by the respective provincial or territorial governments, and administer probation sentences and sentences of less than two years' incarceration, hold inmates on remand awaiting bail, trial, or sentencing, as well as those on immigration hold (Malakieh, 2018). In Ontario, Canada's most populous province, provincial corrections are under the jurisdiction of the Ministry of Community Safety and Correctional Services (MCSCS); there are 25 provincial correctional facilities throughout the province (Ministry of Community Safety and Correctional Services, 2018b). Over two-thirds (70%) of those in provincial custody in Ontario are being held on remand (Malakieh, 2018).

There are laws and norms internationally and locally that identify a duty to provide health care to incarcerated individuals. The United Nations General Assembly adopted and proclaimed the *Basic Principles for the Treatment of Prisoners* in 1990. Principle nine states, "prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (United Nations General Assembly, 1990). In 2015, the *Standard Minimum Rules for the Treatment of Prisoners*, first adopted in 1977, were revised and adopted as the *Nelson Mandela Rules* (United Nations General Assembly, 2015). The *Nelson Mandela Rules* further recognized that medical and health care services for those in prison are the state's responsibility and should be provided at an equal standard to those available in the community. Though neither of the United Nations' proclaimed principles or rules are legally binding, they act as a framework and a primary source of standards for the treatment of prisoners.

Canadian legislation follows similar principles: the *Canada Health Act* (*CHA*) identifies the primary objective of health care policies, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (*Canada Health Act*, 1985). However, the *CHA* explicitly excludes federal correctional inmates—those under the jurisdiction of the Correctional Service of Canada serving a sentence of two years or more in a federal penitentiary. For federal inmates, the *Corrections and Conditional Release Act* assigns the Correctional Service of Canada the duty to provide "every inmate with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration in the community" ("Corrections and Conditional Release Act," 1992).

Provincial and territorial correctional inmates remain as insured persons under the *Canada Health Act*. In Ontario, health services to the public are organized under the auspices of the Ministry of Health and Long-Term Care, however, the health care of inmates is managed in isolation from the public by MCSCS. The Ontario *Ministry of Community Safety and Correctional Services Act* reflects the view of health care as merely one of a number of service programs offered to inmates, with the superintendent of an institution responsible for arranging outside hospitalization when an inmate requires medical treatment not available within the correctional facility (Independent Review of Ontario Corrections, 2017). MCSCS as a ministry, and superintendents as decision-makers for the institution, have no particular expertise in the design, delivery, management, or oversight of health care for any patient population, let alone a complex correctional population. The new *Correctional Services and Reintegration Act, 2018*, passed in May 2018, identifies that every inmate shall be provided with access to health care services, including mental health services, and outlines principles of health promotion and disease prevention. This yet-to-be proclaimed legislation reflects a shift in perspective in Ontario to health care identified as a right of inmates.

Health Status and Risks of Adult Correctional Populations

Presently, MCSCS does not broadly collect data on the health status of provincial inmates in Ontario. As a result, it is necessary to look to targeted studies on correctional populations to understand the common health status, risks, and needs of inmates in custody. Generally, adult correctional populations have been identified as having poor physical and mental health. When compared with the general population, international studies have shown that correctional populations have a heightened prevalence of chronic illnesses including hypertension, asthma, hepatitis, diabetes, human immunodeficiency virus (HIV), and arthritis (Binswanger, Krueger, & Steiner, 2009; Fazel & Baillargeon, 2011; Harris, Hek, & Condon, 2007; Wilper et al., 2009). Further, compared with the general population, correctional inmates have exhibited a heightened prevalence of mental illnesses and substance use disorders, including comorbid disorders (Birmingham, 2003; Butler, Indig, Allnutt, & Mamoon, 2011; Fazel, Bains, & Doll, 2006; Fazel & Danesh, 2002; Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016; Fazel & Seewald, 2012; Fazel, Yoon, & Hayes, 2017; James & Glaze, 2006).

Canadian studies have produced similar findings. For example, self-reported rates of HIV and hepatitis C virus (HCV) infections among male and female federal inmates in 2007 were substantially elevated compared with the general population in Canada (Zakaria, 2010). Over 70% of newly sentenced federal male inmates in Canada between 2012 and 2014 met the criteria for at least one mental disorder, including alcohol or substance use disorders (Beaudette, Power, & Stewart, 2015). Localized studies on Canadian inmate populations have further noted a heightened prevalence of psychiatric, substance use, and comorbid disorders (Bland, Newman, Thompson, & Dyck, 1998; Brink, Doherty, & Boer, 2001; Lafortune, 2010).

