EDITORIAL

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Reconciliation and community well-being: Collaborating by design in the city of Winnipeg

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With over 40 years of Canadian law enforcement experience, I have lived through sea changes in technology, social demands, gender and cultural awareness, and responsiveness. I have observed a positive, yet slow trajectory in the relationship between police and Indigenous people in Canada. Today, as the inaugural Team Lead of Winnipeg's newly established Community Safety Team, I am striving to carry on and continue to improve those positive relationships. This opportunity to consolidate our city's efforts in community safety and well-being offers a promising model that will inform others around the world as we all try to remove the often intractable and deep systemic barriers to well-being and social equity in our respective communities.

The historic tension between Indigenous people and the police is well documented through high-profile inquiries and commissions that have flowed from tragic clashes across Canada, including too many right here in the city located where the Red and Assiniboine rivers meet. On a larger scale, confrontations across Canada have stemmed from long-simmering conflicts over land ownership and occupation, while others have been derived from the simple challenges of sharing spaces at the local level.

The police, while struggling to remain impartial, are often dragged in as reluctant but duty-bound agents of the state. They are repeatedly thrust into difficult enforcement roles that move them away from the preferred image as impartial peacekeepers into situations in which they are perceived as more concerned with enforcing laws or protecting property than with the well-being of individuals. The police are also often faced with the challenge of fulfilling their law enforcement duties while balancing peoples' rights to protest and exercise free speech.

Sometimes, it is the most high-profile events that have inflamed police–community conflict. It is important to point out, however, that it is just as likely that many lower-profile daily events and lived experiences can have a larger overall effect. Among my policing colleagues, we have shared a conventional understanding that any one negative event can undo years of positive trust building. I believe there is ample evidence that most Canadians take pride in our multiculturalism, and in our characteristic respect for a society built upon diversity and inclusiveness. A lot of Canadians will have difficulty acknowledging even the most blatant injustices that have made national news. But for those most affected, such incidents may amplify a host of exclusionary and unjust realities encountered in daily life.

In my own experience, I have seen a significant change in organizational cultures as they pertain to racial and gender bias and sensitivity to diversity in the Canadian policing profession. This alone offers a constructive starting point for a new trajectory of reconciliation in the justice system. Now, we need to do more, and we must be sure more than ever that we do it together, beyond policing alone, and across the broader spectrum of the human services and community life. Getting at the root causes of social problems, I believe, is the essence of reconciliation.

Conventional wisdom is that we cannot overcome or even make a dent in most social issues through unilateral law enforcement. Without addressing the root causes of problems, prosecutions will have little effect. When former Police Chief Devon Clunis took office, he assigned me for several years to help drive his vision of crime prevention through social development. We strived to make the Winnipeg Police Service (WPS) more problem-solving oriented, seeking to address the root causes of social issues rather than only the symptoms.

Crime is most often a symptom of deeper issues, not a cause of them. If you keep arresting a child involved in gang activity without interrupting what brings them to the gang, the child is doomed to repeat their criminal activity. The same dynamics apply to substance use, and we know that the required factors apply to many other conditions that marginalize some, heighten risks for many, and diminish social equity for everyone. Going forward, we must strive more to connect people in need with all the available and most appropriate resources in the community to address their problems.

Partnering across social agencies is critical. Some of the most highly celebrated initiatives in modern policing have involved partnering police and social workers for a full range of services for clients. One example is the counter-exploitation work I was involved in as the sergeant in charge of the WPS Missing Persons Unit from 2005 to 2010. We collaborated with partners in the child protection system, taking innovative approaches to intervening in the sex trafficking and exploita-

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tion of young women and girls. Police officer–social worker partnerships allow social workers to operate more safely. Child protection workers bring expanded powers under the Child and Family Services Act that the police can use to broaden the scope of their authorities and increase their effectiveness in protecting children.

Through these and other collaborations, we have led Canada to change the paradigm around counter-exploitation, identifying vulnerable children and wrapping the full range of services around them. We overcame historical systemic animosity by sharing information, resources, and authorities and working together for the common goal of rescuing and protecting children. Multi-sectoral approaches are more common now, and are decidedly the way of the future. It only makes sense as every social problem overarches the mandates of social services, health, child welfare, education, police agencies, and many other community-based specialties.

The same principle applies to trust building. Reconciliation cannot be imposed on people; it has to be done in partnership with everyone feeling they are contributing. A colonial attitude is to tell people, "This is your problem, and this is how we are going to fix it." A conciliatory attitude listens more and creates an environment in which everyone plays a part in identifying problems as well as solutions. Reconciliation is everyone's responsibility, and it must be shared.

WINNIPEG'S NEW TEAM

Winnipeg has had a growing crisis of unsheltered people living in encampments throughout the city. While most disenfranchised people are peaceful and dealing to the best of their ability with an unlucky draw in life's lottery, many struggle with addictions and various mental health issues. Those without homes often ride the buses and sleep in bus shelters to escape the brutal elements of our prairie climate. The bus shelters have become a growing network of unintended homeless shelters, depriving regular riders from using them. It is a life-threatening problem when it is minus 40 degrees Celsius as one can freeze to death within minutes. City crews have done regular clean-ups, and it is normal to find shopping carts and piles of syringes accumulated overnight, from the day prior. Methamphetamine-induced violence has become commonplace on buses and in shelters, to the extreme that it has affected ridership, and made it difficult for Winnipeg Transit to retain or hire enough new drivers. It is a difficult social problem as there are not enough shelters and we have a shortage of affordable housing in our province. Transit is a refuge for many. Offering safe transportation for Indigenous people to community resources is included among the recommendations of Canada's Truth and Reconciliation Commission.

In his 2023 election campaign, Mayor Scott Gillingham promised to do something about the crisis in Winnipeg, and safety within the city's transit system. Once elected, he followed through with the commitment, and a permanent new team was funded. The unique challenge and clear imminent need for it enticed me to apply for the job, as the Mayor's vision aligned with my own. We both felt a compassionate, multi-sectoral, and collaborative approach was needed. I left policing to contribute to it.

We have currently completed the establishment of Winnipeg's new Community Safety Team (CST) in a record-breaking 6 months. The first cohort consists of 23 officers and two support staff, with me as Team Lead reporting to the city's Chief Administrative Officer. The officers were all selected for their compassionate attitude toward service delivery, combined with the ability to be trained to use force responsibly for self-defence and to protect others when required. The team is highly diversified and representative of differing age, experience, gender, and cultural backgrounds. They all share a passionate commitment that was tested from the first day, as they were asked to quit their jobs and start training for this new team within 2 weeks.

We brought in special training to provide trauma-informed, compassionate interventions to improve a sense of safety for all citizens. While the initial commitment is entirely focused on the transit system, the team is envisioned with a broader mandate to address social problems across the city. The long-term vision is to prove the concept, and then likely scale up. Similar initiatives have been built across Canada, with variations in most provinces. In Winnipeg, we are taking a uniquely trauma-informed and compassionate approach. Empowered by unique changes to the provincial Police Services Act, and the city of Winnipeg, the Safety Officers embody the best qualities of social work and law enforcement.

Creating something from a blank page was wrought with challenges, but also presented great opportunities as we remained true to the original vision. One of those values is a determination to make this new team a leader in reconciliation. We initiated training with wise words from an Indigenous Elder, and ended it with the graduation in the same way. We are striving to show an open-mindedness to improving law-enforcement-Indigenous trust. The team's training included Indigenous perspectives, cultural sensitivity, and an emphasis on empathic conflict resolution and partnership with community organizations. We followed up the first 2 weeks on the street with a full day of teachings and a sweat lodge for the entire team. One thing I am excited about is the "round room" built into our new office, large enough for a permanent circle of chairs that we utilize daily for our ongoing team debriefings and community collaboration and sharing. We attribute this cultural practice to the incredible bond our team has developed, as well as providing the opportunity to support mental health by discussing daily events and lessons learned, as a team.

Our first two months of deployment in the street was positive. We learned many lessons and clarified roles with the emergency services we sought to support. More importantly, we saved several lives, with lifesaving first aid, resolved hundreds of disputes, and lent support-finding resources and alternatives for hundreds of unsheltered people. I view this new initiative in our city as a positive reconciliation effort and believe that our experience will inform similar initiatives across Canada and beyond. The long-term outcomes are yet to be seen, but the need for multi-sector partnerships like this are inevitable and, in my view, are here to stay.

CONFLICT OF INTEREST DISCLOSURES

The author has no conflicts of interest to declare.

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ORIGINAL RESEARCH

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Mental health issues of children and youth encountered by police

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ABSTRACT

The purpose of this study was to identify major characteristics of children and youth with mental health problems who have contact with police officers and to determine which variables lead to the highest probability of police intervention and if there are differences between children and youth compared to adults. Two samples were taken from data obtained from the use of a new police brief mental health screener (interRAI BMHS) in a large southwestern Ontario city between April 2016 and April 2019: 619 cases under age 18 and 4,084 cases over age 18. Univariate and bivariate analysis revealed that all 23 variables on the BMHS were significantly associated with police intervention except for intoxication by drugs or alcohol, squalid home environment, and refusal to take prescribed medication. Variables with the highest odds of police intervention included hallucinations, diminished cognitive skills for daily decision-making, and family or others concerned for potential self-harm. Logistic regression analysis indicated that the variables most predictive of police intervention were hallucinations, lack of insight into their own mental health problems, violent ideation, violence to others, self-injurious attempt in the last 7 days, suicide plan, diminished cognitive skills for daily decision-making, and family or others concerned for self-harm. As to the differences between under and over age 18, adults had higher frequencies of intoxication, hallucinations, delusions, pressured speech, and abnormal thoughts, while under age 18 had slightly higher frequency of socially inappropriate/disruptive behaviour. Risk of harm variables were high in both groups; however, they were clearly higher in the under age 18 group, in particular self-injurious attempt in the last 7 days. The results of this study indicate that there are distinct differences between why police officers intervene with children and youth as opposed to adults which should be reflected in police training and intervention policy.

Key Words Mental illness; screening; child and youth; mental health indicators; early intervention; early identification.

INTRODUCTION

The majority of adults living with mental health issues can trace the onset of their disorders to childhood and adolescence (Patel et al., 2007; Stewart & Hamza, 2017; Stewart & Hirdes, 2015). It is generally accepted that undetected and untreated mental health problems in children and youth can lead to lifelong adverse consequences to the individuals themselves and their families. Recent evidence suggests that the sub-population of children and youth involved in the criminal justice system are particularly vulnerable, many of whom experienced higher rates of exposure to trauma often commencing early in life (Dierkhising et al., 2013; Lyons et al., 1998, 2001; Stewart et al., 2020). Over 60% of children and youth in juvenile detention and correctional facilities have a diagnosable mental health condition (Fazel et al., 2008; Stewart et al., 2015; Teplin et al., 2002), with the most common treatable disorders being depression and attention-deficit hyperactivity disorder (ADHD) in males and posttraumatic stress disorder (PTSD) and even higher levels of depression in females (Beaudry et al., 2021; Fazel et al., 2008). Compared to adults, adolescents in juvenile detention and correctional facilities are at higher risk of self-injury, suicidal ideation, and recent self-harm and are more verbally and physically abusive (Beaudry et al., 2021; Fazel et al., 2008).

It is recognized that due to the unique needs of children and youth with mental health issues who are involved in the correctional system, particular emphasis should be placed on early screening for risk factors (Stewart et al., 2015). Some of the earliest possible junctures for screening and intervention have traditionally been the school system, courts, probation services, and youth detention centres. Yet, undeniably,

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contact with police officers remains a primary gateway to the criminal justice and mental healthcare systems for children, youth, and adults (Lamb et al., 2002). Police officers have been increasingly called upon to respond to calls for service involving persons with mental disorders as part of their general patrol duties, as members of crisis intervention teams, and as partners in various co-responder models pairing a mental health worker with a police officer (Livingston, 2017; Shore & Lavoie, 2018). However, their involvement is often restricted to instances where the child, youth, or adult is experiencing a mental health crisis or has committed, or likely to commit, a criminal offence. That is, the role of police officers remains predominantly reactive in responding to the crisis or criminal event. There is, however, growing awareness of the potential role police officers could play as an early warning system in proactively identifying and making efforts to connect or re-connect persons, including children and youth, to mental health service providers before they enter the correctional system (Evangelista et al., 2016; van den Brink et al., 2012). To determine if, in fact, it is feasible for police officers to act as part of this early warning system, it is important to review what is known about the frequency and context of police officer involvement, and what are the major clinical characteristics exhibited by the child and youth they interact with.

The research devoted to the subject of police contact with persons with mental health problems is almost entirely focused on adults (Liegghio et al., 2021). For example, it has been well documented that interactions between police officers and persons with mental disorders have been on the rise and continue to rise (Livingston, 2017; Shore & Lavoie, 2018). It is known that about 7–15% of police calls for service involve a person with a mental disorder (Cotton & Coleman, 2008). There is very little empirical evidence on the frequency of calls involving children and youth with mental health problems. However, these calls will likely continue to rise as seen in the adult population. As to the context of police officer interactions, much of what we know is derived from research on adults. About 65% of adults newly admitted to inpatient and community psychiatric services have had some sort of encounter with police over their lifetime (Brink et al., 2011). Also, police interactions with adults often arise in situations where the person poses a threat to themselves or others, is a suspect or victim in criminal activities, or requires transportation to a hospital for psychiatric evaluation (Coleman & Cotton, 2010; Cotton & Coleman, 2008).

Very few studies address the reasons underlying police officer involvement with children and youth with mental health issues. Van der Koep et al. (1997) found that youth using community-based mental health services are nearly three times more likely to be referred to by police officers. Robst et al. (2013) reported that children and youth in group home settings have higher arrest rates than those in inpatient psychiatric settings. Only one study specifically focused on children and youth in contact with police officers based on a community mental health sample of 1,449 children and youth up to 24 years old (Liegghio et al., 2017). About 16% of these service users had police contact related to their mental health. The major reasons for police involvement were similar to those of adults but also include requests for support in the home for a distressed child, as well as concerns about a child's conduct and behaviour in the community (Liegghio et al., 2017). Specifically, caregivers required help in de-escalating verbal or physical altercations; responding to a child or youth who threatened harm to self or others; managing a child's behaviour in the community; or transporting the child or youth to hospital due to suicide threats or attempts (Liegghio, 2017; Liegghio & Jaswal, 2015; Liegghio et al., 2017; Liegghio et al., 2020).

Most research on the major clinical characteristics of persons with mental health issues interacting with police is also focused on adults. Typically, research studies have examined the characteristics of adults brought to the emergency department by police officers and compared them to referrals from other sources, such as family, friends, or self-referral (Hoffman, 2013). Adults who are taken to hospital by police officers are most often males in their mid- to late-30s and are more likely to be intoxicated or have substance abuse issues (Hoffman, 2013). They often present with symptoms of psychosis and are considered more severely psychiatrically disturbed than referrals from other sources. Hoffman et al. (2016) reported on the results of the use of a new screener used by police officers, the interRAI Brief Mental Health Screener (BMHS) that captures indicators of major mental health disorders in persons who have police contact. They found that variables significantly associated with psychiatric admission included abnormal thought process, delusions, hallucinations, and little insight into their mental health problems. They also found that there was a higher probability of drug or alcohol use and dangerous and aggressive behaviours toward themselves (Hoffman, 2013; Hoffman et al., 2016). In contrast, although some of the contextual factors have been identified for police officer involvement with children and youth with mental health problems, there are very few data pertaining to clinical characteristics other than generally disruptive behaviour indicative of a distressed child and indicators associated with suicidality.

Currently, there is a gap in knowledge pertaining to the clinical characteristics of children and youth with mental health problems in contact with police officers and the reasons underlying such encounters (Liegghio & Jaswal, 2015; Liegghio et al., 2017, 2020).

The purpose of this study is to use the BMHS to identify the clinical characteristics of children and youth with mental health problems who have contact with police officers and to identify the risk factors that have the highest probability of leading to police intervention. Identifying the signs and symptoms of mental health problems in children and youth would contribute to enhancing police training by providing more detailed information on the indicators of major mental health problems that may lead to early intervention and treatment. It would also assist police officers in determining the most appropriate referrals, whether that is to the hospital or community mental health services.

METHODS

Data Collection Instrument

Data pertaining to the demographic and clinical characteristics of children and youth with mental health disorders having contact with police officers were collected through the use of the interRAI BMHS (Hoffman et al., 2016). The BMHS is a brief mental health screener designed to assist police officers

identify key indicators of mental health disorders and document and articulate their grounds for believing that a person has a mental health disorder (Hoffman et al., 2016). A copy of the BMHS can be obtained from interRAI[1]. It is also used to facilitate improved communication between police officers and mental health service providers as part of an integrated mental health information system (Hirdes et al., 2020; Hoffman et al., 2016, 2021; Pizzingrilli et al., 2015).

The BMHS was developed by interRAI, an international, not-for-profit consortium of researchers committed to improving care for vulnerable persons with complex health needs through evidence-informed clinical practice and policy decision-making (Hirdes et al., 2020). The government of Ontario previously partnered with interRAI to develop and implement the Resident Assessment Instrument for Mental Health (RAI-MH), the assessment system mandated for use on all persons admitted into inpatient psychiatric care in the province (Hirdes et al., 2000/2001). Core items on the BMHS are based primarily on an analysis of RAI-MH data together with input from representatives from healthcare, police services, and patient groups, resulting in the development of the 23-item assessment consisting of three sections: demographical data, a section on clinical indicators of disordered thought, and a section on indicators of risk of harm (Hoffman et al., 2016).

As to the psychometric properties of the BMHS, face validity was achieved through consultation with police officers, mental health professionals, and persons with lived experience who had input into the development of the instrument. Content validity was established through a scoping review of the scientific literature, grey literature, and practical guidelines, and the three sections of the BMHS correspond to police apprehension authorities (indicators of disordered thought, and dangerousness to self or others) as defined in Ontario's Mental Health Act (Mental Health Act, 1990, s. 17). Also, the development and subsequent approval of the final version was guided by an international clinical and scientific review from the interRAI Network for Mental Health (iNMH) committee and the interRAI Instrument and Systems Development Committee (ISD) (Hoffman et al., 2016). Convergent validity was demonstrated through the association between risk scores on the BMHS and clinical reasons for psychiatric admission. Finally, predictive validity was established through the ability of the items on the BMHS to predict the characteristics of persons transported by the police officer to the hospital and who are ultimately admitted into psychiatric care (Hoffman et al., 2016; Hirdes & Hoffman, 2016; Hirdes et al., 2020).

The BMHS is currently being used by multiple police services in Canada (all western provinces and about half of those in Ontario) and some in the United States. When a police service decides to adopt the BMHS, training is provided for members of the police service's training branch who then deliver it to their frontline police officers. The training session delivered to frontline police officers consists of explaining the meaning of the items on the screener and how to use the accompanying software. For example, they learn that whenever the BMHS is completed, risk scores are calculated on three scales: danger to self, danger to others, and inability to care for self. The software provides scores on a 10-point scale for each scale and tracks them by date so that the information will be available to police officers who may have subsequent interactions with the same person. Also, if a police officer has difficulty recalling the meaning of particular mental health indicators, such as hallucinations or delusions, by clicking on the item, the definition will appear similar to a tooltip. The police officers are instructed to complete the BMHS on all persons (children, youth, and adults) who they believe may have a mental health disorder, regardless of whether there was evidence of criminal activity. This is particularly important because in the past, police officers typically would not get involved unless there was some form of criminal activity or threat thereof.

As to identifying indicators of mental health disorders, they are told to continue to comply with the appropriate sections of the mental health legislation which are based on three core criteria: danger to self, danger to others, and acting in a disorderly manner. They are informed that the BMHS will help them to better articulate their grounds and in particular, what is meant by acting in a "disorderly manner." It is explained that the BMHS does not diagnose disorders, rather it helps police officers describe the behaviour they are observing in the language of the health system. That is, the terms used in the screener are consistent with those used in the health system and that by learning and using these terms, it will help them better articulate their grounds for believing someone has a mental health problem. Further, using the same language will help to build a bridge between the criminal justice and health systems and ensure that persons with mental health issues receive help from mental healthcare providers. Finally, it is stressed that the BMHS does not *direct* their actions but rather is to be used as a decision support tool. The officers must still use their professional judgment regarding the nature of mental health considerations and the need to take the person to a hospital, refer them to a community mental health service provider, or that no action is required.

Setting and Sample

The setting was a large city in southwestern Ontario which was selected because of its well-established community mental health agencies and three large hospitals. The size of the police service made it possible to obtain enough cases for the study, and members of the police service had been using the BMHS for 2 years and its officers are well acquainted with its purpose and use. Regarding demographics, the population of the city is less than 1 million and is representative of national cultural demographics (about 20% are born internationally) with a variety of ages and socioeconomic backgrounds and a relatively good balance of manufacturing industries, education services, healthcare, technology, and finance.

As part of the licensing agreement with interRAI, police services that use an interRAI instrument submit anonymized information collected through the use of the BMHS to the interRAI Canada database held on secure servers at the University of Waterloo, Ontario. This database is the source of the data used in the current study. A stratified sampling technique was used to identify a sample of 619 unique cases of children and youth, under age 18, and a sample of 4,084 adults, 18 years and over, who had contact with police officers between April 2016 and April 2019.

[1]https://catalog.interrai.org/BMHS-Police-Assessment-Form-PIY.