Studies specifically on Ontario correctional populations have also identified an elevated prevalence of bloodborne viruses, illicit drug use, and mental health issues. For example, compared with the general population, prevalence rates of HIV were 11 times higher and rates of HCV were 22 times higher in a sample of inmates on remand from 13 facilities across Ontario in 2003-2004 (Calzavara et al., 2007). Of 500 inmates in a provincial institution in 2009, 56% had used opioids, cocaine, crack, or methamphetamines in the

last year (Kouyoumdjian, Calzavara, Kiefer, Main, & Bondy, 2014). Nearly two-thirds (65%) of an Ontario inmate sample reported having a chronic health condition, including 42% who reported suffering from depression, and 21% who reported having bipolar disorder, mania, manic depression, or dysthymia in the 12 months prior to incarceration (Green, Foran, & Kouyoumdjian, 2016).

In addition to inmates' existing health issues, the physical correctional environment itself also contributes to their poor health. For example, unhealthy living conditions, such as overcrowding, a lack of fresh air, and an inadequate means of maintaining personal hygiene can exacerbate the transmission of communicable diseases (*Moscow Declaration*, 2011; John Howard Society of Ontario, 2016). Isolation and a lack of stimulation and social supports pose mental health challenges to inmates (World Health Organization, 2013). Further, years of difficult and/or unhealthy living prior to incarceration, coupled with the stresses of life behind bars, may add years to the physiological age of an inmate (John Howard Society of Ontario, 2016).

An aged inmate population implies an additional burden on health care services for incarcerated individuals. The proportion of the inmate population in Canada aged 50 or older—the typical standard for "older" inmates accepted by the Correctional Service of Canada—in federal custody has grown to 25% in 2016, up from 12% in 2000 (Sapers, 2015; Zinger, 2017). In Ontario provincial institutions, older inmates comprised about 13% of inmates in custody between October 2017 and March 2018 (Ministry of Community Safety and Correctional Services, 2018a). Moreover, the proportion of admissions to custody in Canada for older inmates has been increasing. Of admissions to federal custody, 16% in 2015-2016 were for older inmates, an increase of 22% from five years earlier (Reitano, 2017). About 12% of 2016-2017 admissions to Ontario provincial custody were for older inmates, compared with about 8% in 2007-2008 (Ministry of Community Safety and Correctional Services, 2018a). In addition to shifting demographics and incarceration rates, the impact of recent sentencing (e.g., new mandatory minimum sentences) and parole reforms (e.g., restrictions on parole eligibility criteria) in Canada have contributed to an increasing number of inmates serving longer sentences, and longer portions of that sentence before first release (Sapers, 2011). Identifying and assessing some age-related health conditions, such as dementia, is increasingly difficult in individuals who may already exhibit other behavioural disorders. However, accommodation for these illnesses, in addition to the usual physical, visual, and hearing impairments associated with aging, will be required in correctional institutions with growing older inmate populations.

Risky behaviours of inmates before or during incarceration, such as illicit substance use, needle sharing, or engaging in unprotected sex, also contribute to a heightened risk of transmission of blood-borne viruses and sexually transmitted diseases, as well as elevated mortality rates. A survey of 3,370 inmates in Canadian federal institutions revealed that 22% of men and 29% of women had engaged in injection drug use in the six months prior to admission to custody, and 17% of men and 14% of women had injected drugs while in custody in the six months prior to the survey (Zakaria, Thompson, Jarvis, & Borgatta, 2010). Notably, of inmates who reported injecting drugs while in custody, 55% of men and 41% of women used someone else's needle, and 38% of men and 29% of women knowingly shared needles with someone with HIV, HCV, or an unknown infection status (Zakaria et al., 2010). A number of studies of correctional population samples across Canada, including Ontario provincial inmates, have similarly highlighted the prevalence of injection drug use, including sharing used needles, prior to and during incarceration (Kouyoumdjian et al., 2014; Martin et al., 2005; Poulin et al., 2007; Wood et al., 2005). Further, injection drug use with used needles was equally prevalent, at a rate of 32%, before and during incarceration for injection drug users in six provincial correctional facilities in Ontario (Calzavara et al., 2003).

Sexual contact is formally restricted to conjugal visits in federal correctional institutions in Canada, and explicitly forbidden in Ontario provincial institutions, yet, inmates continue to engage in sexual activity—often by way of unsafe or unprotected practices—while in custody. For example, in a sample of 3,370 federal inmates, 17% of male and 31% of female inmates reported having had sex while in custody in the six months prior to the survey, of which 99% reported at least one instance of having engaged in unprotected oral, vaginal, or anal sex (Zakaria et al., 2010). Though data pertaining to the in-custody sexual activity of Ontario provincial inmates was not available, studies have shown pre-incarceration risky sexual behaviours and a history of sexually transmitted diseases and infections in Ontario correctional populations (Kouyoumdjian et al., 2014; Kouyoumdjian, Main, Calzavara, & Kiefer, 2011).

Correctional populations are also at a heightened risk of death compared with the general population both during incarceration and after release from custody. The Correctional Service of Canada has identified that between 2000-2001 and 2015-2016, 857 deaths occurred in federal custody; more than half of these deaths were due to natural causes, and the most common type of non-natural death was suicide (Correctional Service Canada, 2017). Mortality rates were elevated for inmates in custody in both federal and provincial correctional institutions in Ontario between 1990 and 1999 compared with the average Canadian male population; in particular, homicide and suicide rates were much greater than those of the general population (Wobeser, Datema, Bechard, & Ford, 2002). Of 48,000 adults admitted to provincial custody in Ontario in 2000, 4,126 individuals (8.6%) died in custody or after release between 2000 and 2012; life expectancy was 4.2 years less for men and 10.6 years less for women who had been incarcerated, compared with the general population (Kouyoumdjian, Kiefer, Wobeser, Gonzalez, & Hwang, 2016). Of the 74 deaths that occurred in provincial custody during this time period, nearly a fifth were drug overdose deaths and nearly a quarter were attributed to suicide or self-injury (Kouyoumdjian et al., 2016). A review of coroner records revealed that, in Ontario, one in ten drug toxicity deaths among adults occurred within one year of release from a provincial correctional institution, 20% of which occurred within one week of release (Groot et al., 2016). Inmates with health care needs—including mental health and substance use disorders—may experience interruptions in care or treatment following release from custody, putting them at heightened risk for adverse health outcomes, including death (Binswanger et al., 2007; Pratt, Piper, Appleby, Webb, & Shaw, 2006; Rosen, Schoenbach, & Wohl, 2008).

An Opportunity for Health Care Interventions

Correctional institutions are often a first opportunity for access to health care for incarcerated individuals, as many may have health needs that were poorly addressed in the community before admission to custody. For example, about one third of inmates sampled in Ontario provincial institutions had no primary care provider in the 12 months prior to incarceration, and 48% reported unmet health needs prior to incarceration (Green et al., 2016). Admission to custody may act as a first point of contact with health care services and may be an opportunity for the initiation of chronic disease, mental health, and/or substance use treatment for many individuals with untreated health needs.

However, there are tensions between balancing the provision of appropriate medical care and meeting security needs in institutions (World Health Organization, 2013; International Centre for Prison Studies, 2004), and limited human resources place a strain on the available health care services for inmates in an institution. In the federal correctional system, a vacancy rate for all health care staff positions was reported at just over 8.5% in 2013, varying by position and reaching as high as 29% of psychologist positions lying vacant in Ontario federal institutions (Sapers, 2013). Inmates may be denied access to their prescribed medications while waiting for a physician's assessment or due to lack of inventory, which may allow their health conditions to worsen or destabilize, putting both themselves and others who are incarcerated at risk of illness or injury (John Howard Society of Ontario, 2016). Further, certain health care personnel, such as occupational therapists, physiotherapists, or dieticians, may not be frequently available in correctional institutions to provide care, and therefore only individuals with acute care needs will be treated by such professionals (John Howard Society of Ontario, 2016). This results in reactionary treatment of health needs for individuals in custody and neglects the benefits of preventive medicine and health care.

Given the transient nature of the provincial inmate population, intake assessment of health needs and determining a care plan are difficult, owing to the uncertainty of the duration of incarceration. In 2016-2017, there were 74,664 admissions to Ontario provincial correctional facilities, though some of these admissions may have been the same individual with multiple admissions to custody in one year (Malakieh, 2018). In addition, the duration spent in custody for many admissions was short. By the nature of provincial institutions as facilities for holding individuals awaiting trial or serving sentences of less than two years, the average duration in custody will be considerably shorter than for federal inmates in Canada. For example, of individuals who were sentenced to provincial or territorial custody in Canada in 2016-2017, 30% spent one week or less in custody and 59% spent one month or less in custody (Malakieh, 2018). These proportions were even greater among individuals held on remand: over half (52%) were released after a week or less, and three quarters (76%) spent a month or less in custody in provincial/territorial institutions in 2016-2017 (Malakieh, 2018). Therefore, it can be expected that inmates held in provincial correctional institutions in Ontario are going to be back out in the community within a fairly short period of time.