Data Analysis

BMHS assessments were completed electronically on anyone who police officers believed had a mental health issue. The distributions of the variables were calculated for demographic and contextual variables and for those variables related to indicators of disordered thought and indicators of risk of harm. Chi-square analysis was used to determine if there was a statistically significant relationship between individual independent variables on the BMHS and the binary dependent variable; police intervention versus no police intervention and odds ratios (ORs) were computed to estimate the strength of the relationship. Finally, logistic regression was used to investigate the independent effects of individual variables on police intervention and to control for confounding variables (Zhang, 2016). The aim was to examine the joint and independent effects of each of the items on the BMHS to estimate the probability of police intervention.

Police intervention included all cases where the interaction with the individual resulted in the police officer voluntarily escorting the person to the hospital, apprehending them under an existing order, involuntarily apprehending them, or arresting the person. No intervention included cases where the individual was transferred to the emergency medical service (EMS) or the mobile crisis unit, notifying a caseworker or probation officer or referral to a community mental health agency. Police intervention therefore became the dependent variable for the binary logistic regression analysis.

There were two reasons underlying the rationale for the creation of the binary dependent variable police intervention versus no police intervention. First, the term "police intervention" is meant to describe situations where police officers were involved in a more substantive way as opposed to merely referring the person to another agency for follow-up. These interactions would therefore represent a tangible component of a police officer's job that could be measured and also permit comparisons to be made between the sample of children and youth and the sample of adults. Second, when police are called upon to intervene, their legal authorities require that there is some danger to life or property. Therefore, when police officers are required to intervene, they would be responding to situations that are presumably more serious events. It is important to confirm whether this was the case to ensure that their presence was truly required. That is, do the characteristics exhibited by persons with mental disorders, in fact, require police officers to respond as opposed to other service providers?

RESULTS

Analysis of data from the BMHS assessments from 2016 to 2019 for a medium-sized police service in southwestern Ontario produced two samples: the first included 619 cases between the ages of 6 and 17 and the second included 4,084 cases between the ages of 18 and 96. Police intervention occurred more frequently in under age 18 (68%) versus over age 18 (59%), the majority of whom were between the ages of 13 and 17 (89%), while in the adult sample the majority were under age 44 (68%) with 41% being between ages 25 and 44. Sixty percent of the under age 18 group were females (61%), while the majority in the over age 18 group were males (55%). In the under age 18 sample, two-thirds of the sample (67%) were taken to the hospital (voluntarily or involuntarily) compared to 55% in the over age 18 group with one-third of cases in both groups being referred to a caseworker, probation services, and community mental health agencies. Ten percent of the over age 18 group were identified as homeless compared to 3% of the under age 18 group, and in both groups about one-third of the samples had previous contact with police officers.

With regard to the indicators of disordered thought variables, those in both the under and over age 18 groups exhibited irritability and little to no insight into their mental health problems for more than 50% of the cases. Intoxication by drugs or alcohol was evident twice as often in the over age 18 group (40%) as in the under age 18 group (17%). As to hallucinations and delusions, they were evident in the over age 18 group (51%) versus in the under age 18 group (13%). There was also a higher frequency of the adult sample showing signs of abnormal thought processes (50% vs. 39%) and pressured speech (31% vs. 22%) while the under age 18 group had a slightly higher frequency of socially inappropriate/disruptive behaviour (42% vs. 35%).

As to indicators of risk of harm, self-harm was evident in over half of both samples, particularly for the following variables: considered a self-injurious act in the last 30 days and family or others concern that the person is at risk of self-injury. However, the frequency for both variables was much higher in the under age 18 group at closer to three-quarters of the sample. Similarly, self-injurious attempt in the last 7 days occurred in over 50% of the under age 18 group but only in 33% in the over age 18 group. Suicide plan, violent ideation, and intimidation of others also occurred in over one-third of the under age 18 group but much less in the over age 18 sample.

Chi-square analysis revealed that all independent variables in the over age 18 group were significantly associated with police intervention; however, for the under age 18 group the following variables were not significantly associated with police intervention: intoxication ($\chi^2 = 1.2$, $df = 1$, $p = 0.273$) (Tables I and III), home environment ($\chi^2 = 0.025$, $df = 1$, $p = 0.874$), and refusal to take medications ($\chi^2 = 1.03$, $df = 1$, $p = 0.309$) (Tables II and IV).

ORs were calculated to measure the strength of the association between the independent variables and police intervention using a convenient cut-off of only those variables where the odds were almost twice as likely for there to be police intervention. For under age 18, the variables with the highest odds of police intervention were hallucinations (OR = 5.93; confidence interval (CI): 0.50–70.01), diminished cognitive skills (OR = 2.0; CI: 1.16–3.44), and family or others concerned for self-harm (OR = 2.09; CI: 1.27–3.44). For over age 18, the variables with the highest odds of police intervention included command hallucinations (OR = 2.36; CI = 1.59–3.50), diminished cognitive skills for daily living (OR = 1.99; CI= 1.66–2.44), self-injurious attempt in the last 7 days (OR = 2.04; CI = 1.67–2.49), suicide plan (OR = 2.13; CI = 1.73–2.61), violence to others (OR = 1.85; CI = 1.22–2.62), and refusal to take medications (OR = 1.78; CI = 1.43–2.21).

Binary logistic regression analysis was used to estimate the probability of police intervention for the over age 18 group, resulting in a model that included hallucinations,

TABLE 1 Chi-square analysis of disordered thought variables for under age 18 and police intervention, $n = 619$

Variable	Police Intervention		*df*	χ^2	*p* value
	No (%)	Yes (%)			
Irritability					
No	112 (41.8)	156 (58.2)	1	18.720	0.000
Yes	89 (25.4)	262 (74.6)			
Hallucinations					
No	198 (33.8)	388 (66.2)	1	8.690	0.003
Yes	3 (9.1)	30 (90.9)			
Command hallucinations					
No	200 (33.4)	398 (66.6)	1	7.612	0.006
Yes	1 (4.8)	20 (95.2)			
Delusions					
No	199 (33.4)	396 (66.6)	1	6.635	0.010
Yes	2 (8.3)	22 (91.7)			
Hyper-arousal					
No	165 (36.5)	287 (63.5)	1	12.425	0.000
Yes	36 (21.6)	131 (78.4)			
Pressured speech or racing thoughts					
No	172 (35.5)	312 (64.5)	1	9.510	0.002
Yes	29 (21.5)	106 (78.5)			
Abnormal thought process					
No	152 (40.1)	227 (59.9)	1	25.978	0.000
Yes	49 (20.4)	191 (79.6)			
Socially inappropriate or disruptive behaviour					
No	151 (41.9)	209 (58.1)	1	35.209	0.000
Yes	50 (19.3)	209 (80.7)			
Verbal abuse					
No	157 (38.3)	253 (61.7)	1	18.764	0.000
Yes	44 (21.1)	165 (78.9)			
Intoxication by drug or alcohol					
No	172 (33.4)	343 (66.6)	1	1.200	0.273
Yes	29 (27.9)	75 (72.1)			
Degree of insight into mental health problem					
No (full insight)	107 (41.8)	149 (58.2)	1	17.312	0.000
Yes (limited to none)	94 (25.9)	269 (74.1)			
Cognitive skills for daily decision-making					
No (independent)	165 (40.7)	240 (59.3)	1	36.530	0.000
Yes (any impairment)	36 (16.8)	178 (83.2)			

command hallucinations, delusions, abnormal thought, socially inappropriate behaviour, intoxication, lack of insight, self-injurious attempt in the last 7 days, suicide plan, known to carry or use weapons, violent ideation, and violence or intimidation of others. The saturated model was applied to the sample of adults producing a c-statistic of 0.73, indicating a good model predictive of police intervention. The same model was applied to the under age 18 group and after removing the

TABLE II Chi-square analysis of risk of harm variables for under age 18 and police intervention, $n = 619$

Variable	Police Intervention		*df*	χ^2	*p* value
	No (%)	Yes (%)			
Person has been known to carry or use weapon(s)					
No	175 (35.1)	323 (64.9)	1	8.275	0.004
Yes	26 (21.5)	95 (78.5)			
Violent ideation					
No	179 (41.9)	248 (58.1)	1	56.049	0.000
Yes	22 (11.5)	170 (88.5)			
Intimidation of others or threatened violence					
No	178 (39.4)	274 (60.6)	1	36.469	0.000
Yes	23 (13.8)	144 (86.2)			
Violence to others					
No	187 (38.9)	294 (61.1)	1	40.373	0.000
Yes	14 (10.1)	124 (89.9)			
Self-injurious attempt in the last 7 days					
No	119 (40.9)	172 (59.1)	1	17.763	0.000
Yes	82 (25)	246 (75)			
Considered performing a self-injurious act in the last 30 days					
No	69 (39)	108 (61)	1	4.793	0.029
Yes	132 (29.9)	310 (70.1)			
Suicide plan in the last 30 days					
No	149 (41)	214 (59)	1	29.434	0.000
Yes	52 (20.3)	204 (79.7)			
Family, caregiver, friend, or others express concern that the person is at risk for self-injury					
No	74 (49.3)	76 (50.7)	1	25.669	0.000
Yes	127 (27.1)	342 (72.9)			
Home environment – squalid condition, e.g., extremely dirty, infestation by rats or bugs[a]					
No	176 (33.1)	355 (66.9)	1	0.025	0.874
Yes	5 (31.3)	11 (68.8)			
Refused to take some or all of prescribed medication in the last 3 days					
No	179 (33.2)	360 (66.8)	1	1.036	0.309
Yes	22 (27.5)	58 (72.5)			

[a]Missing data for home environment: 72.

variables that were not statistically significant, the resulting model obtained a c-statistic of 0.77.

The model for under age 18 was further refined by adding items shown to have higher odds of police intervention. That is, the variables with the highest odds of police intervention for under age 18 including hallucinations, diminished cognitive skills, and family or others concerned for self-harm were added to the model, and logistic regression analysis was again performed, resulting in a c-statistic of 0.798. A final logistic regression was performed after removing statistically insignificant variables, resulting in the most parsimonious model with a c-statistic of 0.786 (Table V). A summary of the variables that are most related to police intervention comparing under age 18 to over age 18 is presented in Table VI.

DISCUSSION

Through a review of the literature it was determined that little is known about the characteristics of children and youth with mental health problems who have contact with the police. The purpose of this study was to attempt to fill this void by using data generated by the use of the BMHS

TABLE III Chi-square analysis of disordered thought variables for over age 18 and police intervention, n = 4,083

Variable	Police Intervention		*df*	χ^2	*p* value
	No (%)	Yes (%)			
Irritability					
No	1,003 (51.1)	961 (48.9)	1	158.640	0.000
Yes	671 (31.7)	1,448 (68.3)			
Hallucinations					
No	1,490 (44.5)	1,858 (55.5)	1	94.449	0.000
Yes	184 (25)	551 (75)			
Command hallucinations					
No	1,615 (43.7)	2,028 (56.3)	1	116.529	0.000
Yes	59 (15.3)	327 (84.7)			
Delusions					
No	1,409 (45)	1,723 (55)	1	88.408	0.000
Yes	265 (27.9)	686 (72.1)			
Hyper-arousal					
No	1,374 (46.9)	1,555 (53.1)	1	149.683	0.000
Yes	300 (26)	854 (74)			
Pressured speech or racing thoughts					
No	1,316 (46.4)	1,519 (53.6)	1	112.658	0.000
Yes	358 (28.7)	890 (71.3)			
Abnormal thought process					
No	1,045 (51)	1,003 (49)	1	170.757	0.000
Yes	629 (30.9)	1,406 (69.1)			
Socially inappropriate or disruptive behaviour					
No	1,342 (50.6)	1,309 (49.4)	1	289.365	0.000
Yes	332 (23.2)	1,100 (76.8)			
Verbal abuse					
No	1,457 (47.3)	1,624 (52.7)	1	205.376	0.000
Yes	217 (21.7)	785 (78.3)			
Intoxication by drug or alcohol					
No	1,176 (46.3)	1,366 (53.7)	1	77.139	0.000
Yes	498 (32.3)	1,043 (67.7)			
Degree of insight into mental health problems					
No (full insight)	827 (50.3)	817 (49.7)	1	98.505	0.000
Yes (limited to none)	847 (34.7)	1,592 (65.3)			
Cognitive skills for daily decision-making					
No (independent)	1,317 (51)	1,266 (49)	1	289.956	0.000
Yes (any impairment)	357 (23.8)	1,143 (76.2)			

by the police to identify variables associated with police intervention. Further, the attempt was made to determine how the characteristics of children and youth with mental health problems who have contact with police officers differ from adults with mental health problems. Analysis of data from the BMHS assessments from 2016 to 2019 was used to assist in answering these questions and help fill this gap in the literature.

TABLE IV Chi-square analysis of risk of harm variables for over age 18 and police intervention, *n* = 4,083

Variable	Police Intervention		*df*	χ^2	*p* value
	No (%)	Yes (%)			
Person has been known to carry or use weapon(s)					
No	1,535 (43.5)	1,992 (56.5)	1	68.111	0.000
Yes	139 (25)	417 (75)			
Violent ideation					
No	1,511 (46.8)	1,715 (53.2)	1	216.618	0.000
Yes	163 (19)	694 (81)			
Intimidation of others or threatened violence					
No	1,558 (46.7)	1,776 (53.3)	1	246.802	0.000
Yes	116 (15.5)	633 (84.5)			
Violence to others					
No	1,591 (45.3)	1,918 (54.7)	1	194.471	0.000
Yes	83 (14.5)	491 (85.5)			
Self-Injurious attempt in the last 7 days					
No	1,264 (46.2)	1,473 (53.8)	1	92.190	0.000
Yes	410 (30.5)	936 (69.5)			
Considered performing a self-injurious act in the last 30 days					
No	837 (43.3)	1,095 (56.7)	1	8.186	0.004
Yes	837 (38.9)	1,314 (61.1)			
Suicide plan in the last 30 days					
No	1,276 (45.8)	1,512 (54.2)	1	82.622	0.000
Yes	398 (30.7)	897 (69.3)			
Family, caregiver, friend, or others express concern that person is at risk for self-injury					
No	743 (43.8)	955 (56.2)	1	9.141	0.002
Yes	931 (39)	1,454 (61)			
Home environment – squalid condition, e.g., extremely dirty, infestation by rats or bugs[a]					
No	1,372 (45.1)	1,668 (54.9)	1	39.271	0.000
Yes	79 (26.3)	221 (73.7)			
Refused to take some or all of prescribed medication in the last 3 days					
No	1,469 (44.4)	1,837 (55.6)	1	84.723	0.000
Yes	205 (26.4)	572 (73.6)			

[a]Missing data for home environment: 743.

TABLE V Logistic regression analysis under age 18 with insignificant variables removed, *n* = 619

Variable	Parameter Estimate	Standard Error	OR (95% CI)	*p* value	*c* value
Violent ideation	1.126	0.284	3.09 (1.77–5.38)	0.000	0.786
Violence to others	1.348	0.341	3.85 (1.97–7.51)	0.000	
Self-injurious attempt in the last 7 days	0.657	0.203	1.93 (1.30–2.87)	0.001	
Suicide plan	0.878	0.214	2.41 (1.58–3.66)	0.000	
Cognitive skills	0.793	0.232	2.21 (1.40–3.48)	0.001	
Family/friends concerned	0.716	0.219	2.05 (1.33–3.15)	0.001	

CI = Confidence interval; OR = odds ratio.

TABLE VI Comparing variables related to police intervention: Under (*n* = 619) versus over age 18 (*n* = 4,084)

Under Age 18	Over Age 18
Violent ideation	Hallucinations
Violence to others	Command hallucinations
Self-injurious attempt in the last 7 days	Delusions
Suicide plan	Abnormal thought process
Cognitive skills	Intoxication by drug or alcohol
Family/friends concerned	Degree of insight into mental health problem
	Person has been known to carry or use weapon(s)
	Violent ideation
	Violence to others
	Self-injurious attempt in the last 7 days
	Considered performing a self-injurious act in the last 30 days
	Suicide plan

As mentioned, there is a gap in the literature regarding the clinical characteristics exhibited by children and youth with mental health problems who have contact with police officers. Other than generally disruptive behaviour indicative of a distressed child and behaviours associated with suicidality, very little else was known. However, the current study added significantly to our knowledge regarding additional variables associated with police intervention. Chi-square analysis of the sample for under age 18 revealed that all variables on the BMHS were statistically significant except for intoxication by drugs or alcohol, living in a squalid or extremely dirty home environment (if observed by the officer), and refusal to take prescribed medications with the highest ORs for hallucinations, diminished cognitive skills, and family and others concerned for self-harm. This would appear to be reasonable and consistent with the currently available literature. Adults would have easier access to alcohol due to regulations in Canada. In addition, research shows that youth consume alcohol much less frequently than adults (Harding et al., 2016). Further, children and youth would be most likely supervised when taking prescribed medications. Home environment would probably not be significant as well because parents or caregivers would be responsible for upkeep.

Although suicidality has been identified in the literature as a characteristic of children and youth who have police contact, there is no literature on predictors of police involvement. This study fills a gap in the literature by identifying specific predictor variables. Logistic regression analysis and OR indicated that the variables most predictive included hallucinations, lack of insight into their own mental health problems, violent ideation, violence to others, self-injurious attempt in the last 7 days, suicide plan, diminished cognitive skills for daily decision-making, and family or others concerned for self-harm.

Another aim of this study was to determine if the characteristics of children and youth with mental health problems having contact with police officers differed from those of adults having mental health problems. Results from the univariate analysis of demographic and contextual variables revealed that the sample of children and youth was similar to the sample of adults except for there being a slightly higher frequency of females in the under age 18 group compared to the over age 18 group. In addition, children and youth were more likely to be taken to the hospital by police officers. In terms of indicators of disordered thought, adults had higher frequencies of intoxication, hallucinations, delusions, pressured speech, and abnormal thoughts (hence indicators of though disorder), while under age 18 had slightly higher frequency of socially inappropriate/disruptive behaviours. As to risk of harm variables, indicators of self-harm were high in both groups, but clearly higher in the under age 18 group, in particular self-injurious attempt in the last 7 days.

This analysis identified areas where there were significant differences between children and youth and adults with mental health problems. Through the results of this analysis, it was determined that it was more likely that adult mental health calls for service involve a higher degree of psychiatric disorders such as hallucinations, delusions, command hallucinations, and diminished insight into their mental health problems compared to children and youth. Further, although violent ideation and violence to others were significant predictor variables in both age groups, violence might be considered more pronounced with adults possibly because of the addition of intoxication and weapons. In contrast, children and youth appear to be characterized predominantly by suicidality. Additionally, police encounters with females were more frequent for under age 18, whereas over age 18 males were more frequent. This could be explained by Hagan's power control theory. Hagan suggested that within patriarchal power relations among family systems, daughters are subject to more supervision than sons. Therefore, parents could be attempting to control their daughters more than their sons (Whitely, 2014).

The results of this study suggest that how police officers respond to children and youth with mental health problems should differ from how they respond to the adult population. Police training needs to be adapted to meet the needs of children and youth. The training police officers receive on responding to children and youth who are experiencing a mental health crisis is minimal at best. It has been reported that police officers receive inadequate training for responding to adults with mental health problems and almost nothing for children and youth. They do not receive sufficient training on the identification of mental health problems, and the information gleaned from this study could be used for such a purpose. For example, training could be provided on how to de-escalate situations where children and youth express violent ideation or violence toward others. Police officers should also pay particular attention to indicators of the child or youth having a suicide plan or having recently attempted to harm themselves and the importance of listening to the

concerns of family and friends. The results also demonstrate the importance of family members' perspectives on mental health needs as a factor influencing the police response to mental health concerns. The BMHS engages family members in two ways: (1) as informants to provide insights into the occurrence of difference mental health indicators; and (2) to report on their own concerns related to the persons' mental health needs. The former function improves the measurement properties of the BMHS by providing additional sources of information and the latter provides an additional level of sensitivity for identification of self-harm-related risk.

When conducting this study, some limitations were identified. First, there are areas where the BMHS could be analyzed in greater depth, for example, the violence to others variable should receive more study to identify sub-categories. That is, violence to others in children and youth may be simple acting out behaviour or related to suicidality. The literature states that risk factors such as homelessness are associated with substance abuse, sex work, and criminal behaviour, which not surprisingly increase the likelihood of a confrontation with police. It is also reported that a high proportion of homeless youth are experiencing mental health problems. Homeless youth represented too small a proportion of our sample to allow for more detailed investigation. As more data become available from the growing use of the BMHS in North America, it will be possible to undertake future analyses with this small but important population.

The BMHS does not include any items related to school settings. To better understand the setting in which a child or youth makes contact with the police could assist in the training for not only police officers but could help teachers identify early signs of mental health problems. Setting in general may be useful, for example, if a youth is living in a group home; the BMHS can be a source of information to early warning signs and training for group home officials who work closely with children and youth.

In conclusion, the BMHS was found to be useful as a means of identifying characteristics of serious mental disorders in children, youth, and adults. Traditionally, police officers receive basic and in-service training on police officer apprehension authorities under mental health legislation and on major indicators of mental health problems. Almost no training is offered on how mental health disorders are exhibited in children and youth, and the information from the BMHS fills this gap. The ability to identify the characteristics of children and youth who have contact with police officers is significant because it helps to ensure police officers receive appropriate training on how to identify and respond to the signs and symptoms of mental health issues in children and youth. Information from this study could also be used to facilitate early intervention and treatment. In the past, if no criminal activity was involved, police officers would not typically intervene. However, given that the BMHS is completed on anyone who police officers believe may have a mental health disorder, it is possible to identify children and youth who may have been overlooked by parents, school, and agency authorities. Of greater significance, if new referral pathways are created from police officers to local mental health service providers, it would help to facilitate prompt access to mental health services and strengthen the relationship between police services and community mental health service providers.

CONFLICTS OF INTEREST DISCLOSURE

The authors have no conflicts of interest to declare.