The point of release is a critical moment posing a heightened risk of negative health consequences for correctional populations, including death (Binswanger et al., 2007; Chang, Lichtenstein, Larsson, & Fazel, 2015; Pratt et al., 2006). In particular, recently released inmates are at a greater risk of death due to drug toxicity than the general population, and are especially susceptible to death involving opioid use (Andrews & Kinner, 2012; Farrell & Marsden, 2008). About 10% of all adult drug-toxicity deaths in Ontario between 2006 and 2013 were attributed to individuals who had been released from a provincial institution within the last year; 20% of these deaths occurred within one week of release, and 77% involved opioids (Groot et al., 2016).

The short duration of custody for provincial inmates poses a challenge for adequate and timely assessment of health needs, initiation of treatment, and discharge planning to ensure continuation of health care services upon release from custody. Leaving an institution with health problems hinders successful reintegration into the community, and, in a cyclical manner, structural and systemic factors—such as restrictive employment policies or unstable housing that pose barriers to attaining social stability—also impact the ability to engage in treatment or health services following release (Davis et al., 2009; John Howard Society of Ontario, 2016; Visher & Mallik-Kane, 2007).

DISCUSSION

It is clear that individuals who are incarcerated experience heightened health problems before, during, and after incarceration. There is a legal and ethical obligation to provide health care services to correctional populations. The provincial inmate population will, in the majority of cases, be returning to the community following a short duration in custody. Assessing and treating the health care needs of inmates in Ontario provincial institutions—and ensuring continuity of care and connections with community treatment and health services—would be beneficial not only for the health and safety of individuals who have been in custody, but also for public health.

Considering the heightened needs and challenges that correctional populations face, it is of utmost importance that those with the most experience and expertise in providing health care services and planning be responsible for ensuring that the health needs of these individuals are met. Untreated health conditions will inevitably require costly treatment interventions. Early screening and access to primary care can help reduce the severity of illness and act as preventive measures towards the development of comorbidities and more serious health issues that result in a higher health care burden and the use of more costly medical and/or emergency services.

As provincial inmate health care is currently governed and delivered by MCSCS, and not the Ministry of Health and Long-Term Care, correctional health care service and delivery may vary from the services and objectives of the body governing health for the rest of Ontarians. There is an international and academic consensus that the responsibility for health care in correctional facilities must rest with the government authority in charge of health. Many jurisdictions around the world, including four provinces in Canada—Alberta, British Columbia, Nova Scotia, and Newfoundland and Labrador—have moved to transition the responsibility for health care in

their correctional facilities to their respective health authorities (Independent Review of Ontario Corrections, 2017).

In the *Corrections in Ontario: Directions for Reform* report, released in September 2017, the Independent Review of Ontario Corrections recommended that the Government of Ontario clearly articulate a commitment to transfer the responsibility for the provision of health care within provincial correctional institutions to the Ministry of Health and Long-Term Care. This included the establishment of a common understanding of what services are to be transferred, and the development of a timeline for the transfer. Further, the report outlined that any proposed service delivery models should be evaluated against their ability to provide a principled, health-focused approach to care in corrections (Independent Review of Ontario Corrections, 2017). The chosen model must subscribe to a broad definition of health and health care, thus allowing for a comprehensive approach to correctional health care that follows the whole-prison approach (World Health Organization, 2007). In addition, the model must ensure equivalency, accessibility (physical and economical), and continuity of care for inmates, including facilitating seamless transitions between providers within and outside of institutions. Third, the model must ensure the clinical independence of health care professionals to operate and provide services within the public safety and security context of a correctional facility. Furthermore, the model must be integrated into the broader provincial health care system, including training, research, and provincial and local health priorities and initiatives. Additionally, the model must have robust accountability mechanisms to ensure that it adheres to core principles and standards, including accreditation and quality control measures. Lastly, the model must facilitate a stable, health-focused employment environment to develop a sustainable, experienced, and dedicated work force to deliver health care and meet the complex needs of the incarcerated population.

When *Corrections in Ontario: Directions for Reform* was released, the Government of Ontario recognized the need for change in the provision of health care in its correctional facilities. Legal and ethical obligations support the notion that the health care of inmates in provincial institutions should be managed in the same manner as the health care of Ontarians in the community. Reforming health services for this population and transitioning responsibilities to the Ministry of Health and Long-Term Care is a necessary—though complex and multi-step—process. On February 20, 2018, the provincial government announced that it would be "improving health outcomes for those in custody" by creating a new expert advisory committee, engaging in public consultations, and completing a comprehensive review of the health care needs of inmates and current services provided in each correctional facility (Ministry of Community Safety and Correctional Services, 2018c). The advice provided in the report submitted to the Government of Ontario by the expert advisory committee aligns with the health care recommendations made in the *Corrections in Ontario: Directions for Reform* report.