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ORIGINAL RESEARCH

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COMMUNITY SAFETY & WELL-BEING

A pilot study on the efficacy of an online mindfulness intervention for Canadian police officers

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ABSTRACT

Police officers experience higher levels of mental illness compared to the general population. These traumas are known as operational stress injuries and are the result of operational and organizational stressors. These stressors often result in elevated levels of stress, anxiety, and depression. Mindfulness is widely becoming a mainstream method to help individuals cope with these disorders; however, while rapidly growing, the literature on the efficacy of mindfulness programs for police officers is in its infancy. Given the atypical work schedules officers keep, and the COVID-driven demand for remote service delivery, this pilot study examined the efficacy of a modified version of the online mindfulness program called MindFit Cop. Officers in our study completed a series of surveys before and after the 9-week intervention. We found significant results across timepoints for total mindfulness and self-compassion scores, and a significant interaction for time × group for non-reactivity. No significant results were found for group. This pilot study lends further support for the benefits of mindfulness for police officers in improving overall mindfulness and self-compassion.

Key Words Police; mental health; mindfulness; self-compassion.

INTRODUCTION

Police officers experience mental illness at higher rates compared to the general public (Carleton et al., 2018, 2020). Carleton and colleagues (2018) found that 19.6% of municipal/provincial police and 31.7% of Royal Canadian Mounted Police (RCMP) officers screened positive for major depressive disorder; 21.3% of municipal/provincial police and 34.7% of RCMP screened positive for any mood disorder; 14.6% of municipal/provincial police and 23.3% of RCMP screened positive for generalized anxiety disorder; 10.0% of municipal/provincial police and 18.7% of RCMP screened positive for social anxiety disorder; and 23.7% of municipal/provincial police and 37.3% of RCMP screened positive for any anxiety disorder. Elevated rates were also found in a recent systematic review and meta-analysis of 272,463 officers internationally (Syed et al., 2020).

Officers are exposed to a plethora of dangers (i.e., shootings) and experience immense bureaucratic stressors (i.e., paperwork), referred to as operational and organizational stressors, respectively (McCreary & Thompson, 2006; McCreary et al., 2017). In a recent systematic review, Purba and Demou (2019) found strong evidence for the association of organizational stressors and occupational stress with psychological distress, psychiatric symptoms, emotional exhaustion, and feelings of personal accomplishment. Acquadro Maran and colleagues (2022) found similar themes in their thematic review, while also noting that these outcomes could impact mental health outcomes (i.e., anxiety and depression). Mindfulness and self-compassion

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training are widely gaining traction as a viable option for officers and other first responders to address their mental health needs.

Mindfulness

In the West, mindfulness is commonly defined as the practice of paying attention to one's experience in the present moment and orienting oneself toward those experiences with an attitude of curiosity, openness, and acceptance (Kabat-Zinn, 1994). Trait mindfulness is most commonly measured using the Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006), which divides dispositional mindfulness into the following five facets: observing (noticing internal and external sensations, thoughts, and feelings); describing (labelling thoughts, feelings, and emotions); acting with awareness (engaging in the present moment with undivided attention); non-judging (accepting the present moment with a non-evaluative stance); and non-reactivity (not reacting impulsively to one's experience). Meta-analyses (i.e., Carpenter et al., 2019; Goldberg et al., 2018) and systematic reviews (i.e., Tomlinson et al., 2018) suggest that certain facets of mindfulness are associated with lower levels of stress, anxiety, and depression in the general population. The benefits of mindfulness for police officers can be relied upon from studies examining the same construct in military veterans, given their similar occupation and structure (i.e., Colgan et al., 2019; Serpa et al., 2021; Stephenson et al., 2017).

Self-Compassion

Self-compassion is defined as one's ability to be open to one's suffering and reducing it via acts of kindness toward oneself (Neff, 2003b). Self-compassion disposition is often measured using the Self-Compassion Questionnaire (Neff, 2003a) or its short form (Raes et al., 2011). In a recent scoping review of self-compassion and veteran's health, Steen and colleagues (2021) found benefits for those suffering from symptoms of post-traumatic stress disorder (PTSD), trauma-related guilt, and depression.

Mindfulness and Self-Compassion in Police Officer Samples

Based off the mindfulness-based stress reduction (MBSR) program (Kabat-Zinn, 1990), Christopher and colleagues (2016) found significant improvement in mindfulness, occupational stress, and perceived stress in a pilot study of mindfulness-based resilience training; however, Christopher et al. (2018) highlighted the need for booster sessions to maintain gains long-term. Navarrete et al. (2022) found significant pre–post differences for mindfulness, self-compassion, depression, anxiety, and stress symptoms. In a recent meta-analysis of mindfulness-based interventions (MBIs) for police officers, Vadvilavičius and colleagues (2023) found that these programs were efficacious in reducing operational and organizational stress and levels of perceived stress, while also increasing disposition to self-compassion, facets of mindfulness, and mindfulness processes amongst others. In another meta-analysis, Lu and Petersen (2023) examined the efficacy of psychological skills training for police officers, of which mindfulness training was included; they came to the same conclusions as Vadvilavičius and colleagues (2023).

Systematic reviews and meta-analyses have shown promise in using online mindfulness interventions for treating stress, anxiety, and depression (Sommers-Spijkerman et al., 2021; Spijkerman et al., 2016; Zhang et al., 2020). Small increases in overall mindfulness disposition have also been found in non-police samples (Sommers-Spijkerman et al., 2021). Similarly, studies for delivering self-compassion online have demonstrated positive results (Finlay-Jones et al., 2017). This is promising, as online delivery appears to be the preferred method (Wahbeh et al., 2014). In Canada, most of the research has focused on internet-delivered cognitive behavioural therapy for public safety personnel, with promising results (i.e., Hadjistavropoulos et al., 2021; McCall et al., 2020); however, there is a significant lack of published data with Canadian public safety personnel and the use of MBIs (Stevenson, 2022). To date, we are aware of five papers from three authors that consider Canadian officers, none of which investigated the efficacy of an MBI (Fleischmann et al., 2021; Stevenson, 2018, 2022; Sylven, 2021, 2023). Efficacy studies for online MBIs in other populations such as firefighters (i.e., Joyce et al., 2018) and veterans (i.e., Reyes et al., 2020) have been conducted elsewhere, also with promising results. To our knowledge, there are only two studies that have evaluated the efficacy of an online MBI for police.

Fitzhugh and colleagues (2019) compared a bespoke online mindfulness program called MindFit Cop (MFC), developed in the United Kingdom, to the popular mindfulness app Headspace®, or a waitlist control. They found that Headspace® improved the primary outcomes of well-being, life satisfaction, resilience, and performance at 10 and 24 weeks. MFC improved well-being and life satisfaction at 10 weeks; however, all primary outcomes were improved at 24 weeks. They also found that Headspace®, but not MFC, improved mindfulness disposition scores at 10 weeks, and that Headspace® was more effective than MFC at 10 weeks. However, both were equally effective at 24 weeks with no added benefits seen from using MFC. Similar results were found in a randomized control trial conducted by Fitzhugh and colleagues (2023), in which they examined the benefits of mindfulness on employee well-being at individual and organizational outcomes in a sample of employees across five police forces.

Fitzhugh and colleagues' (2019) study, on which the present pilot study is based, has several limitations. These include a lack of real-time access to facilitators; no retreat (an essential aspect of the MBSR program); use of Headspace® as a comparison without controlling which modules the participants have access to; and lack of measurement of self-compassion, occupational stress, and perceived stress, anxiety, and depression. The current pilot study aimed to address these limitations by comparing a modified version of MFC to an active control group in a sample of Canadian officers. Based on previous research, we hypothesized the following: (1) participants in the MFC group will experience greater decreases in occupational stress and perceived stress, anxiety, and depression outcomes compared to those in the home practice group; and (2) participants in the MFC group will experience greater increases in self-reported mindfulness and self-compassion dispositions compared to those in the home practice group.

THE PRESENT STUDY

Method

Participants

A flow diagram detailing the number of participants and reasons for exclusion can be found in Figure 1. Skewness and kurtosis were calculated to confirm normality ($|Z| < 3.2$). Participant demographics can be found in Table I.

Procedure

Participants were recruited via social media (Twitter) and direct contact with various police agencies across Canada, with information distributed via an electronic flyer. Interested participants were encouraged to enrol in a 1-hour, no-commitment information session hosted via Zoom. Several dates and times were offered to accommodate different schedules and time zones. After the information session, those still interested contacted the team via e-mail to express their interest. Once the enrolment date closed, all participants were randomly assigned to either the MFC or home practice group using the RAND formula on Excel. Participants were informed of the random selection procedure during the information session. After being assigned, all participants were sent several surveys to complete online using LimeSurvey. At the conclusion of the study, and 3 months later, participants were asked to fill out the same measures again. A satisfaction survey was sent out at the 3-month follow-up. Of note, data from the follow-up are not reported given the small and unbalanced number of individuals who completed these measures ($n_{MFC} = 8$; $n_{HP} = 3$). In addition, while the authors attempted to run a second group, this was not possible due to COVID-related challenges.

Those in the MFC group were then instructed to follow the assigned outline, which directed participants through the program. The authors modified the curriculum slightly by requiring participants to attend weekly check-ins via Zoom, which lasted about 30 minutes. In these sessions, extra information based on the week's topic was provided by facilitators. Participants were also divided into breakout rooms to discuss their own experiences. Handouts were sent electronically at the end of each session with a brief summary, instructions for their daily practice, and relevant supplemental readings. We also added an extra week to accommodate a half-day virtual retreat, which occurred during week 5. Requests for program materials can be sent via e-mail to the first author.

Those in the home practice group were simply asked to follow a generic YouTube-guided meditation each day for 9 weeks. The video was 20 minutes in length, with no additional didactic component from the recording or the researchers.

All participants were asked to fill out daily practice logs. They were asked to record how many times each day they practised formally and informally, the average time spent practising, and any notes or observations. These were sent back to facilitators via e-mail on a weekly basis.

All participants were given the option of enrolling in a raffle to win one of six $100 gift cards as compensation. This study received ethical approval from McGill University's Research Ethics Board-II (file # 20-11-060).

Measures

Alpha values can be found in Table II.

Police Stress Questionnaire: The Police Stress Questionnaire (PSQ; McCreary & Thompson, 2006) is a 40-item questionnaire composed of two 20-item subscales. These subscales

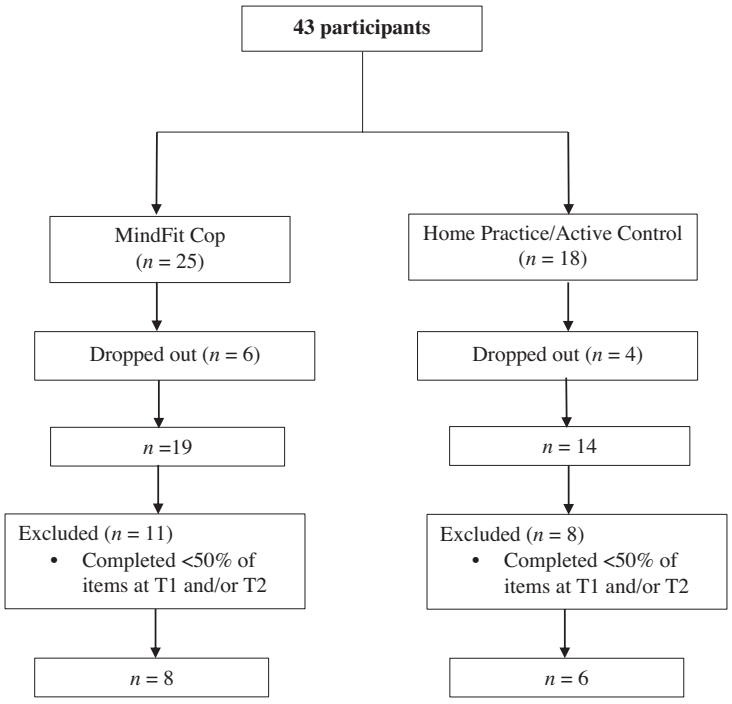

FIGURE 1 Participant flow diagram

TABLE I Sociodemographic characteristics of participants

Variable	n	%
Gender		
Male	8	29.6
Female	5	18.5
Non-binary	1	3.7
Age		
20–29	2	14.3
30–39	6	42.9
40–49	2	14.3
50+	3	21.4
Ethnicity		
White/Caucasian	12	44.4
Indigenous	1	3.7
Other	1	3.7
Rank		
Constable	7	25.9
Sergeant	3	11.1
Staff sergeant	1	3.7
Other	1	3.7
Province		
Ontario	9	33.3
Manitoba	2	7.4
Saskatchewan	1	3.7
Alberta	1	3.7
British Columbia	1	3.7

Note. Not all participants provided information for all demographics.

TABLE II Reliability calculations

Measure	Home Practice Pre-Test (*n* = 6)	Home Practice Post-Test (*n* = 5)	MindFit Cop Pre-Test (*n* = 8)	MindFit Cop Post-Test (*n* = 8)
FFMQ total	0.92	0.86	0.79	0.92
SCS total	0.96	0.90	—[a]	0.97
PSQ-Op	0.51	0.91	0.75	0.75
PSQ-Org	—[c]	0.84	0.92	0.96
DASS-21				
Depression	0.35[b]	0.71[b]	.86	0.84
Anxiety	0.28[b]	0.47[b]	0.92	0.73
Stress	0.76	0.49[b]	0.86	0.74

[a]Calculations were not possible due to participants in this group not completing item 1 of the SCS. When SCS item 1 was not included, the alphas were 0.97 for total and 0.85 for self-judgment.
[b]There is a warning that these measures have zero variance items.
[c]Reliability calculations were not possible due to the small sample size.
Note. DASS-21 = Depression Anxiety Stress Scale-21; FFMQ = Five Facet Mindfulness Questionnaire; PSQ-Op = Police Stress Questionnaire – Operational; PSQ-Org = Police Stress Questionnaire – Organizational; SCS = Self-Compassion Scale.

assess perceived operational stress (PSQ-Op) and organizational stress (PSQ-Org). Each item is ranked on a seven-point Likert scale from *no stress at all* to *a lot of stress*. The PSQ has demonstrated excellent reliability and validity (McCreary & Thompson, 2006). In the present study, both subscales demonstrated good to excellent internal consistency.

Five Facet Mindfulness Questionnaire: Trait mindfulness was measured using the 39-item FFMQ (Baer et al., 2006). This scale assesses the five facets (i.e., observing, describing, acting with awareness, non-judging, and non-reactivity) as it is presently conceptualized. Each item is rated on a five-point Likert scale from *never or very rarely true* to *very often or always true.* The FFMQ has demonstrated good reliability and validity (Baer et al., 2008) and has been used in previous studies of mindfulness and policing (i.e., Christopher et al., 2016; Fleischmann et al., 2021). In the present study, the facets showed good to excellent internal consistency.

Self-Compassion Scale: The Self-Compassion Scale (SCS; Neff, 2003a) is a 26-item measure that measures trait self-compassion. The SCS is rated on a five-point Likert scale from *almost never* to *almost always*. Total SCS scores have been found to have good internal reliability, as did the six subscales on development and validity sample of undergraduate students (Neff, 2003a). The SCS has been used in previous policing research (i.e., Márquez et al., 2021). In the present study, total scores demonstrated poor to excellent internal consistency, likely due to the small sample size.

Depression Anxiety Stress Scale-21: The Depression Anxiety Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995) is a 21-item scale that measures stress, anxiety, and depression symptoms. Items are answered on a four-point Likert scale from *did not apply to me at all* to *applied to me very much or most of the time.* The DASS-21 has demonstrated excellent reliability and validity (Dreyer et al., 2019) and has been used in previous samples of police officers (i.e., McDonald et al., 2020). In the present study, the subscales demonstrated poor to excellent internal consistency, likely due to the small sample size.

Data Analysis

Data analysis was conducted using IBM SPSS (Version 29). Participants had to complete at least 80% of the items within each variable to be included. List-wise deletion was used to omit missing data, and univariate outliers were removed (± 3.5 standard deviation (SD)). Multiple repeated-measures analyses of variance (ANOVAs) were conducted to assess whether there was a difference between and within pre- and post-test data for both the MFC and home practice group. The data were analyzed for any deviations in normality using Shapiro–Wilk's test. Results indicated that not all variables conformed to normality; however, as ANOVAs are relatively robust to deviations in normality, and because this is a pilot study, we elected to proceed. Homogeneity of variance was

TABLE III Descriptive statistics of repeated-measures ANOVAs

Measure	Condition	Baseline *M* (SD)	Post-Intervention *M* (SD)
FFMQ total score	MFC	3.30 (0.35)	3.57 (0.53)
	HP	3.08 (0.55)	3.51 (0.37)
SCS total score	MFC	2.88 (0.76)	3.26 (0.77)
	HP	3.08 (0.82)	3.44 (0.43)
PSQ-Op	MFC	3.68 (0.58)	3.68 (0.62)
	HP	3.40 (.81)	3.33 (0.93)
PSQ-Org	MFC	3.81 (0.92)	3.61 (1.23)
	HP	3.12 (0.37)	3.06 (0.84)
DASS-21 (stress)	MFC	1.09 (0.59)	0.97 (0.42)
	HP	1.08 (0.67)	0.92 (0.36)
DASS-21 (anxiety)	MFC	0.71 (0.75)	0.62 (0.47)
	HP	0.33 (0.26)	0.16 (0.21)
DASS-21 (depression)	MFC	0.77 (0.66)	0.66 (0.49)
	HP	0.37 (0.20)	0.43 (0.25)

Note. ANOVA = Analysis of variance; DASS-21 = Depression Anxiety Stress Scale-21; FFMQ = Five Facet Mindfulness Questionnaire; HP = home practice; MFC = MindFit Cop; PSQ-Op = Police Stress Questionnaire – Operational; PSQ-Org = Police Stress Questionnaire – Organizational; SCS = Self-Compassion Scale; SD = standard deviation.

tested using Levine's test. Deviations were found for time 1 depression scores. Although this is a limitation, ANOVAs are generally robust to heterogeneity when group sizes are similar (largest/smallest is <1.5; Stevens, 2002). Means and SDs can be found in Table III.

RESULTS

Mindfulness

We found significant results across timepoints for total FFMQ scores, $F(1, 12) = 14.56$, $p = 0.002$, partial $\eta^2 = 0.55$. We only found a significant result for time × group for non-reactivity, $F(1, 12) = 5.89$, $p = < 0.05$, partial $\eta^2 = 0.33$. No significant results were found for group (i.e., MFC vs. home practice; all $p > 0.05$).

Self-Compassion

We found significant results across timepoints for total SCS scores, $F(1, 11) = 5.72$, $p = < 0.05$, partial $\eta^2 = 0.34$. No significant results were found for group (i.e., MFC vs. home practice; all $p > 0.05$).

Operational and Organizational Stress

No significant results for time, group, or time × group was found (all $p > 0.05$).

Perceived Stress, Anxiety, and Depression

No significant results for time, group, or time × group was found for measures of perceived stress, anxiety, or depression (all $p > 0.05$).

DISCUSSION

To our knowledge, this is the first study to empirically evaluate the efficacy of a bespoke online MBI for police officers in Canada. We did not find support for hypothesis 1; that is, there was no difference in occupational stress, perceived stress, anxiety, and depression outcomes based on group. We also did not find support for hypothesis 2 in that participants in the intervention group did not exhibit higher levels of mindfulness and self-compassion across timepoints compared to those in the active control group. However, overall levels of mindfulness and self-compassion increased independent of group, consistent with Visted and colleagues (2015) who found improvements in mindfulness scores in an active control group in a non-police sample. This is not surprising, as one could reasonably expect changes over 9 weeks of daily dedicated practice.

Lack of support for hypothesis 1 is somewhat surprising, as previous intervention research found positive changes on mental health and self-reported mindfulness and self-compassion outcomes (i.e., Christopher et al., 2016, 2018; Eddy et al., 2021; Grupe et al., 2021; Hoeve et al., 2021; Kaplan et al., 2017, 2020; Krick & Felfe, 2020; Navarrete et al., 2022; Trombka et al., 2018, 2021). Aside from mindfulness, we were unable to compare our findings to those of Fitzhugh and colleagues (2019) as they had different outcome variables. Our results, in tandem with those of Fitzhugh and colleagues (2019, 2023), suggest that using a bespoke online mindfulness program for police officers may not be necessary to reap the benefits of mindfulness in terms of structure. However, police culture needs to be considered when designing the content; recognizing certain aspects such as oversharing is highly stigmatized and may serve to isolate participants (Christopher et al., 2016). Given the vast number of resources needed to develop a mindfulness intervention, these findings may assist senior police leadership to allocate funds more efficiently if they are interested in introducing mindfulness to their employees.

We only found a significant result for time × group for non-reactivity. These findings are somewhat consistent with those of Christopher and colleagues (2016) who found improvements in overall mindfulness and in non-judging and non-reactivity scores; Christopher and colleagues (2018) who found changes in non-reactivity; and Márquez and colleagues (2021) who found changes in mindfulness, observing, and non-reactivity (although Márquez and colleagues noted that not all trends reached significance). Similarly, we found that overall self-compassion scores increased independent of group.

The most likely reasons for the large discrepancy with previous research are small sample size and lack of multiple cohorts. It is also possible that the method of delivery impacted results. While the MFC group was closely monitored due to the weekly check-ins, the home practice group was left to complete the study relatively unsupervised. Finally, aside from the check-ins, the programs were self-facilitated. Typically, mindfulness programs are delivered in real time. Future researchers may want to consider evaluating asynchronous versus synchronous delivery of the same intervention to ascertain if there is a noticeable difference. This is especially important given the inconsistent work schedules that police officers adhere to.

LIMITATIONS AND FUTURE DIRECTIONS

The most evident limitations of our pilot study are sample size, lack of multiple cohorts, and lack of follow-up data. Moreover, review of participation logs suggests that not all participants were able to engage in a daily practice, something that is necessary to get the full benefits of mindfulness. At present, we do not see any way to circumvent this, especially with individuals on shift work and changing schedules. However, the first two limitations are easier to address, and we encourage other researchers to do so. Based on participant feedback, we also encourage researchers to prolong the amount of time spent in the breakout rooms. We intentionally kept this time short to avoid prolonging the overall duration of the check-in sessions; however, participants reported a desire for more time to discuss their experiences with their colleagues.

To our knowledge, this is the first study to empirically evaluate the efficacy of a bespoke online MBI for police officers in Canada. Similar to the findings of Fitzhugh and colleagues, our results, while limited, suggest that police officers may benefit from a generalized mindfulness practice via an app (i.e., Headspace®) or online videos, and thus, may not necessarily require a specialized program. However, more rigorous research is needed before conclusive findings can be derived for this unique population.

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CONFLICTS OF INTEREST DISCLOSURE

Advertising for this study was sent, but not limited to, the Barrie Police Service. Participation was voluntary and did not impact employment, standing, or promotion.

AUTHOR NOTE

Authors AB, MC, EC, RJ, BK, & MV are listed in alphabetic order by last name. The order of authorship is not intended to convey degree of involvement in this study. The Haven is currently operating on the property of another organization.

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ORIGINAL RESEARCH

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How judges in Canadian criminal courts define intimate partner violence

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ABSTRACT

Intimate partner violence (IPV) is a substantial problem in Canada, leading to over 100,000 victims reporting to police in Canada annually. However, there is no legal definition or Canadian *Criminal Code* offence for IPV. The purpose of this study was to examine how judges in the Canadian prairie provinces (Alberta, Saskatchewan, and Manitoba) define IPV in criminal cases. One hundred full-text, written judicial decisions from 2016 to 2022 were analyzed. Findings indicate that judges tend to discuss IPV as it relates to sexual and psychological violence; threats, coercive control, and physical violence; isolation and stalking; economic abuse and threats to take children away. Given that current Canadian law does not recognize psychological abuse as a criminal offence, this may signal a need for the creation of a legal definition of IPV to align with how more directly it is being discussed in courtrooms.

Key Words Psychological abuse; emotional abuse; coercive control; Canadian Criminal Code; judicial decisions.

Intimate partner violence (IPV) can include physical and sexual assault, as well as non-physical forms of violence and abuse, including economic, emotional, psychological, spiritual abuse, and coercive control (Cotter, 2021; Neilson, 2017; PATHS, 2018). Coercive control is a pattern of behaviour that is typically characterized by intimidation, degradation, isolation, and control; these tactics can occur in conjunction with severe physical and sexual violence or with low-level physical abuse and sexual coercion (Stark, 2013). IPV fits within the broader category of domestic violence, which can also include violence and abuse toward others in the family and home, including children (Neilson, 2017).

In Canada, IPV constitutes approximately one-third of police-reported violent crimes (Conroy, 2021; rate of 346 per 100,000, Statistics Canada, 2023) and the rates of IPV are especially high in the prairie provinces of Alberta (388 per 100,000), Saskatchewan (732), and Manitoba (633). However, it is estimated that up to 70% of victims/survivors do not report incidents of IPV to the police (Burczycka, 2016), likely in part because only physical forms of IPV are chargeable offences under Canada's *Criminal Code*. IPV is not a criminal offence in Canada. Perpetrators of IPV are charged according to incidents (as opposed to patterns of behaviour) that typically relate to physical violence (e.g., assault) or threats (Beaupré, 2015). Other elements of IPV (e.g., emotional abuse, economic abuse, coercive control) are not chargeable offences leading to limited options for legal safety mechanisms (e.g., protective orders) for victims/survivors and for managing perpetrator risk.

Recent Canadian scholarship has examined understandings of and responses to IPV and its impacts on adult and child survivors in the family court system (e.g., Jaffe et al., 2023; Koshan et al., 2023; Neilson, 2023; Sheehy & Boyd, 2020). Since Canadian criminal law does not include a federal definition of IPV[1], there may be differences in how IPV-related behaviours are understood and considered by legal decision-makers in criminal court.

In Canada, most criminal trials are bench trials (i.e., tried by a judge alone; Berger, 2020). The reason for a judge's decision is written down and becomes public knowledge that can be accessed via legal repositories. The use of judicial decisions provides insight into how judges view IPV – at least with respect to their legal decisions. The present research[2]

[1]See the *Divorce Act* (Government of Canada, 1985; amended 2020) for a federal definition now used in family court.
[2]This article is based on the first author's undergraduate honours thesis.

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seeks to address this problem by examining how judges in Canada define IPV in criminal court decisions.

METHODS

The goal of the present study was to examine how judges define IPV in criminal cases in the prairie provinces where IPV rates are higher than the national average (i.e., Alberta, Saskatchewan, and Manitoba). Full-text judicial reports from provincial-level courts (see Table I) in these provinces from 1 January 2016 to 1 January 2022 were obtained from the Canadian Legal Information Institute (CanLII)[3]. Two hundred and three criminal cases were identified using the search terms "domestic violence," "family violence," and "intimate partner violence." Any cases that did not directly involve IPV were removed. For example, some judges referenced the presence of IPV as either a mitigating or aggravating factor for a different crime, where IPV was not the focal crime of the case. This resulted in a final sample of 100 cases (72 out of 124 possible cases from Alberta; 12 from 49 in Saskatchewan; and 16 from 30 in Manitoba).

Coding Strategy

Criminal Code charges frequently associated with IPV (e.g., assault with a weapon, sexual assault, aggravated assault; Beaupré, 2015) and behaviours listed in the *Divorce Act* (e.g., patterns of coercion and control, harassment, psychological abuse, threats to harm or kill, and financial abuse) were coded. The recently amended *Divorce Act* (2020) is the only piece of federal legislation in Canada that offers a comprehensive definition of family violence (including intimate partners). The *Divorce Act* lists behaviours that may be part of the pattern of intimate partner/family violence, including some actions that would constitute a criminal offence and others that would not (e.g., the failure to provide the necessaries of life, psychological abuse, financial abuse, or threats to kill or harm an animal). While this definition only applies to family law contexts, the definition serves as a good benchmark to code for in criminal court settings. Therefore, the IPV behaviours coded for in this study (see Table II) were extracted from the behaviours highlighted in the *Divorce Act*, as well as from other relevant IPV literature. Table II illustrates the proportion of cases where judges noted the nature of IPV. Other items coded included relationship, length, and verdict.

An excellent interrater agreement was established for each item coded (0.88–1.00) using one-third of the cases (N = 32). Agreement was determined using intraclass correlation (ICC) coefficients for continuous variables (ICC > 0.75 = excellent interrater agreement, Cicchetti & Sparrow, 1981) and Cohen's kappa for nominal variables. Any coding discrepancies were resolved through discussion. See the Supplemental Material for the complete coding guide.

[3]The judicial reports included 71 sentencing, 17 trial, and 12 pre-trial or voir dire hearings.

TABLE I Number of court cases by province and court level

	Province			
Court Level	**Alberta**	**Saskatchewan**	**Manitoba**	**Total**
Provincial Court	50	5	6	61
Court of Kings Bench	22	7	10	39
Total	72	12	16	100

Note. The Court of King's Bench is an appeal court for some criminal cases originally tried in Provincial Court. Provincial Court consists of judges appointed by a provincial government, which deals with criminal cases not tried by jury, family matters, and small civil claims.

TABLE II Judge-referenced IPV victim experiences

Victim-Experienced Behaviour	Proportion
Physical violence	0.51
Psychological or emotional abuse	0.33
Threats or intimidation	0.21
Sexual violence	0.17
Coercive or controlling behaviours	0.11
Economic or financial abuse	0.50
Stalking or harassment	0.40
Threats to harm others	0.40
Isolation	0.30
Threats to take children away	0.20
Spiritual abuse	0.20

Note. N = 100. Values are to be interpreted as percentages (e.g., 0.51 = 51%).

RESULTS

Case Characteristics

Most of the cases of IPV in our sample were from Alberta (see Table I). Of the 100 cases included, the majority were sentencing decisions (n = 71), while 17 were trial decisions (i.e., guilty or not guilty). The remaining 12 cases were a pre-trial decision or a voir dire (i.e., determining admissibility of evidence). Over half (n = 58) of the cases involved more than one criminal charge; 42 cases involved a single criminal charge. The maximum number of criminal charges a defendant in this sample received was 7. See Table III for a breakdown of charges associated with IPV in this sample. In more than half of the cases (n = 65, 65%), the relationship between the victim and the perpetrator was a long-standing relationship, followed by a dating relationship (15%), only one intimate occasion (7%), a brief (<1 month) relationship (5%), or the relationship was not reported (8%).

Victim and Defendant Characteristics

Victim and defendant characteristics are outlined in Tables IV and V. Overall, adult women were most often the victims of IPV. The cases with a child (under the age of 18) as the primary victim involved dating violence where both victim and perpetrator were under 18, and cases where the child was a victim in addition to an adult victim (i.e., mother). Nearly all defendants (i.e., perpetrators) were male and, on average, were nearly 15 years older than the victims.

TABLE III Criminal charges linked to IPV

Criminal Charge (Section From Canadian Criminal Code)	Proportion
Assault With a Weapon or Causing Bodily Harm s. 267	0.33
Assault s. 266	0.32
Uttering Threats s. 264.1	0.19
Aggravated Assault s. 268	0.17
Sexual Assault s. 271	0.14
Breach of Order s. 447.2	0.13
Kidnapping s. 279	0.11
Possession of a Weapon s. 88	0.10
Manslaughter s. 236	0.10
Failure to Attend Court s. 145.2	0.06
Hostage Taking s. 279.1	0.05
Attempted Murder s. 239	0.04
Mischief s. 430	0.04
Strangulation s. 246	0.04
Criminal Harassment s. 264	0.04
Sexual Assault With a Weapon s. 272	0.03
Intimidation s. 423	0.03
Breaking and Entering s. 348	0.03
Aggravated Sexual Assault s. 273	0.02
Arson s. 433	0.02
Publication of an Intimate Image Without Consent s. 162.1	0.01
Pointing a Firearm s. 87	0.01

Note. All other chargers were not found, see coding guide. Fifty-eight cases had more than one charge present. $N = 100$. Mischief includes damages and interferences to property (*Criminal Code*, 1985, s. 430) and examples could include damaging the victim's vehicle, such as slashing their tires, or damaging security cameras or other equipment or property at the victim's home. Breach of Order (*Criminal Code*, 1985, s. 447.2) was common when the perpetrator continues to contact the victim while on bail, probation, or another order that stipulates that they not have any contact with the victim. This could include showing up at the victim's home or workplace, calling or texting, or contacting others connected to the victim.

IPV = Intimate partner violence.

TABLE IV Victim and defendant characteristics

	M (Age)	SD (Age)	Female	Male
Primary victim	21.3	13.50	90	10
Second victim	7.6	6.35	1	5
Defendant	37.6	11.35	11	89

Note. Second victim: six instances involving two victims.

Thirty-six judges noted that the defendants witnessed IPV in their childhood and of those, judges in 17 cases (47%) noted this experience as a mitigating factor (2% or 6% note it as an aggravating factor).

TABLE V Victim type

	Adult Victim	Child Victim
Primary victim	89	11
Second victim	1	5

Note. Child victims are under 18 years of age.

How Do Judges in Canadian Criminal Courts Define IPV?

Judges in 51% of the cases noted that victims of IPV experienced physical violence, 33% noted psychological or emotional abuse, and 21% noted that victims experienced threats or intimidation (see Table II). To explore the factorial structure of the themes discussed by judges in IPV cases, all 11 items from Table II were entered into an exploratory factor analysis with varimax rotation (principal component analysis). The factor analyses revealed a four-dimension solution (see Tables VI and VII for statistical results), described later.

Dimension 1: Sexual and Psychological Violence

The most prominent dimension used by judges when discussing IPV was surrounding elements of "Sexual and Psychological Violence." This dimension includes various forms of sexual, emotional, and psychological violence, including spiritual abuse. For example, in one case, the judge emphasized the psychological and sexual trauma experienced by the victim by stating that due to her intense anxiety associated with the sexual assault, she was unable to read her victim impact statement and ultimately unable to attend court. This victim was also diagnosed with post-traumatic stress disorder (PTSD) because of the abuse (*R. v. Oka*, 2021).

> [Victim] suffers from Post-Traumatic Stress Disorder (PTSD) and anxiety. She has a fear of enclosed spaces. At the time of sentencing, because of intense anxiety associated with the assault and sexual assault she was unable to attend the court to read her Victim Impact Statement as she could not face taking an elevator to the courtroom. [Victim] also was unable to attend court remotely by WebEx or telephone as, even with a court support worker, she found the sentencing too much to face (*R. v. Oka*, para. 47, 2021).

Dimension 2: Threats, Coercive Control, and Physical Violence

Victims in the "Threats, Coercive Control, and Physical Violence" dimension were noted by judges to have experienced physical violence and abuse, coercion and control, as well as various forms of threats towards themselves or other people. For example, in the case *R. v. Paquette*, the judge reiterated the victim's impact statement by emphasizing that she suffered distress and physical pain because of the threats and assaults she experienced. As well, this victim is now unable to live on her own because of the fear stemming from the physical violence and threats she experienced (*R. v. Paquette*, 2020). In another case, the judge noted that the victim was too afraid to leave the hotel room where she was being abused,

TABLE VI EFA of behaviours noted by judges when discussing IPV

	Factor Loading					
Items	**1**	**2**	**3**	**4**	**Communality**	**Dimension Label**
Sexual violence		**0.842**			0.764	Sexualized emotional violence
Psychological or emotional violence	0.527	**0.615**			0.688	
Spiritual abuse		**0.601**			0.411	
Threatening/intimidation	**0.731**				0.604	Coercive and threatening behaviours
Physical violence	**0.588**	0.368			0.551	
Coercive and controlling behaviours	**0.669**				0.457	
Threats to harm others	**0.76**				0.63	
Stalking/harassment				**0.873**	0.78	Persecution
Isolation	0.352			**0.611**	0.545	
Threats to take children away			**0.733**		0.606	Socioeconomic abuse
Economic or financial abuse			**0.824**		0.801	

Note. The Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis, KMO = 0.597. Bartlett's test of sphericity (55) = 211.75, $p < 0.001$, indicated that the correlation structure is adequate for factor analyses. The maximum likelihood factor analysis with a cut-off point of 0.30 and the Kaiser's criterion of eigenvalues greater than 1 (see Field, 2009) yielded a four-factor solution, accounting for 61.98% of the variance. Bolded factor loadings indicate the items that were grouped into each of the four factors.

EFA, Exploratory factor analysis; IPV, intimate partner violence.

TABLE VII Rotated principle component analysis (PCA) eigenvalues, percentages of variance, and cumulative percentages for factors

Factor	Eigenvalue	% of Variance	Cumulative %
1	2.313	21.2%	21.0%
2	1.813	16.5%	37.5%
3	1.379	12.5%	50.0%
4	1.313	11.9%	62.0%

Note. $N = 100$.

as her abuser threatened to harm her and her children (*R. v. Toulejour,* 2016).

> … She was shaking and anxious and seemed deeply distressed when reading her statement. … She cannot see herself living on her own for quite some time as the threats made to her have left her fearful. …Due to the incident, her PTSD and anxiety have gotten worse… She does not feel she can go to school or work because she is "scared for my life from the threats and abuse she suffered from the incident". She has not been able to hold down a job, and as a consequence does not have the income to continue counselling (*R. v. Paquette,* para. 17, 2020).

Dimension 3: Isolation and Stalking

Victims in the "Isolation and Stalking" category were reported by judges to have experienced various forms of stalking and harassment, as well as isolation in the forms of kidnapping or unlawful confinement. For example, in one case, the judge noted that the perpetrator kidnapped the victim and confined her against her will, which contributed to her inability to be in large crowds, and her diagnosis of severe anxiety and depression (*R. v. Baht,* 2018).

> [Victim] is fearful of Mr. Baht. She indicated that the events of July 18, 2017 have had a negative impact on her life. She has gone from being a very outgoing, fun, happy, open person, to someone who does not want to socialize in big crowds. She has developed severe anxiety and depression. She has lost some friends and distanced herself from other friends… (*R. v. Baht*, para. 10, 2018).

Dimension 4: Economic Abuse and Threats to Take Children Away

Individuals in the "Economic Abuse and Threats to Take Children Away" category experienced threats to take their children away. These results are in line with IPV research that contends that 60% of abuse perpetrators threaten to take the victim's children away (Stark, 2012). This category also included forms of economic abuse, including financial abuse. For example, in *R. v. Wood* (2021), the judge noted that victims of IPV may remain in a dangerous relationship due to housing and other financial reasons. In this case, the victim remained with her abusive husband as she and her children had nowhere else to go; she ultimately was found dead at the hands of her abuser (*R. v. Wood*, 2021).

> …Underpinning this factor are two important societal concerns. First, the violent breach of the highly valued trust of a domestic union. Second, the cunning nature of domestic abuse where, despite the abuse and the ongoing risk of abuse, a victim often is compelled or lured by emotional, psychological, family, shelter or financial reasons to remain in a dangerous relationship (*R. v. Wood*, para. 48, 2021).

DISCUSSION

This study aimed to examine how judges in the Canadian prairie provinces define and/or discuss IPV in criminal court. Our results suggest that judges in our sample describe IPV in a way that maps onto four dimensions: Sexual and Psychological Violence; Threats, Coercive Control, and Physical Violence; Isolation and Stalking; and Economic Abuse and Threats to Take Children Away.

As physical forms of IPV (e.g., physical and sexual assault) and threatening behaviour (e.g., criminal harassment) have accompanying criminal charges in Canada, it was not surprising that these elements made up a notable portion of how judges' descriptions of IPV in our sample. Despite not being chargeable offences in Canada, we also found that judges in our sample also recognized non-physical forms of IPV (e.g., psychological violence, coercive control, economic abuse) in their decisions. Psychological and emotional abuse were the second most common behaviours noted by judges in our sample. In particular, these elements of IPV were often considered by judges as aggravating factors and referenced when providing further context to the crime that does exist in the *Criminal Code* (e.g., assault). Psychological and emotional IPV behaviours were noted by over 33% of judges in our sample, and 11% additionally acknowledged the presence of controlling and coercive behaviours.

Psychological abuse is the most common form of IPV reported by victims in Canada (Cotter, 2021). Stark (2012) reported that 60–80% of IPV victims experience forms of control and coercion, sometimes in conjunction with physical forms of violence. As such, the judicial consideration of psychological violence and coercive control in their legal decisions suggests a familiarity with the dynamics of IPV. Overall, the results demonstrate that criminal court judges in the Canadian prairies do have a comprehensive understanding of the nature of IPV that aligns with definitions of IPV employed by researchers and advocates (Cotter, 2021; Neilson, 2017; PATHS, 2018).

Findings from this study point to the need for a standard definition of IPV in the Canadian legal system. This study demonstrated first that judges already have a comprehensive understanding of IPV, by acknowledging the complexity of IPV, yet they do not have any legal mechanisms in place (i.e., a federal definition) to accurately describe and respond to IPV. Other jurisdictions do have mechanisms in place to ensure accurate and consistent decision-making regarding IPV (coercive control has been legislated in other jurisdictions such as the UK in the *Serious Crime Act 2015*; and Scotland in the *Domestic Abuse Act 2018*). Similar legislation would likely have utility in Canada. Second, the establishment of a comprehensive definition of IPV, which considers the range of behaviours employed by perpetrators (inclusive of the four dimensions highlighted in this study), will allow for improved survivor experiences and management of future IPV risk (e.g., court-appointed treatment programs for the non-physical elements of IPV). Additionally, a federal definition would provide more consistency in responses to IPV beginning with police investigations and charging, through to sentencing for those found guilty of IPV, and mandating risk reduction strategies such as participation in treatment programs or risk reduction strategies such as electronic monitoring (see *Bill C-233*). As well, a victim's decision to report IPV to police can be influenced by numerous factors; however, much of these factors can be deduced to the discrepancy in IPV interpretations in both victim and perpetrators of IPV, but also law enforcement who are called to IPV instances. A federal definition of IPV may increase how many instances of IPV are reported to police.

Limitations

Exploring descriptions of IPV in judicial decisions offers several advantages but also some limitations. First, we only analyzed instances of IPV in which the case went to criminal court. As such, our results do not account for instances where a defendant accepted a plea (i.e., settled outside of the courtroom), participated in a provincial Domestic Violence Court, or cases where IPV was not acknowledged by the judge in their written decision. Second, judicial decisions may not report all IPV behaviours present in a case, as the information included in each written decision is at each judge's discretion; aspects of IPV may not have been reported, recognized, or acknowledged in the written decisions. In addition, given that a criminal offence of IPV does not exist in Canada, elements of IPV beyond physical violence and threatening behaviours may not be presented to judges. Third, we used the search terms "intimate partner violence," "domestic violence," or "family violence" to identify cases; it is possible that cases relating to IPV were not identified in our search if judges used different terminology. Future work examining trial transcripts may provide a more complete insight into the behaviours present in IPV cases.