On May 7, 2018, the *Correctional Services and Reintegration Act, 2018*, received Royal Assent, and it is set to repeal and replace the *Ministry of Correctional Services Act*. The legislation proposes a phased implementation plan in order to ensure that the provincial correctional system is ready for the transformation ahead. This includes making sure that appropriate supports are in place to maintain a safe environment for both inmates and staff. Once proclaimed, this legislation will mandate the completion of an initial assessment on all newly admitted inmates to provincial institutions in Ontario to identify their needs while in custody and upon release. The legislation will require that an individualized case management plan be created for every inmate in order to address his or her unique needs and establish a plan for successful reintegration into the community. It will affirm the provincial government's obligation to provide patient-centred, equitable health care services that respect clinical independence and will define the health care services that incarcerated individuals should have access to, including health promotion, mental health and addictions care, and traditional Indigenous healing and medicines.

The *Correctional Services and Reintegration Act, 2018*, was passed shortly before an election in June 2018 that brought in a new provincial government. We encourage the Government of Ontario to proclaim the *Correctional Services and Reintegration Act, 2018*—thus adopting a public health approach to health care in provincial corrections—to continue the momentum of recent reform efforts in Ontario. There is a window of opportunity to turn aspirations of a fairer, more empathetic, and more effective justice system into a reality. Providing adequate, appropriate, and accessible health care services to incarcerated individuals is one crucial aspect of this vision.

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CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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REFERENCES

Acheson, D. (1988). *Public Health in England: The Report of the Committee of Inquiry into the Future Development of the Public Health Function, 1988*. London, England: Her Majesty's Stationery Office.

Andrews, J. Y., & Kinner, S. A. (2012). Understanding drug-related mortality in released prisoners: a review of national coronial records. *BMC Public Health, 12*(1), 270.

Beaudette, J. N., Power, J., & Stewart, L. A. (2015). *National prevalence of mental disorders among incoming federally sentenced men offenders* (Research Report, R-357). Ottawa, ON: Correctional Service Canada.

Binswanger, I. A., Krueger, P. M., & Steiner, J. F. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the United States compared with the general population. *Journal of Epidemiology & Community Health, 63*(11), 912–919.

Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. *New England Journal of Medicine, 356*(2), 157–165.

Birmingham, L. (2003). The mental health of prisoners. *Advances in Psychiatric Treatment, 9*(3), 191–199.

Bland, R. C., Newman, S. C., Thompson, A. H., & Dyck, R. J. (1998). Psychiatric disorders in the population and in prisoners. *International Journal of Law and Psychiatry, 21*(3), 273–279.

Brink, J. H., Doherty, D., & Boer, A. (2001). Mental disorder in federal offenders: a Canadian prevalence study. *International Journal of Law and Psychiatry, 24*(4-5), 339–356.

Butler, T., Indig, D., Allnutt, S., & Mamoon, H. (2011). Co-occurring mental illness and substance use disorder among Australian prisoners. *Drug and Alcohol Review, 30*(2), 188–194.

Calzavara, L., Burchell, A., Schlossberg, J., Myers, T., Escobar, M., Wallace, E., … Millson, M. (2003). Prior opiate injection and incarceration history predict injection drug use among inmates. *Addiction, 98*(9), 1257–1265.

Calzavara, L., Ramuscak, N., Burchell, A. N., Swantee, C., Myers, T., Ford, P., … Raymond, S. (2007). Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities. *Canadian Medical Association Journal, 177*(3), 257–261.

Canada Health Act, C-6 (1985).

Chang, Z., Lichtenstein, P., Larsson, H., & Fazel, S. (2015). Substance use disorders, psychiatric disorders, and mortality after release from prison: a nationwide longitudinal cohort study. *The Lancet Psychiatry, 2*(5), 422–430.

Correctional Service Canada. (2016). *Our role*. Retrieved from http://www.csc-scc.gc.ca/about-us/006-0001-eng.shtml.

Correctional Service Canada. (2017). *Annual report on deaths in custody 2015/2016*. Ottawa, ON: Correctional Service Canada.

Corrections and Conditional Release Act, 20 (1992).