Future Research Directions

This was the first study to examine how judges in criminal courts in the Canadian prairies defined IPV in their decisions. The results provide an important baseline or benchmark for any future changes to how IPV is defined in the Canadian legal system. In 2020, Canada amended the *Divorce Act* (applicable to married couples who are divorcing) to include a comprehensive definition of IPV. Legislation also passed in 2021 to require the provision of professional development relating to sexual assault (*Bill C-337*) and IPV and coercive control (*Bill C-233*) for federally appointed judges. In addition, Canada is currently considering legislating a criminal offence of coercive control[4], as has been implemented in the UK, Scotland, Ireland, Northern Ireland, and New South Wales, Australia. All of these recent or upcoming changes will result in a shift to how IPV is discussed in criminal courts. Future research will provide valuable insight regarding if and how the implementation of the above legislative changes impacts the way judges describe IPV in their decisions.

In addition, future research should examine how judges in family courts in the Canadian prairies define IPV in their decisions. This research would add important insight into the consistency between criminal and family courts and add to the body of knowledge on understandings of and responses to IPV within the Canadian family court system (Jaffe et al., 2023; Koshan et al., 2023; Neilson, 2023; Sheehy & Boyd, 2020).

[4]A private member's bill (*Bill C-322*) was introduced in May 2023 and recently passed the second reading in the House of Commons (February 2024). It is currently being considered in committee.

CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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SUPPLEMENTARY MATERIAL

Supplementary material is linked to the online version of the paper at https://www.journalcswb.ca/index.php/cswb/article/view/387/supp_material.

- Coding Guide

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ORIGINAL RESEARCH

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A stake in their future: Advancing local community engagement in Northeast Nigerian development initiatives

Hussain T. Oyewo

ABSTRACT

This article examines the level of local community engagement in development initiatives in the northeast of Nigeria, highlighting the importance of local community engagement in the successful implementation and sustainability of development projects and their current challenges. The study delves into the existing literature and reports using a desk research methodology, providing a comprehensive overview of current practices and the barriers hindering effective community involvement. This exploration identifies several key research gaps, including the lack of consensus on effective community engagement measurement, insufficient understanding of participation dynamics, and limited investigation into the long-term effectiveness of capacity-building initiatives. In response to these gaps, the article proposes strategies to improve community engagement in the region, such as developing robust metrics for community engagement, implementing inclusive participation practices, and incorporating capacity-building components in development initiatives. The article underscores the critical need for further research in this area and advocates for more inclusive, sustainable, and effective community engagement in Northeast Nigeria's development efforts.

Key Words Northeast Nigeria; community engagement; development initiatives; conflict-affected regions; Boko Haram insurgency; local participation; capacity-building; gender equality.

INTRODUCTION

Today's world is ever more interdependent and interconnected, making local communities' active and meaningful engagement in development initiatives relevant and vital. Local communities are a fount of wisdom, resilience, and change; they are beneficiaries of development initiatives, of course, but more importantly, they also play a pivotal role in shaping and sustaining these initiatives (Mansuri & Rao, 2012). Despite this, their participation is often overlooked or given lesser importance in development discourse and practice. This gap in community involvement is particularly pronounced in complex, conflict-ridden environments, such as Northeast Nigeria, where long-standing instability, repeated humanitarian crises, and numerous developmental challenges persist.

Located in the Sahel, Northeast Nigeria comprises six states: Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe. These states are home to a rich tapestry of cultural diversity, yet they are also areas of significant socio-economic disparities and stark contrasts. Over the last decade, the region has been in the grips of an armed conflict that has mushroomed into a full-blown humanitarian crisis. Thousands have lost their lives, and millions have been displaced, destabilizing entire communities (Osewa, 2019).

In response to this crisis, many development initiatives have been launched in the region. These range from emergency relief operations to longer-term development projects aimed at addressing the root causes of the conflict, such as poverty, illiteracy, and economic deprivation. International aid agencies, non-governmental organizations (NGOs), and the Nigerian government have pumped resources into these

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initiatives, hoping to bring about meaningful change (Uscategui & Andrea, 2017).

Despite these well-intentioned efforts, however, the region remains mired in challenges. A significant reason for this stagnation is the lack of effective community engagement in development initiatives. Engaging with local communities is not just a desirable component of development work; it is essential for the success and sustainability of these projects. Understanding local cultures, needs, and power dynamics can improve project design, enhance community ownership, and ultimately lead to more impactful outcomes. This study sets out to address this gap by advancing our understanding of local community engagement in the context of development initiatives in Northeast Nigeria. It aims to uncover the nuances, shed light on the complexities, and outline actionable strategies for improving community participation.

LITERATURE REVIEW

A review of the literature shows that local community engagement in development projects is not a new concept. For years, scholars and practitioners alike have emphasized the importance of involving local communities in the planning, implementation, and evaluation of development initiatives (Arnstein, 1969; Chambers, 1994). However, the understanding and operationalization of community engagement are far from uniform, and there is an ongoing debate about its meaning, process, and outcomes.

At one end of the spectrum, community engagement is viewed as a way of collecting information from the community to inform project design (Reed, 2008). On the other end, it is seen as empowering the community to make decisions about projects affecting them (Hickey, 2004). In between, multiple perspectives see community engagement as a tool for improving project effectiveness, building social capital, reducing conflicts, and promoting sustainable development (Cornwall, 2008).

Within the context of Northeast Nigeria, a few key studies shed light on local community engagement in development initiatives. These studies underscore the challenges and potential of community engagement in this region. For instance, a report by the International Crisis Group (2017) highlights how the Boko Haram insurgency has strained traditional community structures and posed significant barriers to community participation in development initiatives. On the other hand, studies by Bolarinwa and Osuji (2022) and Mercy Corps (2018) demonstrate how locally led peacebuilding and resilience-building initiatives have effectively navigated complex socio-political dynamics and achieved impactful outcomes.

Conceptually, this study is grounded in Arnstein's (1969) ladder of citizen participation and Cornwall's (2008) idea of participatory spaces. Arnstein's ladder presents a spectrum of citizen participation, ranging from manipulation and therapy (non-participation) to partnership and citizen control (citizen power). This ladder provides a useful framework for analyzing the degree and quality of community engagement in development initiatives. Meanwhile, Cornwall's idea of participatory spaces draws attention to the institutional arrangements and power dynamics that enable or constrain community engagement. By examining "created" and "invited" spaces of participation, we can gain deeper insights into how community engagement unfolds in Northeast Nigeria's complex context.

Despite these contributions, there is still a dearth of comprehensive studies on local community engagement in Northeast Nigeria's development initiatives. Many existing studies tend to focus on specific projects or sectors, offering limited insights into the broader trends and patterns. Furthermore, most studies primarily focus on the challenges of community engagement, with less attention paid to its potential and strategies for improvement. This study aims to fill these gaps and contribute to a more nuanced understanding of community engagement in Northeast Nigeria.

METHODOLOGY

This study employs a desk research approach, an established method in social sciences that involves collecting, evaluating, and synthesizing existing research and data to answer specific research questions (Hart, 1998). This approach is particularly relevant for this study because it allows us to leverage the breadth and depth of existing literature and reports on local community engagement in development projects in Northeast Nigeria.

The data sources for this research are varied and encompass academic literature, project reports, policy documents, and other secondary sources. These sources are accessed through multiple databases, including Scopus, JSTOR, and Google Scholar, and websites of relevant organizations, such as the World Bank, United Nations, NGOs, and the Nigerian government. The search terms used included "community engagement," "local participation," "development projects," "Northeast Nigeria," and related terms.

Selection criteria were employed to ensure that the sources used were relevant and reliable. Firstly, the sources had to be directly related to the topic of local community engagement in development projects. Secondly, they had to provide insights into the context of Northeast Nigeria. Thirdly, most of the sources had to be published within the last 10 years to ensure that the findings were relevant and up-to-date. Lastly, the sources needed to be from reputable authors or organizations with recognized expertise in the field.

To ensure the quality of the study, I adhered to the standards of reliability, validity, and ethics. Reliability was maintained by keeping a detailed record of the data collection and analysis process to ensure that other researchers could replicate the study. Validity was enhanced by cross-checking information across multiple sources and by grounding the interpretations in the data. In terms of ethics, I made sure to cite all sources correctly and avoid any form of plagiarism.

The desk research approach has its limitations, including the dependence on the quality and availability of existing data and the lack of primary data that could provide more current and nuanced insights. Despite these limitations, the approach allowed for a comprehensive overview of the state of local community engagement in Northeast Nigeria and facilitated the identification of critical research gaps.

THE CRISIS IN NORTHEAST NIGERIA

The crisis in Northeast Nigeria is a long-standing conflict that has brought immense suffering to the region. It is a complex situation driven by various factors, including religious, political, ethnic, and economic elements, leading to violence and instability.

The origin of the crisis can be traced back to the early 2000s when Boko Haram, a radical Islamist group, emerged in Northeastern Nigeria (Mansuri & Rao, 2012). Initially, Boko Haram focused on addressing perceived social and economic injustices, but over time, it transformed into a militant organization with a jihadist ideology. The situation escalated in 2009 when Nigerian security forces launched a crackdown, resulting in the death of the group's leader, Mohammed Yusuf. Subsequently, Boko Haram became more violent, targeting civilians, security forces, and government institutions (Mansuri & Rao, 2012).

The crisis has had profound socio-economic consequences in Northeast Nigeria. The region, which was already one of Nigeria's poorest (Dunn, 2018), has witnessed a severe economic decline due to the destruction of infrastructure, disruption of agricultural activities, and displacement of millions of people. Access to education and healthcare has been severely hindered, exacerbating poverty and food insecurity (Dunn, 2018).

The humanitarian toll of the crisis has been devastating. Millions of people have been displaced from their homes within Nigeria and as refugees in neighbouring countries. Access to basic necessities such as clean water, sanitation, and healthcare remains a significant challenge in conflict-affected areas (Ewang, 2022). The crisis has also led to a severe protection crisis, with reports of widespread human rights abuses, including gender-based violence.

Amid the ongoing crisis in Northeast Nigeria, development initiatives have played a crucial role in providing relief and support to the affected communities. These initiatives encompass various efforts, including infrastructure rehabilitation, educational programs, and economic empowerment projects.

DEVELOPMENT INITIATIVES IN NORTHEAST NIGERIA

Northeast Nigeria, which comprised six states – Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe – is an area of complex crisis marked by persistent poverty, food insecurity, and prolonged conflict. This conflict, mainly attributed to the insurgent group Boko Haram, has disrupted social, economic, and political structures, causing massive displacements, loss of lives and property, and extreme human suffering (UNOCHA, 2020). These unique circumstances have triggered many development initiatives to alleviate suffering, reduce poverty, and set the region on a path to recovery and development.

The Nigerian government launched the Presidential Initiative for the North East (PINE) in 2013 to facilitate the reconstruction and development of the region. This comprehensive development initiative aims to rebuild infrastructure, restore public services, revive the economy, and improve security in the insurgency-affected states. However, despite its commendable objectives, the PINE has been criticized for alleged corruption, minimal community involvement, and limited impact on the ground (Adebayo, 2016). Such issues have raised questions about governance and the efficacy of top-down development approaches in such a complex and fluid context.

In addition to national initiatives, Northeast Nigeria has seen an influx of development projects initiated by international organizations. For instance, the United Nations Development Programme (UNDP) introduced the Integrated Community Stabilization Programme in 2017. This project targets communities affected by the Boko Haram insurgency and focuses on enhancing livelihoods, restoring basic services, improving security, and fostering peace (UNDP, 2017). The holistic approach adopted by the UNDP recognizes the interconnectedness of the region's challenges and the need for integrated solutions.

The World Bank and the African Development Bank have also provided substantial funding for various development and recovery projects in Northeast Nigeria. These projects cover a broad range of sectors, including agriculture, infrastructure, health, and education, targeting key vulnerabilities and promoting economic recovery (African Development Bank, 2019; World Bank, 2023). Furthermore, many NGOs have launched initiatives in the region. These organizations, including Mercy Corps, Oxfam, and the Norwegian Refugee Council, are actively involved in providing humanitarian assistance, building resilience, and advocating for the rights of the affected communities (Mercy Corps, 2023; Norwegian Refugee Council, 2023; Oxfam, 2023b).

However, despite these concerted efforts, the region continues to grapple with enormous challenges. The development initiatives have had mixed results, with some achieving moderate successes while others have not fully met their objectives. Factors hindering progress include the ongoing conflict, logistical complexities, endemic corruption, limited capacity of local institutions, and, most importantly, the limited engagement of local communities in these initiatives.

Local community engagement is increasingly recognized as a vital ingredient for the success of development projects. It facilitates tailoring interventions to local needs, enhances ownership, and fosters sustainability. However, it appears that local community engagement in Northeast Nigeria's development initiatives has been less than optimal (International Crisis Group, 2017).

THE IMPORTANCE OF LOCAL COMMUNITY ENGAGEMENT

Local community engagement, often interchangeably used with terms such as public participation, community involvement, or stakeholder engagement, is a process that entails the active participation of community members in the decision-making processes that impact their lives. This concept is deeply rooted in democratic ideals and is increasingly recognized as a crucial component of effective development initiatives (Rong et al., 2023).

Engaging communities is not a novel idea. Traditional societies worldwide have always sought the wisdom of the community in making decisions that affect collective welfare. What is relatively new, however, is the recognition of

this practice's value by modern institutions such as governments, international organizations, and corporations. Today, local community engagement is seen as a principle of good governance and a necessary ingredient for sustainable development (Arnstein, 1969). The importance of local community engagement in development projects cannot be overstated, particularly in fragile and conflict-affected regions such as Northeast Nigeria. Here, it takes on a multidimensional significance.

Firstly, local community engagement helps ensure that the solutions proposed by development projects meet the actual needs of the people they are intended to serve. When people are involved in identifying their issues and proposing solutions, the chances of these interventions being relevant and accepted are much higher (Mansuri & Rao, 2012). For instance, a health project aimed at reducing maternal mortality might be more successful if women from the community are involved in the design and implementation process, as they are best positioned to understand the barriers they face in accessing healthcare services.

Secondly, community engagement enhances the legitimacy and local ownership of development projects. In contexts characterized by conflict and mistrust, such as Northeast Nigeria, it is vital for initiatives to build trust with the communities they serve (OECD, 2018). Engaging communities in the decision-making process enhances transparency, allows for a sense of ownership, and builds trust, thereby increasing the chances of the project's success and sustainability.

Thirdly, community engagement can act as a catalyst for social cohesion and peacebuilding. By involving diverse community groups, including women, youth, and marginalized populations, in development processes, these initiatives can help reduce social tensions, address grievances, and build social capital, essential ingredients for peace and stability (World Bank, 2011). Finally, community engagement is an empowerment process. Community members gain knowledge, skills, and confidence by participating in decisions that affect their lives, which can enhance their capacity to influence future developments in their community and beyond (Cornwall, 2008).

A prime example is the FADAMA project series in Nigeria, which stands out as a pioneering example of community-driven agricultural development, notably in Plateau, Akwa Ibom State, and Niger State. This project revolutionized the sector by decentralizing decision-making and empowering local stakeholders, as seen in FADAMA II. Through structures such as FADAMA User Groups and FADAMA Community Associations, it ensured diverse representation, including farmers, women, and youth, fostering inclusivity and grassroots participation. Coupled with capacity-building and financial empowerment initiatives such as the FADAMA Users Equity Fund, significant increases in incomes and agricultural productivity were achieved, leaving a legacy of good governance and community-driven development (Chakib & Adetunji, 2022).

However, it is crucial to note that while community engagement holds significant potential for improving the outcomes of development projects, it is not a magic bullet. Its effectiveness is contingent upon various factors, including the quality of engagement, the inclusiveness of the process, and the socio-political context. In Northeast Nigeria, the realization of this potential is challenged by various factors, including conflict, insecurity, gender inequality, and socio-cultural norms.

In light of these factors, this study seeks to understand the current state of community engagement in development initiatives in Northeast Nigeria, identify gaps in practice and knowledge, and propose strategies for enhancing local community engagement.

CHALLENGES IN LOCAL COMMUNITY ENGAGEMENT IN NORTHEAST NIGERIA

Achieving effective local community engagement in Northeast Nigeria is akin to navigating a challenging terrain filled with various socio-political, cultural, and economic hurdles. Despite the impressive strides made towards fostering inclusive practices, many roadblocks persistently hinder the integration of local communities into different stages of funded projects, from design to implementation and evaluation.

Arguably, the most formidable barrier is the incessant conflict plaguing the region. This endemic insecurity spawns a volatile and unpredictable environment that disrupts community life, hindering consistent and effective community engagement in development projects (World Bank, 2023). The relentless insurgency by Boko Haram and other armed factions has precipitated widespread displacement and loss of livelihoods, leading to significant social fragmentation. This disruption of community cohesion complicates efforts to mobilize and involve communities in development initiatives. Additionally, the heightened security risks pose a daunting challenge for project personnel, constraining their ability to establish and maintain a continuous, productive presence within the community.

Moreover, deep-seated cultural intricacies also pose substantial obstacles to community engagement. Northeast Nigeria is home to an array of ethnic, religious, and linguistic groups, each possessing unique traditions, norms, power structures, and worldviews. These cultural elements profoundly influence community receptiveness and capacity to participate in development projects and equally impact the project staff's ability to communicate effectively and build robust relationships with the community members (UNDP, 2017). Navigating this cultural labyrinth requires sophisticated, nuanced approaches and a significant investment of time and resources, often scarce in funded initiatives.

The gender dynamics within the region represent another critical concern. Prevailing gender norms and practices often inhibit women's active participation in public life, including their engagement in development projects (Oxfam, 2023a,b). This gender imbalance is not only a breach of women's rights and opportunities but also a critical detriment to the effectiveness of projects. Women often possess unique insights and capacities that, when tapped, can significantly bolster project outcomes.

Several insightful reports and studies elucidate these challenges in practical terms. The World Bank's (2021) evaluation of its various development projects in Northeast Nigeria paints a stark picture of the destructive impacts of regional conflict on community engagement. The report meticulously details how insecurity and displacement disrupted community gatherings, delayed project timelines, and spurred

high staff attrition rates, contributing to substantially eroded community trust and participation.

In contrast, a comprehensive study by the UNDP (2017) sheds light on the cultural impediments to community engagement in the region. The study found that project personnel often grappled with understanding and respecting local customs and languages, leading to frequent misunderstandings and resentment among community members. In addition, the study exposed that traditional power structures often dominated decision-making processes, consequently marginalizing less influential groups, including women and youths.

Oxfam's report (2023a) brings to the fore the gender-related barriers that stifle community engagement in Northeast Nigeria. The report vividly narrates the experiences of women who faced severe constraints to their participation in development projects due to entrenched cultural norms, overwhelming domestic responsibilities, and fear of violence. These women reported a deep-seated sense of being voiceless and disempowered. Their exclusion resulted in development projects missing out on the unique perspectives and skills that these women could have contributed, leading to less effective project outcomes.

The enormity and complexity of these challenges necessitate an even more context-sensitive, flexible, and inclusive approach to local community engagement. Those in charge of project implementation need to comprehend the local conflict dynamics, respect cultural diversities, and promote gender equality earnestly. By embedding these principles in their engagement strategies, we can hope to surmount these barriers and unlock the true potential of local community engagement in the development projects of Northeast Nigeria.

STRATEGIES FOR EFFECTIVE COMMUNITY ENGAGEMENT

The challenges identified underscore the complexity and the criticality of fostering effective community engagement in Northeast Nigeria. Armed with these insights, here are several potential strategies to bolster community engagement, informed by the existing literature, the context-specific hurdles of Northeast Nigeria, and the global best practices.

Cultivating Trust Through Continuous Dialogue

Building trust with communities is foundational to any successful engagement effort (World Bank, 2018). This trust can be nurtured through continuous and respectful dialogue with community members. Regular meetings, town halls, focus groups, and individual interviews can serve as platforms for open communication, where community concerns can be heard, project objectives can be clarified, and collective solutions can be formulated. Such communication channels must be inclusive, ensuring all segments of the community – especially marginalized groups – have an opportunity to voice their thoughts and influence project decisions.

Developing Tailored Participation Mechanisms

While participation is essential, not all participation is equal. Tokenistic or superficial participation can lead to frustration and disengagement (Pretty, 1995). To prevent this, projects need to develop participatory mechanisms that are meaningful and adapted to local realities. This might include forming community steering committees, using participatory planning methodologies, or leveraging traditional decision-making structures. Such mechanisms should be designed collaboratively with community members to ensure their relevance, acceptability, and effectiveness.

Strengthening Capacities for Engagement

For communities to engage effectively, they need the right skills and knowledge. Capacity-building efforts should be a core component of any engagement strategy (UNDP, 2016). This could include workshops on project management, training on specific technical skills, or educational sessions on rights and advocacy. To maximize their impact, these capacity-building efforts should be tailored to community members' learning needs and styles and incorporate local languages and cultural practices.

Mainstreaming Gender Equality

Promoting gender equality should be another key priority. This could involve providing safe spaces for women to participate, giving women leadership roles in project activities, or designing project interventions that address gender-specific needs and challenges (Oxfam, 2023a). Moreover, efforts should be made to engage men and traditional leaders in discussions about gender equality to challenge harmful gender norms and promote more inclusive attitudes and behaviours.

Effective Community Participation in Conflict-Affected Areas

In areas experiencing ongoing conflict, such as Northeast Nigeria, it is crucial to find innovative and adaptable methods to ensure community involvement in project decision-making. Prioritizing safety measures, such as collaborating with local authorities for security, is essential to create secure spaces for dialogue. Trusted intermediaries who are familiar with the local context can facilitate communication and build trust, while incorporating technology such as mobile phones or virtual platforms can overcome logistical challenges and reach isolated communities. It is vital to integrate conflict-sensitive approaches into project design and implementation to mitigate tensions and promote social cohesion. By being flexible and sensitive to the complex dynamics of conflict-affected areas, inclusive community engagement can be achieved, aligning projects with local needs and contributing to sustainable development goals.