Davis, L. M., Nicosia, N., Overton, A., Miyashiro, L., Derose, K. P., Fain, T., … Williams III, E. (2009). *Understanding the public health implications of prisoner reentry in California*. Santa Monica, CA: Rand Corporation.

Farrell, M., & Marsden, J. (2008). Acute risk of drug-related death among newly released prisoners in England and Wales. *Addiction, 103*(2), 251–255.

Fazel, S., & Baillargeon, J. (2011). The health of prisoners. *The Lancet, 377*(9769), 956–965.

Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: a systematic review. *Addiction, 101*(2), 181–191.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *The Lancet, 359*(9306), 545–550.

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: prevalence, adverse outcomes, and interventions. *The Lancet Psychiatry, 3*(9), 871–881.

Fazel, S., & Seewald, K. (2012). Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry, 200*(5), 364–373.

Fazel, S., Yoon, I. A., & Hayes, A. J. (2017). Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addiction, 112*(10), 1725–1739.

Green, S., Foran, J., & Kouyoumdjian, F. G. (2016). Access to primary care in adults in a provincial correctional facility in Ontario. *BMC Research Notes, 9*(1), 131.

Groot, E., Kouyoumdjian, F. G., Kiefer, L., Madadi, P., Gross, J., Prevost, B., … Persaud, N. (2016). Drug toxicity deaths after release from incarceration in Ontario, 2006–2013: review of coroner's cases. *PLOS One, 11*(7), e0157512.

Harris, F., Hek, G., & Condon, L. (2007). Health needs of prisoners in England and Wales: the implications for prison healthcare of gender, age and ethnicity. *Health & Social Care in the Community, 15*(1), 56–66.

Independent Review of Ontario Corrections. (2017). *Corrections in Ontario: Directions for reform*. Toronto, ON: Government of Ontario and Independent Review of Ontario Corrections.

International Centre for Prison Studies. (2004). *Prison health and public health: The integration of prison health services*. Paper presented at the International Centre for Prison Studies, London, England.

James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: Office of Justice Programs, U.S. Department of Justice.

John Howard Society of Ontario. (2016). *Fractured care: Public health opportunities in Ontario's correctional institutions*. Toronto, ON: John Howard Society of Ontario.

Kouyoumdjian, F. G., Calzavara, L. M., Kiefer, L., Main, C., & Bondy, S. J. (2014). Drug use prior to incarceration and associated socio-behavioural factors among males in a provincial correctional facility in Ontario, Canada. *Canadian Journal of Public Health/Revue canadienne de santé publique, 105*(3), e198–e202.

Kouyoumdjian, F. G., Kiefer, L., Wobeser, W., Gonzalez, A., & Hwang, S. W. (2016). Mortality over 12 years of follow-up in people admitted to provincial custody in Ontario: a retrospective cohort study. *CMAJ Open, 4*(2), E153.

Kouyoumdjian, F. G., Main, C., Calzavara, L. M., & Kiefer, L. (2011). Prevalence and predictors of urethral chlamydia and gonorrhea infection in male inmates in an Ontario correctional facility. *Canadian Journal of Public Health/Revue Canadienne de Santé Publique, 102*(3), 220–224.

Lafortune, D. (2010). Prevalence and screening of mental disorders in short-term correctional facilities. *International Journal of Law and Psychiatry, 33*(2), 94–100.

Malakieh, J. (2018). *Adult and youth correctional statistics in Canada, 2016/2017*. Ottawa, ON: Statistics Canada.

Marks, L., Hunter, D. J., & Alderslade, R. (2011). *Strengthening public health capacity and services in Europe: A concept paper*. Copenhagen, Denmark: World Health Organization and Durham University.

Martin, R. E., Gold, F., Murphy, W., Remple, V., Berkowitz, J., & Money, D. (2005). Drug use and risk of bloodborne infections: a survey of female prisoners in British Columbia. *Canadian Journal of Public Health/Revue Canadienne de Santé Publique, 96*(2), 97–101.

Ministry of Community Safety and Correctional Services. (2018a). [Age at Admission Trends FY 0607 to 1617]. Unpublished raw data.

Ministry of Community Safety and Correctional Services. (2018b). *Correctional Services*. Retrieved from https://www.mcscs.jus.gov.on.ca/english/corr_serv/CS_main.html.

Ministry of Community Safety and Correctional Services. (2018c). *Ontario Transforming. Newsroom*. Retrieved from https://news.ontario.ca/mcscs/en/2018/2/ontario-transforming-adult-correctional-system.html.

Ministry of Health and Long-Term Care. (2018). *Protecting and promoting the health of Ontarians—Ontario public health standards: Requirements for programs, services, and accountability*. Toronto, ON: Government of Ontario.

Moscow Declaration. (2011). First global ministerial conference on healthy lifestyles and noncommunicable disease control, Moscow, Russia.

Poulin, C., Alary, M., Lambert, G., Godin, G., Landry, S., Gagnon, H., … Claessens, C. (2007). Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons. *Canadian Medical Association Journal, 177*(3), 252–256.

Pratt, D., Piper, M., Appleby, L., Webb, R., & Shaw, J. (2006). Suicide in recently released prisoners: a population-based cohort study. *The Lancet, 368*(9530), 119–123.

Reitano, J. (2017). *Adult Correctional Statistics in Canada, 2015/2016*. Ottawa, ON: Statistics Canada.

Rosen, D. L., Schoenbach, V. J., & Wohl, D. A. (2008). All-cause and cause-specific mortality among men released from state prison, 1980–2005. *American Journal of Public Health, 98*(12), 2278–2284.

Sapers, H. (2011). *Annual report of the Office of the Correctional Investigator 2010-2011*. Ottawa, ON: The Correctional Investigator Canada.

Sapers, H. (2013). *Annual report of the Office of the Correctional Investigator 2012–2013*. Ottawa, ON: The Correctional Investigator Canada.

Sapers, H. (2015). *Annual report of the Office of the Correctional Investigator 2014–2015*. Ottawa, ON: The Correctional Investigator Canada.

United Nations. (1990 December 14). General Assembly. Resolution 45/111, *Basic principles for the treatment of prisoners*, A/RES/45/111. Available from https://www.ohchr.org/en/professionalinterest/pages/basicprinciplestreatmentofprisoners.aspx.

United Nations. (2015 December 17). General Assembly. Resolution 70/175, *United Nations standard minimum rules for the treatment of prisoners*, A/RES/70/175 Stat. Available from https://undocs.org/A/RES/70/175.

Visher, C. A., & Mallik-Kane, K. (2007). Reentry experiences of men with health problems. In R. Greifinger (Ed.), *Public health behind bars* (pp. 434–460): New York, NY: Springer.

Wilper, A. P., Woolhandler, S., Boyd, J. W., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). The health and health care of US prisoners: results of a nationwide survey. *American Journal of Public Health, 99*(4), 666–672.

Wobeser, W. L., Datema, J., Bechard, B., & Ford, P. (2002). Causes of death among people in custody in Ontario, 1990–1999. *Canadian Medical Association Journal, 167*(10), 1109–1113.

Wood, E., Li, K., Small, W., Montaner, J. S., Schechter, M. T., & Kerr, T. (2005). Recent incarceration independently associated with syringe sharing by injection drug users. *Public Health Reports, 120*(2), 150–156.

World Health Organization. (2007). *Health in prisons: A WHO guide to the essentials in prison health*. Copenhagen, Denmark: World Health Organization Regional Office for Europe.

World Health Organization. (2013). *Good governance for prison health in the 21st century. A policy brief on the organization of prison health*. Copenhagen, Denmark: World Health Organization Regional Office for Europe.

Zakaria, D. (2010). *Testing and treatment for human immunodeficiency virus and hepatitis C virus infections among Canadian federal inmates*. Ottawa, ON: Correctional Service of Canada.

Zakaria, D., Thompson, J. M., Jarvis, A., & Borgatta, F. (2010). *Summary of emerging findings from the 2007 national inmate infectious diseases and risk-behaviours survey*. Ottawa, ON: Correctional Service of Canada.

Zinger, I. (2017). *Annual report of the Office of the Correctional Investigator 2016-2017*. Ottawa, ON: The Correctional Investigator Canada.

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Police Leadership During a Pandemic

Matthew Torigian*

Canadians vilified Prime Minister Kim Campbell in 1993, when she reportedly quipped, "An election is no time to discuss serious issues." Days later, the Prime Minister clarified that what she really meant was that 47 days of an election campaign is not *enough* time to discuss serious issues. We still argue today about the impact such a statement had on the election, with some suggesting it led to a thrashing at the polls, while others suggest Canadians were just angry with the policies of her predecessor, Prime Minister Brian Mulroney. Regardless, her statement was met with disdain by the Canadian media of the day, and rightly so. Would the leader of a police service say the same thing in our situation today? Isn't now exactly the time to discuss a serious issue, such as whether the police have the moral authority to enforce extraordinary legal measures, and whether public health knowledge about community safety and well-being is a better guide than older ideas about "public order"?

Three elements readily come to mind to help us address these questions. Namely, the role of the police; the role of policing; and, perhaps most importantly, the role of police leaders amid these challenging and unprecedented times.