Instituting Rigorous Impact Measurement

Lastly, to learn from our efforts and continuously improve our practices, we need to measure the impact of our community engagement strategies (USAID, 2023). This might involve conducting surveys to assess community satisfaction, tracking indicators related to community participation, or using participatory evaluation methods to understand community perspectives on project impacts. These impact measurement efforts should be integrated into the project cycle, informing planning, implementation, and reporting processes.

By adopting these strategies, we can significantly enhance local community engagement in Northeast Nigeria, making our development efforts more inclusive, effective, and sustainable. However, it is important to remember that each

community is unique, and these strategies should be adapted and iterated upon to fit each community's specific context and needs. Only then can we truly realize the transformative potential of community engagement.

CONCLUSION

The journey through the realm of local community engagement in Northeast Nigeria has been rich and revealing. I started with a broad overview of the socio-political and economic landscape of the region, delving into the historical context of funded projects and the role of community engagement within this sphere. As I traversed this landscape, I identified a set of interlocking challenges: socio-political tensions, cultural complexities, and gender disparities, among others, which obstruct effective community engagement.

I then navigated the terra incognita of research gaps in the field. A paucity of knowledge around operational aspects of community participation, capacity-building necessities, gender dynamics, and impact measurement stood starkly apparent. Lastly, I charted potential pathways towards more effective community engagement, underscoring the importance of trust-building, tailored participatory mechanisms, capacity enhancement, gender inclusion, and rigorous impact evaluation.

Yet, the journey is far from over. Each of these topics warrants further exploration and interrogation, and the strategies proposed merely scrape the surface of possibilities. As a global research community, we are only beginning to understand the multifaceted and dynamic nature of community engagement, particularly in contexts as diverse and complex as Northeast Nigeria. There is a pressing need to better understand how local communities in Northeast Nigeria can actively participate in, influence, and benefit from the projects implemented in their localities. This calls for collaborative, participatory, and action-oriented research endeavours that involve local communities at every stage of the research process – from problem definition and data collection to analysis and dissemination.

Equally important is the need to translate this research into practice. Policymakers, practitioners, and project funders need to take note of these research gaps and make concerted efforts to address them. They can do this by investing in capacity-building initiatives, developing more inclusive participation mechanisms, mainstreaming gender equality, and instituting robust systems for impact measurement.

In conclusion, this article reaffirms the power and potential of community engagement in shaping the outcomes of funded projects in Northeast Nigeria. It sheds light on the complexities and nuances of this process, illuminates the gaps in our current knowledge and practice, and offers a vision for a future where community engagement is not just an add-on but a core principle of development practice.

In the end, development is not something that can be done to or for communities; it is something that communities must do for themselves. By engaging local communities in meaningful and empowering ways, we can improve the effectiveness and sustainability of development projects and foster social cohesion, resilience, and self-reliance among community members. To realize this vision, we need to commit ourselves to a journey of continuous learning, reflection, and action. It is a journey that begins with acknowledging and addressing the research gaps that currently exist in the field of community engagement.

CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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REVIEWS

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The mental health of Indigenous Peoples during the COVID-19 pandemic: A scoping review

Sarah J. Ponton*, Mikaela D. Gabriel*, Jay Lu*, Suzanne L. Stewart*, Roy Strebel*, Sabina Mirza*

ABSTRACT

Indigenous Peoples face significant disparities related to mental health and well-being due to colonization and its ongoing impacts, further impacted by COVID-19. Following Arksey and O'Malley's six-stage framework and Bartlett's Indigenous Two-Eyed Seeing approach, a reflexive review of the literature about Indigenous mental health during the pandemic was undertaken. Consultant interviews were also completed, and thematically organized, with Indigenous People from three Indigenous-serving mental health organizations in Ontario. Key themes included: highlighting Indigenous voices, historical context, challenges and strengths in culturally based services, virtual transition, financial support for Indigenous services, health service delivery and well-being, and culture and community connection. The themes bridge gaps in service provision, the mental health impacts of loss of connection with community due to pandemic restrictions, how mental health supports can be improved, and which services provided during the pandemic should continue. This review provides service providers clear recommendations based on the findings to help improve Indigenous mental health and service provision.

Key Words Indigenous wellness; mental health; service provision; Two-Eyed Seeing; COVID-19 pandemic; scoping review.

INTRODUCTION

Achieving mental health and holistic healing is an urgent problem for Indigenous Peoples in Canada. Indigenous Peoples have disproportionately experienced health risks and inequities due to colonization (Allen et al., 2020; Fish, 2019; Mehl-Madrona, 2019), further exacerbated by the COVID-19 pandemic (United Nations, 2021). To advance Indigenous health and wellness, healthcare systems must address the pervasive, systemic barriers that impact the health of Indigenous Peoples. *Shkaakaamikwe gchi twaa miigwewin* (Mother Earth's Gifts) is a national research network for ending Indigenous illness through promotion of Indigenous mental health and healing. Through academic and community partnerships in 20+ sites across Canada (i.e., Ontario, Saskatchewan, Alberta, British Columbia) and international Indigenous communities (i.e., Hawai'i, Australia). These partnerships support a national shift from Western, biomedical-based, crisis-focused models, which perpetuates Indigenous mental illness and unbalance through limited-term interventions and supports.

The goal of this scoping review is to provide an overview of the emerging literature of Indigenous mental health during the COVID-19 pandemic, identify existing gaps, and inform recommendations on how to improve culture-based services during the COVID-19 and potential future pandemics. To meaningfully address the lived realities of Indigenous communities, consultant interviews were conducted with key informants within the Indigenous community of Toronto to explore barriers of well-being, immediate needs, and existing supports contextualizing the provision of culture-based mental health services during the COVID-19 pandemic.

METHODS

This scoping review follows the six-stage framework developed by Arksey and O'Malley (2005) that enables a comprehensive, reflexive review of literature on Indigenous well-being, providing an iterative, non-linear process. This method complements the Two-Eyed Seeing approach, which incorporates the strengths of both Indigenous and Western

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ways of knowing, supported by the Two-Eyed Seeing approach often employed in Indigenous-led, community-based research (Bartlett et al., 2012; Iwama et al., 2009).

Search Strategy

A holistic approach to searching for literature inclusive of peer-reviewed academic articles and grey literature identified relevant literature, and the following databases were searched: (1) Ovid APA PsycInfo, (2) Ovid MEDLINE, (3) Ovid EMBASE, (4) Scopus, and (5) Google Search Engine. For each database, five search terms were used and were restricted by the publication years of 2020–2021 (see Appendix A for Search Terms).

Three inclusion criteria were used for this scoping review: (1) Literature should include a sample of Indigenous People, or be based around a discussion about Indigenous People, in or outside of Canada; (2) Literature was published between 2020 and early 2021; and (3) Literature should discuss overall mental health, experiences providing holistic mental health services during COVID-19. Nine included papers met the inclusion criteria. Based on the research questions, review of the identified articles, and consultant interviews, common themes were found (see Table I), as discussed later (see Results).

Consultation with Experts

To contextualize these findings, three senior leadership Indigenous experts in providing culturally based mental health services for Indigenous People during the COVID-19 pandemic were consulted from three separate organizations based in Ontario (i.e., two Indigenous organizations, and one non-Indigenous organization that provides Indigenous mental health services). Each semi-structured narrative interview was approximately 30 minutes (see Appendix B for Interview Questions). Interviews were transcribed, anonymized, and coded from an Indigenous narrative methodology developed by Stewart (2008) to identify themes. Consultant insights informed the results and recommendations for providing mental health services for Indigenous People during the COVID-19 pandemic.

TABLE I Summary of papers and themes extracted

Author (Date)	Country	Objectives	Services Discussed	Themes			
				Highlighting Indigenous Voices	Historical Context	Challenges in Providing Services	Strengths in Providing Services
Arriagada et al. (2020)	Canada	To discuss the COVID-19 pandemic effect on the mental health of Indigenous People in Canada.	NA		X	X	
Dudgeon et al. (2020)	Australia	To explore the mental health and emotional needs of Indigenous People during COVID-19.	NA	X	X	X	X
Ineese-Nash (2020)	Canada	To discuss the factors that influence the effects of colonization, suicide, and self-harm in Indigenous youth and young adults during COVID-19.	NA	X	X	X	
Júnior et al. (2020)	Brazil	To describe the state of the mental health of Indigenous populations during the COVID-19 pandemic.	NA		X	X	
Tanana (2020)	United States	To explore the connection between the COVID-19 pandemic on the mental and overall health of tribal communities in the United States.	NA	X	X	X	X
Urbatsch & Robledo (2020)	United States	To provide a review of the physical and mental health impacts of COVID-19 in Navajo communities in the United States.	Online power hour	X		X	X
Usher et al. (2020)	Australia	To discuss the ways in which the COVID-19 pandemic reinforces inequities in the provision of mental health services for Indigenous People in Australia.	NA	X	X	X	
Walker et al. (2021)	Australia	To examine if utilizing digital technology could be of use to connect Indigenous youth to their culture, community, and land to support mental health and well-being during COVID-19.	Online mental health resources	X		X	X
Wendt et al. (2021)	United States and Canada	To discuss the disproportionate vulnerabilities facing Indigenous populations in terms of settler-colonial impacts.	Indigenous-serving SUD clinics		X	X	X

SUD = Substance use disorder.

RESULTS

Literature Metathemes

Four metathemes emerged from the scoping review: (1) highlighting Indigenous voices, (2) historical context, (3) challenges in providing culturally based services, and (4) strengths in providing culturally based services.

Highlighting Indigenous voices

This theme included the recognition of authors' identities; cultural affiliation; description of cultural involvement in navigating COVID-19 coping skills and protocols; and the need for cultural practices in navigating a global pandemic. Only two chosen articles were written by Indigenous authors (Ineese-Nash, 2020; Tanana, 2020), two were written by both Indigenous and non-Indigenous authors (Dudgeon et al., 2020; Usher et al., 2020), and the remaining articles were written by non-Indigenous authors. Upon review, stark differences emerged in terms of author orientation, disclosure of tribal affiliation and community identification, narrative voice, personal connection, and discussion of historical context (see Theme: historical context).

This theme supported the need for community and cultural factors to support mental health. Past research promoted Indigenous perspectives as community and culture, treatment (Brady, 1995; Dumont, 2014; Green, 2010; Rowan et al., 2014), and impact of cultural suppression with factors related to autonomous, sovereign Indigenous health management and approaches to wellness (Júnior et al., 2020). Dudgeon et al. (2020) described that Indigenous mental healthcare responses to COVID-19 must include Indigenous perspectives, viewpoints, cultural understanding, and historical factors and be trauma-informed. Walker et al. (2021) also expressed the importance of cultural factors to mental health; Indigenous perspectives in the construction and formation of these services; and the integration of Indigenous values into service delivery (i.e., strength-based; Indigenous responses and knowledge sharing).

Indigenous authors expressed how their tribal identity supported specific narrative approaches and methodologies in the reception and reflection of research and components. Urbatsch and Robledo (2020) described the ways in which Indigenous identity shaped the perspective of COVID-19, with consideration of historical factors that precipitated the severity of COVID-19 in Indigenous communities.

Non-Indigenous authors did not explicitly discuss the value of culture or community unless it was specifically mentioned by the Indigenous People who were interviewed in their articles. Authorship positionalities impact explorations of COVID-19 and existing disparities faced by Indigenous People, particularly the analysis of historical, social, and political factors that directly contribute to Indigenous domains of health and access to services.

Historical context

Indigenous authors contextualized COVID-19 within the ongoing impacts of colonization on Indigenous health disparities and barriers to accessibility of services, as well as the depth and scope of governmental actions that have and continue to contribute to Indigenous health inequities and disparities in mental health service access and use (Arriagada et al., 2020; Júnior et al., 2020; Tanana, 2020); identifying the need for specialized services and training; and pre-pandemic indicators of service use and present service limitations that burdened health systems and their impact on existing mental health rates (Júnior et al., 2020; Wendt et al., 2021). Mental health symptoms connected to colonization include depression, untreated suicide ideation leading to suicide, and substance use (Chandler & Lalonde, 1998; Dudgeon et al., 2020; Ineese-Nash, 2020; Tanana, 2020; Wendt et al., 2021).

In the absence of Indigenous colonial and historical context, less emphasis was placed by authors on Indigenous culture, history, politics, service delivery, and systemic challenges to appropriate care. Wendt et al. (2021) described that telemedicine mental healthcare, specifically for substance use, was previously not approved for substance use treatment; however, this changed in COVID-19 providing improved accessibility of healthcare and support for substance use treatment in remote or smaller communities. This service was not deemed a necessity until COVID-19 left no further alternatives despite pre-existing needs for community members. Historic context offers important gaps to address systemic care barriers for communities.

Strengths and challenges in culturally based services

While virtual connection was necessary for maintaining connection, pandemic protocols challenged Indigenous communities which are generally closer, interdependent, and value collective collaboration (Tanana, 2020). Pandemic protocols and ensuing isolation increased rates of substance use and severity of mental health issues (i.e., anxiety and depression) and noted a severe impact on the physical, mental, and emotional health of global Indigenous communities.

Across articles, Indigenous communities reported strengths in culturally based services to address mental health and addictions. Telehealth services provided increased accessibility to medication that supported opioid addiction treatment alongside traditional healing practices being offered online (Wendt et al., 2021). Hotlines and phone-supported services were found to be most beneficial for older, transitory community members.

The Navajo Nation of Arizona was heavily impacted by COVID-19, and challenged community hopelessness by promoting programs and messages of self-compassion, self-forgiveness, and providing community connection through virtual programs. Mental healthcare services were adapted for three virtual-based interventions: telehealth visits; virtual check-ins; and electronic-visits (e-visits), and this led to the creation of the Indian Health Service (Tanana, 2020).

Dudgeon et al. (2020) provided key insights into how the COVID-19 pandemic impacted the Aboriginal and Torres Strait Islander (ATSI) people and developed recommendations for their physical and mental healthcare. ATSI people were recognized as having been especially impacted by COVID-19 due to systemic and pervasive poverty, poor living conditions, and subsequent impacts to health, and telehealth was ensured for continuation of ATSI health services. Key recommendations from the report were the right to self-determination; creating a strong healthcare workforce; addressing cultural determinants of health, including digital and telehealth; appropriately supporting cultural needs in mental health; and acknowledging data sovereignty (Walker et al., 2021).

With regard to barriers, one of the most significant identified barriers was the lack of appropriate funding, noting the lack of specialized and culturally safe resources for Indigenous People and Indigenous youth (Ineese-Nash, 2020; Júnior et al., 2020; Tanana, 2020; Walker et al., 2021; Wendt et al., 2021), as well as the lack of services offered in other languages. Júnior et al. (2020) discussed that lockdown protocols reduced mental health services, placing a strain on the already overburdened mental healthcare system in Canada. Additional difficulties were in transitioning to virtual service (Tanana, 2020; Walker et al., 2021; Wendt et al., 2021), lack of access to technological devices and internet connection (Dudgeon et al., 2020; Ineese-Nash, 2020; Walker et al., 2021; Wendt et al., 2021), barriers to immediate healthcare interventions (Tanana, 2020), and privacy issues with using virtual mental healthcare (Wendt et al., 2021). Physical isolation of communities was also a barrier (Dudgeon et al., 2020; Júnior et al., 2020) and that isolation and loneliness were still challenges (Ineese-Nash, 2020; Tanana, 2020; Urbatsch & Robledo, 2020; Wendt et al., 2021).

Privacy issues and lack of funding intersected with systemic racism, colonialism, and historical and ongoing trauma that affect Indigenous People in Canada (Arriagada et al., 2020; Dudgeon et al., 2020; Tanana, 2020; Urbatsch & Robledo, 2020; Usher et al., 2020; Walker et al., 2021; Wendt et al., 2021). Due to the historical context of colonialism and lack of funding, Indigenous communities were more vulnerable to poverty, overcrowding, homelessness, and food insecurity; these were acute risk factors that increased vulnerability to COVID-19 because of reduced access to facilities and resources needed to follow public health guidelines (i.e., sanitizing one's environment, inability to isolate). This led to a worsening of mental health over the course of the pandemic as people experienced fears, stress, anxiety, job loss and increased financial burden, and the loss of community members (Arriagada et al., 2020; Júnior et al., 2020; Urbatsch & Robledo, 2020; Walker et al., 2021; Wendt et al., 2021). Indigenous women (Arriagada et al., 2020), Elders (Tanana, 2020), and Indigenous youth (Walker et al., 2021) were identified as being particularly vulnerable to worsening mental health. While the need for mental healthcare dramatically increased over the course of the pandemic, yet the same factors which created conditions that worsened mental health for Indigenous People were also significant barriers to healthcare access and use.

Consultation metathemes

The narrative thematic analysis identified three core metathemes from consultant interviews: (1) virtual transition, (2) financial support for Indigenous services, and (3) health service delivery and well-being (Table II).

Virtual transition

Infrastructure and Capacity: Participants described adapting virtual care delivery with the onset of COVID-19,

> We needed a lot of investment in our information technology infrastructure to be able to facilitate so much remote programming … we invested several hundreds of thousands of dollars into our I.T. infrastructure … just in back-end infrastructure to be able to facilitate the work that was needed and that spans many, many different areas. (Consultant A, p. 4)

Technological investment was required for both community member engagement and staff's remote access. Consultant B described receiving donations of cellphones and laptops,

> We were giving them to women so they could stay connected so we could reach them, make sure they don't slip through the cracks, and we can't locate them. But also, for them to engage in programming ... The laptops went to families a lot for the children, because now they're at home … So, when your children have their own for their own uses, then moms have their own for their own uses and cell phones and connectivity. (Consultant B, p. 4)

Community Consultant C, working from the non-Indigenous organization, described needing to hire additional counsellors due to the increase in Indigenous service use, "from 2020, to '21, we had a 109% increase in Indigenous service use" (Consultant C, p. 3). They noted that there was a 26% increase in mental health support live chat conversations from 2019; 59% increase for texting from 2019; and website usage had an increase of 153%, and remote hires "allowed us to hire more Indigenous People without requiring them to leave their communities" (Consultant C, pp. 3–4). There were accessibility and connectivity barriers in remote Indigenous communities, "a lot of communities are struggling … they don't have the broadband to do that, so we have to deliver it to those communities in audio format. So increased connectivity is – would be incredibly helpful" (Consultant C, p. 5).

Service Accessibility: Online adaptation saw great change to community gathering centres and service delivery, something that was significantly impactful to Indigenous Peoples, "so Indigenous People are relationship people or circle people or face to face people. Right. And so not being able to do a lot

TABLE II Across participant analysis: metathemes and themes

Metatheme	Virtual Transitions	Financial Support for Indigenous Services	Health Service Delivery and Well-being	Culture and Community Connection
Theme	Infrastructure and capacity	Systemic underfunding	Holistic health and well-being	Maintaining culture and community connection
	Service accessibility	Financial flexibility	Mental health	Elder supports and supporting elders
				Service responsivity and relationship to community

of that has created the necessity to pivot and change a lot of the services that we do" (Consultant A, p. 2). Some virtual translations were challenging, "we have a whole suite of services of clinicians that are doing one-to-one, and group mental health supports with families, and … working with youth and younger kids. But we can't really do like play based therapy and things like that. That doesn't really work virtually" (Consultant A, p. 1). Despite such challenges, online services improved accessibility for Indigenous clients outside of the urban centre,

> … people are accessing the programs and the services, the ceremonies, the healers from all over. And there are women who have expressed that they have nothing where they are. And more than ever, they needed ceremony or access to a healer just to have a session. (Consultant B, pp. 2–3)

Virtual expansion offered community connection despite protocols, "So we're working really hard to offer as much programming as possible … just to offer up that sense that you still have, like, your sisters and your representation and that there is access to something if you choose to have it" (Consultant B, p. 3).

Connecting to youth in remote areas was a unique barrier, such as youth privacy in accessing mental health services,

> … kids who don't have access to a device, or who don't have connectivity, have less choices in the way that they reach out, and some don't have any choice in the way they reach out, where they can't. ... Access to privacy, having the space to actually reach out to have a confidential conversation free of stigma. (Consultant C, p. 4)

Consultant C described that, "when live chat wasn't available, the kids ... could only reach out through a landline phone ... – depending on your house, if you have crowded housing, it is difficult to find a private space to have a conversation" (p. 4) Additional resources, such as text support, offered covert and ongoing supports for youth,

> ... kids can do it so inconspicuously. They can be sitting on the couch next to their parents, and be texting ... without the parents knowing, and they can retain the conversation for later. So, if they're reaching out about anxiety, the crisis respondent might go work with them to go over let's say some breathing exercises, something to help calm them down. Next time, when they're not engaged in the conversation, they might be feeling the same way, and they refer back to the conversation that they saved and go through the breathing exercises. (Consultant C, p. 4)

Financial support for Indigenous services

Consultants described the necessity of ongoing, flexible funding to be responsive to their communities, especially in the context of systemic, historical underfunding for Indigenous services.

Systemic Underfunding: Participants described substantial gaps in funding and infrastructure of Indigenous organizations, which posed additional barriers to pivoting to online service delivery, "I think that it's fair to say that Indigenous organizations have been chronically underfunded in many ways for decades. ... I'm not sure if you've ever been properly funded, in fact. ... you don't tend to see Indigenous organizations with state-of-the-art IT systems and updated infrastructure" (Consultant A, p. 4). Investment was not only required due to longstanding systemic factors, but also the need to continue supporting the impact of COVID-19 on clients into the future,

> We've seen an outpouring of money. So, the first year of COVID was great. ... tons of money allocated to support mental health and to support organizations to pivot ... My only concern is, how long will that continue? Because, you know, this is not going away in the fall, in the summer. ... Even if we get every Canadian vaccinated by the end of the calendar year, the mental health crisis is going to last for years, the damage has been done. And so we need steady funding to ensure that these services continue. (Consultant A, p. 5)

Financial Flexibility: Community members had unique accessibility limitations and access, and therefore, services needed to be individually responsive, "And that's why I say like the free, unrestricted dollars that allows agencies to say, OK, none of my family, none of our women, none of our men have devices. How are we going to stay connected? And you would have unrestricted funds to go and purchase these things" (Consultant B, p. 4).