Legislation may be the simple avenue to answer the first question of what the police can or might do during these current events. Be it the *Emergencies Act*, the *Quarantine Act*, or respective pieces of provincial legislation, the legal authorities for police are clearly defined. As an example, Ontario's *Emergency Management and Civil Protection Act* (EMCPA) provides the necessary authorities for police, along with the range of penalties for the courts, in the event that a person or business fails to comply with an Order made under the relevant section of the EMCPA. But what about choices and strategies for the deployment of police resources in response to the Order, or the discretion of police officers during the enforcement of such investigations, along with community engagement strategies, or the creative use of technology? How are police leaders, and executives, chiefs, and boards, managing these matters?

The role of the police might take into consideration a pivot from traditional core functions to a more flexible response or might even alter standard operating procedures for everyday events such as 9-1-1 calls. Think tanks and police associations, along with both private and government agencies, have already come together to discuss these questions and offer guidelines and advice for police should they find themselves enforcing laws (or Orders) that represent a significant departure from their usual duties. Although the circumstances of these investigations and situations may be unique to the times, the roles, the operational standards, and the oversight expectations for police and police leaders need not be. Leaders need to be clear that peace and order go hand in hand with principles of good governance.

As to the second question, moving more broadly to the role of policing in our society, Canada is already leading the way in shaping a new policing paradigm for the 21st Century. Our own work in the Global Justice Lab, at the Munk School of Global Affairs and Public Policy, confirms this as we continue to engage with police and justice leaders worldwide. Community safety and well-being has become the lexicon, while multi-sector collaborations, information sharing, upstream interventions, data and evidence-based decision making, research, insight, and oversight have become the practices and studies accompanying and defining the mobilization of communities and community safety. A comprehensive set of reforms, to be sure. This does not come without a lot of work, including numerous symposiums, colloquia, and workshops involving a broad range of actors. It has been happening in earnest in Canada through the better part of the last decade. The shared responsibility for the well-being of our communities does not redefine traditional leadership roles but, rather, creates the environment for leaders to step forward in new ways. Traditional lanes of responsibility are now integrated and dovetail with non-traditional areas of responsibility. Traditional leadership alliances must actively and publicly partner with non-traditional colleagues, now more so than ever.

During the fluidity of a crisis, we cannot spend valuable time debating the purpose, scope, or role of policing. Yet we are all too aware that coerced compliance produces bad outcomes. Now is the time for big bold ideas in policing that move us away from an older model of public order. In Canada, we are lucky to have begun the conversation and subsequent reform years ago. Tactical responses to these unprecedented circumstances make perfect sense. Current discussions about safeguarding community trust in our police services whilst enforcing unfamiliar laws such as curfews, or leaning back to debate definitions of core policing, seem ill-timed when, really, at the core for all public services is the health and well-being of Canadians. Perhaps this is what Prime Minister Campbell actually meant, but she may have inadvertently left out a valuable constituent of the triad… the opportunity for leaders to truly lead.

Winston Churchill, perhaps England's most revered yet still controversial Prime Minister, is often quoted and often credited with providing brave and steady leadership during

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that country's "darkest hour." Although unconventional in style, he was arguably *textbook* in demonstrating what leadership looks like during times of difficulty. The role of leadership cannot be defined by the profession or occupation of its incumbent. We have all witnessed extraordinary leadership in recent months. Sadly, the opposite is also true. Police leaders are no exception to either.

There are clear and precise operational matters that require clarification, adjustment, and in some instances, suspension. These must always be secondary to the well-being and safety of all members within the police service. In the parlance of first responders, "guaranteed arrival" means simply that you can't help someone else if you die getting there. Every police leader must be visible, present (physically or virtually), and must communicate clearly to reinforce the values, mission, and vision of the service. Operational changes, such as flexibility in working conditions, discretionary powers, or the training and education of new powers and authorities, comes second to the mental well-being of those who we all rely upon during these difficult times and the very clear health risks that may impact them.

Knowing that our police leaders are standing alongside fellow community leaders and, in particular, working closely with the Public Health system is comfort to many, and signals that all of our work over the past number of years is paying new dividends when they are needed most. As the saying goes for all leaders, and especially at times like these, no one cares how much you know, people just want to know how much you care.

Such is true for police service members, for all formal and informal leaders in every human service profession and among the community alike. To paraphrase Winston Churchill, even amid crisis, courageous leaders can and will find new ways toward a better future.

CONFLICT OF INTEREST DISCLOSURE

The author has no conflicts of interest to declare.

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