In consideration of future steps, participants endorsed flexibility to support future generations,

> Canada spends about a third less than other countries with our GDP on children and families. We are not investing in our kids and our kids are struggling. I think it's really important for us to recognize as a country that we need to put kids before corporations. We need to invest in those sacred little bundles that come to us from the creator. (Consultant A, p. 5)

Health service delivery and well-being

Holistic Health and Well-being: Participants described the necessity of appreciating mental health within a holistic, Indigenous-based framework,

> I think also from an Indigenous perspective, it's because we think about mental health a little differently. ... our online cultural services also as supporting mental health. So, whereas we have like direct mental health counseling and clinical supports, we also have a lot of online groups that provide parenting support or substance abuse support or, you know, violence against women support or, you know, or just like culture night ceremony language. I feel like all of those also all of those online cultural events that we do are also supporting people's mental health. (Consultant A, p. 1)

Consultant B described holistic approaches as foundational to services,

> … we try to address mental health as a whole, in the person with emotional health, spiritual health, development and growth. A good model, addressing the person as a whole… we have a community wellness worker who will see the whole picture. It's kind of our guiding principle, and that's truly how we're trying to operate. (p. 6)

This theme addresses the holistic efforts of supporting clients, such as curbside delivery of groceries, crafts, and programs,

> We've created like a special gift bag that goes with the hamper. That's like a healthy alternative. So a special bag with a special recipe each week where you can follow the recipe and all your ingredients are in the bag. And we encourage families to do it together or send us pictures of their end product, trying to still build that connection in different ways. (Consultant B, p. 5)

Additional supports for the health and wellness of community members came alongside various supports for children and family units,

> And then one night is for women and the other night it's for children because we wanted to be the children are suffering and they don't always understand complex situations. .... So we created a sharing circle addressing mental health. It's a little bit guided. It's a little bit free with the traditional healers. And through that program, they're also going to be receiving certain gifts and items. So journals for journaling, craft materials, beating stuff. (Consultant B, p. 1)

Consultant B described providing additional supports across areas including legal supports, housing, groceries, childcare, community gathering, cultural practices, and Elder teachings and ceremonies. Programming accessed by women who were navigating housing violence and faced isolation was vital; connection to online programming offered supports for housing, counselling, safety, and community mental health. While mental health was seen as inclusive of holistic health in many Indigenous service approaches, consultants described the significant mental health impacts due to COVID-19 risks, closures, and protocols; a high demand for emergent, flexible, and responsive support arose from the community. However, with high demand came longer waitlists, "For the first time in our 33-year history ... we had waiting lists for our mental health services, and we haven't been able to meet the demand because the pandemic has pushed people in such challenging ways" (Consultant A, p. 1). To address these immediate needs, service providers sought to expand with additional, flexible resources to support their community, "We also last month launched an afterhours mental health support line that's new for [the organization]. … people can call and then have like a crisis clinician help them and de-escalate the situation they may be dealing with and then also refer them to other services" (Consultant A, p. 2).

To address the rise of mental health challenges in the community, Consultant B described creating additional mental health services, such as a weekly group, and an Indigenous clinical therapist. Consultant B described the importance of such supports,

> … But I think when you're thinking about mental health in the community, it's not this it's not that black and white mental health diagnosis … I think that our healers have really seen a value to reach out to folks who have mental health diagnoses, but also who just need stability in their overall wellbeing. It's all sort of circular and tied into each other. What we're trying to do with the traditional healers is, is instead of doing ceremony with community - which we do offer – it's, 'how can we also empower that person to understand a community for themselves?' (p. 6)

Consultant C described teaching mental health skills, the importance of good relationships, and self-care through professional and peer-based counselling supports through virtual methods was important to be flexible in order to meet youths' needs,

> Some kids prefer to use the text-based support even though we're in-person counselling, because they just – it gives them time to kind of put things down, they can do it in the moment. … Other kids are – they don't want to speak with someone that they might know, so they reach out to [organization] because they're confident that what they say to us will remain confidential, and that they're anonymous. (Consultant C, p. 6)

For Indigenous youth accessing mental health services, confidentiality for Indigenous youth is beneficial to avoid discrimination, "Discrimination in the healthcare system is another barrier that, you know, if kids reach out to us anonymously, they know that they're not going to face discrimination because we can't see them" (Consultant C, p. 6). Cultural integration for mental health supports also varies,

> Some kids will want mental health supports that are based in culture ... Some kids might be Indigenous, but they don't identify in that regard, or they feel more comfortable with mainstream supports. So, I say this to put the emphasis on choice, choice in how they reach out, who they reach out to, and the nature of the supports that they receive. (Consultant C, p. 6)

COVID-19 was appreciated as having long-term mental health impacts that would require ongoing supports. Consultant A described, "…we need to understand that mental health is not an isolated issue. ... It's not a siloed endeavor. We need cross sectoral, interdisciplinary, cultural focused investments, and we need them now" (Consultant A, p. 5). Consultant B described the benefit of mental health and ongoing supports both throughout and following COVID-19,

> We are seeing that mental health will become an issue as the pandemic carries on and post recovery. And that's why we try to create the sharing circles and provide people with tools so that we're a bit of ahead of the game in the sense that it doesn't have such a bad impact as we progress through the through the pandemic. (p. 6)

Large-scale holistic supports were also recommended to addressing youth mental health and well-being,

> I think we need a national strategy for children's mental health and wellness. … I think that needs to be attached to a national funding formula that flows through transfer agreements to particular provinces. And there needs to be an Indigenous scope within the context of that. I think that we need some type of a federal office focused on the wellness of children that is connected to provincial counterparts. (Consultant A, p. 6)

Culture and community connection

Maintaining Culture and Community Connection: Participants described the importance of cultural connection and land-based healing for balancing health,

> It's sort of bringing that reconnection back to culture because we think that that's going to be where people find their grounding. When things get overwhelming, we're going to be giving out drums or drum kits, rattles for children, all of these sort of traditional tools that we know is useful in difficult times and in positive times. (Consultant B, p. 1)

Land connection was seen as especially important while coping with the impacts of COVID-19,

> And I think that's really important because as Indigenous People, we know that land is an important part of holistic wellness. ....getting out on the land, you know, in a city like Toronto is amazingly restorative. And so we're also providing those opportunities as well. (Consultant A, pp. 1–2)

COVID-19 limited land-based gatherings and ceremonies, pushing service providers to increase virtual programming. Cultural programming promoted much more than just traditional practices, "…while beading may seem like it's just beading, it's actually reconnecting women back to a traditional craft. And then how do we build off of that to further stabilize their situation?" (Consultant B, p. 5). Community connection helped people connect to additional supports,

> If you're an Indigenous woman facing violence or harassment, I think those safe outlets and assurance that something is there is going to make a big difference. Simple engagement through something online could mean that maybe they engage in all the different programs, and then they seek further support, and maybe they work with the case manager, and they see they see a counselor, and start that healing journey. (Consultant B, p. 3)

Consultant B described the initial stages of virtual community programming to support wellness (i.e., affirmations, journaling, and traditional crafts), family supports (i.e., children, family care), and expanded spiritual supports (i.e., medicines, teachings). The virtual transition to ceremonies was met with mixed responses from community members,

> ...there was some feedback that was not in favor of us sort of moving to virtual platforms for different ceremonies and services. But. With saying that we sort of put out a response that right now is the time where community and Indigenous women are going to be isolated more than ever, and to withdraw those types of services would do more harm than not. (p. 2)

Consultant B reported on the importance of community gathering, and the role of the organization to provide materials, such as medicines, and skills in ceremony to cope with life stressors,

> … having those tools, those drums, the rattles, knowing how to do a full moon ceremony on your own in your home, those are going to be the tools that are going to keep us grounded and hopefully ... lessen stress, lessen anxiety ... we're trying to provide the reminder of where we come from and your ability to connect on your own, so that when you're faced with difficult days, you have your tool kit to ground yourself and have your connection and your identity that keeps us strong and that heals us along the way. (Consultant B, p. 3)

All consultants described the risk of homelessness or experiencing domestic violence required more community connection and support than ever when exploring pathways to stability and security.

Elder Supports and Supporting Elders: Virtual ceremonies were provided on a frequent basis, as well as in individual meetings with clients to support well-being. Consultant A described new cultural supports through programming, such as Elder daily openings through social media,

> … morning prayer and talk about the day. And more and more, community members are logging on to that. And it's a way that they can connect to an Elder and feel supported, connected to community from wherever they are. … the audience for that has expanded to beyond Toronto. So, we are reaching people that we never reached before through our face-to-face stuff, because now somebody in Moose Factory or Moosanee or wherever else can log on. And so, we are able to see that we're reaching broader people. (Consultant A, p. 2)

Virtual platforms have also supported Elders who may have mobility issues,

> …some [Elders] are just old school in their protocol and don't really feel like that's what they should be doing, but do it because they need to support community, but would prefer not to. We have others who have blossomed. We have some Elders who have mobility issues ... it would be really hard for them to get out to community because moving around is hard for them or painful for them. I've heard commentary from Elders and keepers that are like, wow, it's way easier. I can reach way more people. (Consultant A, p. 3)

Elders were able to conduct ceremony with an audience from across Turtle Island. To accommodate Elder connection for community members, new services were created,

> Women can call and get direct access to Elders of the community or seek certain staff in the agency or seek out relocation support. That was a direct response to the first wave of the pandemic and any mental health, because they could call it to speak to an Elder in the moment ... But it also gave the Elders an opportunity to give back and continue working and giving, continuing to offer up what they offer up. (Consultant B, p. 6)

Service Responsivity and Relationship to Community: Services needed to be responsive, available, and expanded to community needs. Participants described working closely with their communities to find how to best reach community members coping with losses and crises concurrent with COVID-19,

> COVID has been a horrible time of community loss. So many community members are dying. It's rough, whether it's the opioid crisis, or family violence, or suicide, or whatever else. We're still having sacred fires for people, right. We're still able to, in a safe way, have a sacred fire with fire keepers and distance and take care of that ceremony in a good way. So I think it is important to say that we are still doing face to face stuff when it's absolutely needed. But we've also been able to innovate, to do things are aligned like never before to support community that way. (Consultant A, p. 4).

Consultant B further elaborated on the need to support community members across all pathways, "in all pockets of the community, we just wanted folks to feel like they had access to items or supports. Their various needs ... basic needs, mental health, spiritual needs, they were all being met, and we hope to continue and to ensure that community feels heard and served" (p. 7). However, understanding and listening to communities required existing relationships to better understand unique community needs, "it's different for every community, so those contacts will help us understand, you know, what are the best messages, what are the best communication channels to reach those youth, and also reach out to us in times of crisis?" (Consultant C, p. 2); however, these relationships need long-term establishment and connection, "we want to ensure that we have relationships in place with communities before they're in a state of crisis, so they can reach out to us if they want our support" (Consultant C, p. 2). Community support and responsivity (i.e., ensuring community connection; evaluation; addressing spiritual needs) included the importance of having broad, accessible services, so that children and youth have options in terms of engagement due to the danger and high risk of community disconnection.

DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

The COVID-19 pandemic had a tremendous impact on culturally based services. This scoping review found that during the pandemic, mental health services for Indigenous Peoples transitioned to a virtual format to reach community members. However, Indigenous cultures, communities, and methods are relational and experiential; therefore, the virtual format was often limiting the profound strength found in culturally based methods. The core values of many Indigenous communities and traditional practices required community gathering, connection, and ceremonial attendance, all of which were significantly impacted. Isolation and community disconnection had detrimental effects on the mental health of Indigenous community members; it became crucial that service providers assisted in cultural engagement through virtual platforms. Feelings of isolation were combatted by virtual streams, which sought to bring healing and wellness to Indigenous People (Urbatsch & Robledo, 2020). However, this required adaptation that challenged some traditional protocols, a challenging decision that hoped to increase accessibility and reach to promote ceremonial and cultural connection across Canada, particularly in remote areas where local access to ceremony was lacking or unavailable.

Importantly, the COVID-19 pandemic also marks a spiritual or thematic parallel to the cultural restrictions and isolation imposed during colonization. These restrictions are akin to a spiritual wounding in the foundations that maintain community strength and wellness, one that necessitates further ceremonial involvement for healing, supporting, and addressing the impacts of COVID-19 on Indigenous communities.

The scoping review and key informant interviews discovered a host of barriers to mental health service provision and online translation; most notable were the lack of funding for culturally based mental health services and pervasive lack of funding in support of Indigenous communities. Several papers included in this review identified the lack of specialized mental health services (Ineese-Nash, 2020; Júnior et al., 2020; Tanana, 2020; Wendt et al., 2021) and discussed how this was partially due to the lack of mental healthcare in Canada (Júnior et al., 2020), further exacerbated over the COVID-19 pandemic.

The consultants, resources, and literature at the time of this scoping review described overcoming technology barriers (i.e., maintaining ongoing internet connection) and access to digital devices (e.g., smartphones, computers, and laptops) were necessary for accessing programming and digital mental healthcare. Technology barriers were systemic, engendered from Indigenous poverty in remote and reserve communities, insecure and overcrowded housing, and especially challenging for those community members experiencing homelessness. Service providers, then, become unfairly responsible for addressing systemic gaps in technology accessibility due to poverty and infrastructure in Indigenous communities and must apply funding to ensure that devices are provided for consistent, stable access to community members and continue care. However, staff loss over the course of the pandemic increased burdens and overworked remaining workers, greatly impacting the availability and quality of care their clients receive.

Limitations of this review include the number of articles included. Even with a wide search of multiple databases, articles may have been missed, especially relevant grey literature studies which were not included in academic

literature databases. Despite this limitation, the findings from assessing the current literature and the key informant interviews provide important clinical significance regarding community-based mental health support and concrete ways for Indigenous mental health supports to improve their services during a pandemic by highlighting the current gaps in service provision and the resources needed to deliver services in an accessible way.

Increasing funding for Indigenous services is a core recommendation based on the results of the scoping review. Increased resources can improve ongoing services, technological infrastructure, and service capacity. Most Indigenous programs are funded by various levels of settler governments; holding government accountable and demanding policy change are needed.

Second, Indigenous communities need to have more sovereignty over their mental health services. This review found that Indigenous community-based knowledge and working with Elders and community leaders were embedded in programs and services that were successful in supporting peoples' mental health. Indigenous-driven, created, and delivered services only seem to happen with Indigenous communities in charge of their own services.

A final recommendation is that cultural safety be centred in the development and delivery of Indigenous mental health services. It is clear from the results of the review that the ongoing process of systemic colonial harms on Indigenous Peoples continues to pervade mental health services. These harms of racism and discrimination exacerbate risks and health barriers and increase concern for more significant negative mental health outcomes during a pandemic. Additionally, services that focus on strengths (such as culture, spirit, ceremony, and creativity) of Indigenous Peoples can provide resistance to these harms.

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CONFLICTS OF INTEREST DISCLOSURE

The authors have no conflicts of interest to declare.

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APPENDIX A

Search Terms Used

1. "Indigenous mental health services" + "COVID-19"
2. "Indigenous mental health" + "COVID-19"
3. "Virtual mental health services" + "Indigenous Peoples" + "COVID-19"
4. "Telehealth" + "Mental Health" + "Indigenous Peoples"
5. "Digital mental health services" + "Indigenous Peoples"

APPENDIX B

Consultant Interview Questions

The Network Environments for Indigenous Health Research

Shkaakaamikwe gchi twaa miigwewin (Mother Earth's Gift): A national network for ending Indigenous illness and promoting Indigenous mental health and healing

Consultation Questions

1. What virtual mental health services are available for your organization's clients during the pandemic?
2. How has the pandemic affected how your organization provides culturally based services? What have been the challenges and benefits?
3. What resources are needed to provide your organization's services during the pandemic?
4. Is there anything you think is important about mental health services during the pandemic in terms of program and policy?

SOCIAL INNOVATION NARRATIVE

Journal of
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Multi-agency safeguarding: From everyone's responsibility to a collective responsibility

Emma Jayne Ball*, Jessica Devon McElwee*, Michelle Ann McManus*

ABSTRACT

Multi-agency collaboration (also termed inter-professional, inter-agency, and multi-sector) between agencies and practitioners has been established as a valuable way of working in safeguarding, to protect people from harm. Whilst multi-agency working is mandated in legislation, policy, and guidance, there are challenges in its implementation. Research has not only highlighted many benefits of multi-agency working, for example, sharing resources and expertise, but also key barriers, including uncertainty of agency roles, remits, and responsibilities. Ongoing challenges, such as information sharing in an appropriate and timely manner, are often cited within various serious practice reviews and inspections. However, what is less explored and understood is how we know and evidence if our multi-agency safeguarding arrangements are effective. This article summarizes the multi-agency safeguarding landscape and highlights an urgent need for the development of a framework that identifies key components to evidence effectiveness. This framework should seek to define, identify, monitor, and review factors that enable effective multi-agency partnership working. In doing so, we argue that the evidence of practice needs to build on safeguarding being "everyone's responsibility" towards establishing a "collective responsibility." This is the first of the two papers mapping developmental journey of "The Collective Safeguarding Responsibility Model: 12Cs".

Key Words Multi-agency; safeguarding; collaboration; multi-sector; inter-professional; inter-agency; effectiveness; collective.

INTRODUCTION

Safeguarding has been defined as "protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse and neglect" (Care Quality Commission, 2022). Whilst this definition can vary across organizations, sectors, and countries, the premise of protecting people from harm is fairly consistent. There is also a general consensus that this cannot be achieved by any one person or organization. Safeguarding requires a multi-agency and collaborative approach within adults (Stevens, 2013) and children (Gray, 2015; Stanley, 2018), with multi-agency working argued as being the "cornerstone of effective child safeguarding" (Dixon et al., 2022, p. 438). There is an abundance of literature over the past three decades detailing the benefits and challenges of multi-agency safeguarding, yet far less evidence to understand how this is successfully translated into practice and how we are assured that the multi-agency safeguarding arrangements are effective.

Multi-agency Legislation, Policy, and Guidance

The strategic commitment to multi-agency safeguarding is evident at the legislative policy level. The United Nations Convention on the Rights of the Child states in Article 19 that "The state must do all it can to protect children from violence, abuse, neglect, bad treatment or exploitation by their parents or anyone else who looks after them" (Save the Children, n.d.). The European Commission Directorate-General Justice and Consumers (2015) advocates for an integrated child protection system whereby services can work together coherently through a multi-disciplinary, cross-sectorial, and inter-agency approach. Within the United Kingdom, the establishment of The Children Act 1989 initiated the statutory requirement for joint working between professionals and inter-agency collaboration (Cheminais, 2009). The Children Act 2004 strengthens the commitment to partnership working by creating a duty for local authorities to coordinate key agencies to improve the well-being of children. Guidance specifically related to multi-agency working in safeguarding was issued in the publication

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of Working Together to Safeguard Children (Department of Health, 1999) and was most recently revised in 2023 (HM Government, 2023). This guidance asserts the importance of all agencies playing a key role in fulfilling their safeguarding responsibilities and how this is a shared endeavour. Regarding adults, the Department of Health (2000) notes that safeguarding adults requires "partnership working between statutory agencies to create a framework of inter-agency arrangements" (p. 14). This was mandated in The Care Act 2014, stipulating that local authorities must take the lead for a multi-agency local adult safeguarding system, aiming to prevent and swiftly stop abuse and neglect (Social Care Institute for Excellence, n.d.).

Multi-agency Safeguarding Models

Whilst there is policy, guidance, and legislation to promote and, indeed, mandate multi-agency safeguarding, the governance, structures and models in facilitating this are often varied and complex (Lane et al., 2016; Madembo, 2015; McManus & Boulton, 2020). Operationally, there are numerous models and approaches designed to facilitate partnership working between sectors, with the collective aim of safeguarding those at risk of harm. Within England, one of the most established models of multi-agency safeguarding is referred to as the Multi-Agency Safeguarding Hub (MASH). The MASH can be in place for adults, children, or both, and aims to improve the safeguarding response for children and adults at risk, through better information sharing and a timely safeguarding response (Home Office, 2014). The core functions of the MASH include the following:

1. Acting as a single point of entry by gathering all notifications related to safeguarding in one place.
2. Enabling thorough research of each case to identify and address risk.
3. Sharing information between agencies supported by a joint information sharing protocol.
4. Triaging referrals, exemplified in the use of agreed risk ratings.
5. Facilitating early safeguarding intervention and prevention.
6. Managing cases through co-ordinated interventions (Home Office, 2014, p. 9).

An example of a multi-agency model in Canada is the Child and Youth Advocacy Centres, which facilitate collaboration between law enforcement, child protection, medical and mental health professionals, and victim advocates, as part of a multi-disciplinary team (Government of Canada, 2023). This collaboration takes place within a child-friendly facility where children, youth, and their families can receive a personalized, co-ordinated, and comprehensive response to child abuse. In Australia, there have been innovative examples of multi-agency working for adult safeguarding through a health-justice model, whereby a lawyer is placed within a health setting who can respond to abuse referrals (Chesterman, 2020). The key objective is to work together to address a variety of issues to reduce the risk of harm.

Benefits of Multi-agency Safeguarding

The benefits of multi-agency working have shown that when organizations work together, they can deliver on values and outcomes, which would be more challenging to deliver individually, by combining resources, expertise, and ideas across agencies (Local Government Agency, 2008). Although there is no agreed set framework for implementing effective multi-agency working internationally, a systematic narrative review of studies from the United States, United Kingdom, Israel, Canada, and Norway has established consistent factors which enhance multi-agency collaborative working. These included standardized procedures and decision-making tools, leadership, multi-agency meetings, and training (Alfandari & Taylor, 2022). Atkinson et al. (2007) noted several positive impacts on multi-agency safeguarding professionals such as taking on new job responsibilities, increasing professional development, and overall job satisfaction. In addition, it is suggested that working in a multi-agency partnership allows for a greater understanding of partner agencies' roles, and cross-disciplinary issues. Furthermore, increased communication and approachability between agencies has been noted to improve information and data sharing, with resources being shared more efficiently (Atkinson et al., 2007). When reflecting on working within a MASH, Shorrock et al. (2019a) detailed practitioner's perspectives which noted that trust between agencies had increased, in addition to facilitating a better understanding of different agency roles and responsibilities. A study in Norway by Jakobsen and Filstad (2020) explored multi-agency collaboration between child welfare services and the police. They found that when working toward the best interests of the child, in relation to domestic abuse, there was improved communication. This allowed for an increased understanding and respect of each other's tasks, procedures, and timelines, enabling collaborative problem-solving.

It is also crucial to understand the perspectives of the people who experience multi-agency safeguarding support and responses. Harris and Allen (2011) explored the perspectives of young people receiving multi-agency support and found that multi-agency work can help to reach children and young people within contexts of risk and vulnerability. The young people perceived multi-agency working to improve behaviour, well-being and confidence, and engagement with learning. Additionally, a survey exploring adults' experiences of safeguarding showed that 53% of respondents felt that agencies worked together to make things (safeguarding experiences) better, such as police and social workers. In addition, 56% felt listened to by services, although a further 20% felt that while they were listened to, their views did not affect safeguarding decisions (Montgomery et al., 2017).

Barriers to Multi-agency Safeguarding

An effective and efficient partnership requires professionals to work across their traditional boundaries, modifying their roles and responsibilities to meet the demands of integrated working (Abbott et al., 2005). However, this requires time, commitment, and investment and, whilst professionals can have known, defined roles, it is harder to motivate individuals to function as an effective team (Feng et al., 2010). Agency workers, for example, have been reported to work less collaboratively, with a preference to work in their professional silos, and as a result, effective multi-agency partnership working can be compromised (Lalani & Marshall, 2020). As many agencies are often involved with the safeguarding process, there is a possibility for disconnect across different

structures, processes, and systems. Moreover, the fragmentation of services can result in silo working *within* as well as between agencies (Brandon et al., 2020). From a practitioner's perspective, professionals can lack the understanding and confidence in fulfilling the duty to share information with other agencies (Rees et al., 2021a). This is also impacted by the implementation of the General Data Protection Regulation and the associated Data Protection Act (2018), which has arguably increased confusion and anxiety among safeguarding practitioners, who may feel anxious to share information due to the fear of inappropriate information sharing (Rees et al., 2021b). Whilst co-location of practitioners across agencies is seen to increase positive relationships, it does not automatically result in an effective multi-agency approach to safeguarding. Rather, for a multi-agency partnership to be successful, consistent practices and processes need to be embedded into daily practices and regularly reviewed (Shorrock et al., 2019b).

Ongoing Challenges in Moving toward a Collective Safeguarding Responsibility

There is undoubtedly a dedicated, hardworking, and skilled workforce of safeguarding practitioners who work tirelessly to support children, adults, and families. There is also a plethora of legislation, guidance, and research advocating for the use of multi-agency working in relation to safeguarding, in addition to many examples of good practice and promising progress (Ball & McManus, 2023; Care Inspectorate Wales, 2023; Government of Canada, 2023; McManus et al., 2022, 2023). However, recent reports suggest continued challenges in multi-agency safeguarding and reoccurring thematic areas of concern regarding effective collaboration. A fundamental challenge is notably how all agencies can implement and take action on a ***collective responsibility*** for safeguarding.

A key forum whereby multi-agency practice is explored, reviewed, and analyzed to enhance greater learning is after a child or an adult has been seriously injured or died, such as within England's local Child Safeguarding Practice Reviews or Adult Practice Reviews. A recent review of Child Practice Reviews in Wales conducted by McManus et al. (2023) highlighted that poor information sharing between agencies remains a long-standing issue, and that the infrastructure in place for agencies to routinely share information is often unclear, as is accountability for coordinating this information. Similarly, a publication from Child Family Community Australia states that many practitioners "simply do not work in ideal collaborative environments, and are left to navigate the 'street-level' complexities of imperfect systems with little explicit training or advice" (Price-Robertson et al., 2020, p. 5). Within Canada, it was observed that while there are avenues which exist for professionals to share information, there continues to be barriers to information sharing, in addition to limited consultation or collaboration (Ministry of Community and Social Services, 2021).

Working in partnership with those requiring safeguarding support is also an area of ongoing challenge. Legislation prescribes that agencies should work in partnership with children, adults, and families who are receiving safeguarding support and ensure their voices are heard; however, the voices of children and young people are not always effectively captured, recorded, or utilized (McManus et al., 2023). Assessing risk and ensuring partnership working with adults who access safeguarding support are also challenges, and Stevens (2013) advised that multi-agency partnerships must continue to balance elements of risks with empowering those who access services, as these individuals retain the right to make their decisions, which do not necessarily indicate a lack of capacity. Whilst there will be many examples of good practice in this area, it remains inconsistent.

Ofsted (2023) reviewed the practices and effectiveness of multi-agency working arrangements for children and families who require help. It was found that whilst there were practitioners who were well-trained, knowledgeable, and undertaking effective work, this was again inconsistent. They also highlighted weaknesses such as ineffective oversight of early help and a lack of multi-agency working. Similarly, Child Family Community Australia argues that there is often poor communication between child protection, and child and family welfare services (Price-Robertson et al., 2020). They also make the distinction between practitioner-level barriers, such as shared understanding, and system-level barriers, such as the lack of resources. In the United Kingdom, the publication of Stable Homes, Built on Love: Implementation Strategy and Consultation (Department for Education, 2023) identified the need for much improved multi-agency working, and increased accountability for how practitioners and agencies are working together and the impact this makes, thus echoing previously identified challenges.

Multi-agency Safeguarding Effectiveness: What Next?

McGuire et al. (2021) reviewed empirical studies to ascertain the effectiveness of community-based multi-agency safeguarding of vulnerable adults. They concluded that no studies were found which could provide a clear indication of the most effective way to safeguard adults at risk. Writing on behalf of Ofsted, Stanley (2018) noted the importance of multi-agency audits but argued that the quality was highly variable and the impact was not always clear. Additionally, not all safeguarding partnerships involved service users to feedback into audits, limiting the overall understanding of their effectiveness.

Whilst progress has been made in multi-agency safeguarding practice, The Child Safeguarding Practice Review Panel (2024) highlights, "Silo working in individual agencies at times led to missed opportunities for partnership relationship building and more effective co-ordinated multi-agency responses" (p. 11). There are continual challenges experienced by practitioners and across the structures and systems within agencies. Resources, funding, and investment within safeguarding services are undoubtedly the biggest barriers when it comes to implementing lessons learned. The issue of recruitment and retention of experienced safeguarding practitioners across sectors is widely reported (Hall, 2023; New Brunswick Association of Social Workers, 2022; Ratwatte, 2023), often alongside reports of increasing demand and complexity in safeguarding concerns, resulting in an insufficient capacity to respond (Koutsounia, 2024).

CONCLUSIONS

Agencies are reliant upon a collaborative approach to fulfill their collective safeguarding obligations, but there is substantial variability of enactment across practice. Whilst variation

is both inevitable and necessary to respond to different environments, there is an urgent need to identify and understand effectiveness coherently and consistently through an agreed multi-agency framework. This framework should seek to define, identify, monitor, and review multi-agency policies and interventions that are put in place by partnerships and organizations. From this, good practice should be extracted to maximize learning, in addition to the identification of challenges and how these are best addressed. As Dixon et al. (2022) observe, it is imperative to review and understand which structural factors and processes can create potential barriers, and where there are areas of divergence and cohesion. Safeguarding is complex, onerous, and dynamic; therefore, understanding the impact of safeguarding activity requires a framework that can demonstrate the enactment of multi-agency safeguarding. The creation of a multi-agency collective safeguarding framework should identify key collaborators, ensure accountability within the system, and ultimately create a collective responsibility for safeguarding.

Furthermore, our research has identified that we must progress and build on the notion that safeguarding is "everyone's responsibility," which inadvertently may encourage individual decision-making. A move towards a "*collective responsibility*," ensures that responsibility holistically addresses the needs and risks across individuals, their families, and their environments and crucially that allows for an accurate understanding of the daily lived experience for those at risk of harm. This paper highlights the abundance of evidence calling for a framework to be developed to help multi-agency safeguarding arrangements understand if and how we are effective, with our follow-up paper introducing The Collective Safeguarding Responsibility Model: 12Cs.

CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

DETAILS OF POSSIBLE PREVIOUS OR DUPLICATE PUBLICATION

Some of this work summarizes reports completed by the authors and available from the National Independent Safeguarding Board Wales.

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"Client health is part of my job": A qualitative study of attitudes and experiences of legal personnel in British Columbia's Downtown Community Court

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ABSTRACT

Established in Vancouver in 2008, British Columbia's Downtown Community Court (DCC) is Canada's first community court. Set up specifically to address offences stemming from mental illness, substance use and poverty, the court brings together justice, health and social services, offering a tailored response to the cycle of reoffending and public safety concerns in the city's core. Focusing on the perspectives of legal actors, we examine the court as an unexpected site of health intervention. This qualitative interview-based study explores how judges, crown counsels and defence lawyers perceive their role and that of the court in relation to the health and wellbeing of court clients. Our findings show that legal personnel typically see health as a central part of the court's intervention and similarly view client health as a critical part of their own jobs. Respondents describe the court's ability to engage with those facing complex health and legal issues as unique, attributing it to its legal professionals' holistic view of their roles, the court's strategic community location and its unusual structure, which facilitates information sharing and attracts personnel invested in its mandate. The article identifies three primary needs: 1) enhanced education on client health for legal professionals, 2) nuanced metrics to evaluate the court's health impacts and, 3) longitudinal client-centred research to measure the DCC's long-term effects on health.

Key Words Criminal justice system; problem-solving courts; therapeutic courts; community courts; Downtown Community Court; therapeutic justice; health; repeat offending.

INTRODUCTION

In 2008, British Columbia created the Downtown Community Court (DCC) in Vancouver. The DCC is an innovative court intended to address repeat offending that is rooted in mental illness, substance use, homelessness and poverty. Housing justice, health and social service agencies in one location, the DCC is able to coordinate individualized intervention plans to address the complex health and social circumstances that lead to chronic reoffending. Consequently, the DCC contributes to improved health of those who come before the DCC ("clients") alongside ameliorations in community safety.

The DCC holds jurisdiction over criminal cases in Vancouver's Downtown Eastside (DTES). When someone is arrested in the area, in lieu of undergoing a traditional trial they can opt to plead guilty, come before a DCC judge, and engage with the DCC team. The court tailors sentences, ranging from community service to incarceration, based on the severity of the offence, the individual's risk of reoffending, and individual circumstances. Sentences are paired with personalized plans addressing each client's reoffending risk and specific health and social needs. Plans may include health treatment strategies, links to cultural services, addiction resources, or referrals for housing and income support. For serious cases involving mental illness or severe drug use, the DCC's case management team oversees detailed intervention and monitoring.

Although health and wellbeing are central to the court's history and design, scant attention has been paid to the court's work in this area. Focusing on the perspectives of legal

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actors, we examine the court as an unexpected site of health intervention viewing legal personnel as health advocates. Drawing on interviews with a representative sample of DCC judges, crown counsels and defence counsels, we offer insight into how legal actors understand their role and that of the court with respect to client health and wellbeing. We explore attitudes, actions and practices of legal actors in relation to client health to gain a better understanding of the formal, informal and attitudinal structures that support the court's interventions on client health. Our study indicates a much broader perceived role and scope of intervention than that suggested by either existing literature or legal training. Legal personnel typically see improving health as a central part of the court's work and view it as a critical part of their own jobs. Respondents attribute the court's ability to engage with those facing complex health and legal issues to the court's strategic community location and to the court's unusual structure, which facilitates information sharing and attracts personnel who are particularly invested in its mandate. The article identifies three primary needs: 1) enhanced education on client health for legal professionals, 2) nuanced metrics to evaluate the court's health impacts and, 3) longitudinal client-centred research to measure the DCC's long-term effects on health.

METHODOLOGY

Semi-structured qualitative interviews were conducted via Zoom or telephone with a representative sample of current and past DCC legal professionals (five defence counsels, four crown counsels, two judges)[1] between August and November 2020. This methodological approach was most appropriate as we were investigating a new area without a solid existing knowledge base. We consequently sought a method that would enable us to explore personal opinions and experiences in detail with the flexibility to follow up, switch the question sequence if needed and, probe for additional detail (Jamshed, 2014). Our open-ended interview questions focused on participants' understanding of their own professional roles within the DCC with respect to client health and wellbeing, and their understanding of the court's role and function in relation to client health and wellbeing. Interviews were audio recorded, manually transcribed verbatim with identifying details removed and checked for accuracy by two team members. Our multi-disciplinary research team engaged in a collaborative data analysis retreat during which we identified emergent themes from the transcripts alongside *a priori* themes from relevant literature (Elliott, 2018). We subsequently applied these thematic codes to the transcripts, using them to sort and categorize data (Gibbs, 2018). Preliminary findings were shared in a draft report and an in-person presentation with court personnel (including DCC staff, judges, crown counsels and defence counsels) in Vancouver in November 2022. At the time, we invited and received feedback on the accuracy and relevance of our results.

[1]In this study, we drew from both current and past DCC legal professionals and did not distinguish between the two to maintain confidentiality. For context, the total current number of legal personnel currently based at the DCC is two judges, two prosecutors and two in-house lawyers. Additionally, any duly licensed criminal lawyer is in theory eligible to represent clients at the DCC.

RESULTS

While formal education or training related to health was rare, respondents largely considered addressing client health to be both part of their job and an important role of the DCC. Judges reported that they constantly considered client health and wellbeing as they carried out their duties. One judge explained that the aim was to "build a plan that restores somebody's personal situation whether that's the health, mental health, dealing with addiction, whatever needs to be addressed." Defence counsels saw one of their primary roles as a go-between, where they helped translate client needs to DCC teams and necessary services. Defence counsels described their roles as "no different" from those in a traditional court, where they would also seek to connect clients to health and wellbeing services, usually in a bid to stay proceedings and minimize jail sentences. However, four of five defence counsels noted that this "connecting" work was easier at the DCC than at the provincial courts due to the DCC's structural set-up and information-sharing culture. Crown counsels listed health and wellbeing as aspects of their professional role. This included, for example, consideration of health and wellbeing at bail and sentencing, as well as provision of information about services and options, and helping connect clients to those resources. Despite the acknowledgement that advancing client health and wellbeing were key components of their role, respondents overwhelmingly also understood their roles within traditional legal definitions and saw the need to frame or justify health and wellbeing within these parameters (i.e., addressing health concerns helps improve community safety and reduce recidivism). One prosecutor explained:

> It's clear that if a person is stabilized in terms of housing, in terms of jurisdiction, in terms of mental health, in terms of the physical health, and if health is linked to curbing re-offending, then obviously as a prosecutor, it was in the public's interest for me to consider ensuring that that person was supported in a way that their health was taken care.

When discussing what factors enabled the DCC to address client health and wellbeing, respondents emphasized the DCC's geographic location, co-located services, courtroom design and inter-professional relationships. A respondent noted, "the primary difference is the neighborhood that [the DCC is] situated in, and that the court possibly uniquely or unprecedently recognized that the neighborhood it was in required a different type of service." Being in the DTES meant that clients were being served in a familiar part of town, and the court's physical contextualization in the neighbourhood meant that all those working in the court were immersed in the DTES and regularly exposed to and familiar with the neighbourhood's characteristics, services and challenges. The court's location also facilitated access to and collaboration with relevant social organizations that DCC clients are familiar with, which in turn facilitates health and wellbeing interventions.

Co-located services were described as facilitating easy access to information, referrals, increased understanding of and respect for each other's roles, trust and relationship

building. One respondent explained, "in traditional criminal court, we don't have as many tools as Downtown Community Court does because of the wraparound services that actually exist in Downtown Community Court." The comprehensiveness of the wraparound services available at the DCC was noted by participants from all response groups. One respondent explained:

> You have a member of the Vancouver Police department that is permanently assigned. You have forensics workers; sometimes nurses, sometimes social workers, some from forensics BC. You also have Vancouver probation or community corrections which is also on-site and present … these people are permanently assigned to that court. Now these agencies all exist at [the traditional court], but they're not co-located … if you wanted an update from a bail supervisor, or from forensics on someone, you would have to go through a number of different channels to be able to get that information. So, it's not at your fingertips.

The co-location of these services also promoted more efficient and effective case resolution. Several respondents noted that co-location allowed an opportunity for things to be done faster than in a traditional court, with one person explaining, "because we have all those services that are right on site with us, there is an immediacy that you never get in the traditional court" whereas "in the traditional court, it usually takes about 4 weeks to get that kind of a report and quite often, people are kept in custody [during that time]." Although respondents often contrasted the DCC with a "traditional court," the legal weight of being a court was also seen to have some positive health implications. As a provincial court, the DCC can, for example, order clients to participate in case management. Although the court cannot enforce treatment, if a client refuses to participate, they could be reassigned to other probation officers and miss access to programs that clients find helpful.

The physical courtroom design was also noted as enabling the DCC to better address client health and wellbeing. In the DCC, respondents noted that the bench is lower, and the client and judge are seated closer together.

> In most courtrooms, people are probably a good 15 or more feet away from the accused, maybe even more, depending on where they are sitting in a courtroom. In our program, […] people actually walked up to the bench to sign their documents. So, the judge was within three and a half feet of the accused. That is a very different perspective, and our first judge articulated out loud, he was so shocked to see the actual state of our clients up close … the judges were far more concerned on a practical level… They were more aware of health conditions, so they took more interest in the health conditions.

This arrangement not only, as explained earlier, enabled a more precise assessment of client health but also was described as more conducive to relational and trusting interactions both among court staff and with clients.

Respondents universally emphasized the importance of relationships within the court as critical in enabling them to consider health and wellbeing in their work. Respondents described their positions within the network of professions present at the DCC, often emphasizing facilitation, information sharing, resource linking and explanation. One defence counsel noted, "if you don't get along with the prosecutors anywhere, but particularly in a place like community court, you're not going to be able to function, you're not going to be able to get things done." Physical co-location was conducive to an enriched teamwork and problem-solving approach to clients' unique needs – as one respondent noted, there is no "not my problem mindset." Rather, people go to great lengths to find solutions collaboratively. Another respondent explained how the DCC "has brought me a better understanding of what other players in the system are doing, and why they are doing it." Respondents reflected a strong level of respect not only within but also between professions – they acknowledged the importance of different actors (probation officers, doctors, etc.) and were willing to defer to respective expertise and express the unique positions and abilities of each. Strong relationships facilitated the transfer and sharing of information, which respondents universally acknowledged as critical in meaningfully considering and addressing factors related to health and wellbeing, particularly in the relatively frequent instances where clients were not able to fully articulate this themselves. Judges reflected on information sharing leading to greater engagement with the clients; defence counsels focused on the benefit of collaboration to the clients; and crown counsels primarily talked about being able to make better-informed decisions as the information-sharing process at the DCC revealed much more about a client than the information-sharing process in traditional courts. A crown counsel described the importance of support and a shared approach, noting "I think in traditional courts, it's harder because you don't have that collaboration. You don't have that information that helps you make those kinds of really informed decisions."

Recruitment and acculturation also came through as key factors when looking at personnel within the DCC – people do not come to work at the DCC by accident, are not necessarily representative of their professions at large and, often are seeking a different way to work. Many respondents expressed the belief that at the DCC, they had a greater opportunity to "look at the whole picture" and be part of a "positive outcome" by addressing the underlying causes of criminality. A judge noted: "it's a different type of judging, where you do, I think, a lot of listening. I think you have a greater opportunity to engage with the individual in a way in which regular judging does not permit you to do." They described a work environment marked by collective "buy-in" commitment, a shared "philosophy" or "ideology" and a "culture of trust."

A critical question that surfaced repeatedly in interviews is the challenge of measuring and defining success for both the court and its clients. So much hinges on "success," including the continued support and funding for the DCC and its replication and adaptation elsewhere. Respondents predominantly defined success around the notion of "client stabilization" supported by the DCC's health and social support. Success, therefore, is conceived primarily in relation to how well the court can address the root causes of offending

so that clients will have better options and will "not be forced to break into cars to steal things … to get more drugs, driven by the lack of resources to eat."

DISCUSSION

While an emerging body of literature examines law enforcement officers and their role in responding to and addressing health-based calls (Butler & LePard, 2022), research is lacking on legal actors' position in the court addressing client health and wellbeing. Similarly, existing literature examining courts' impact on health largely focuses on the role of healthcare professionals in supporting the court participants rather than court processes and structures (Garcia et al., 2019).

Our research sheds light on how legal actors within the DCC understand their role and the role of the court in relation to health and wellbeing. DCC legal personnel take a broad view of their responsibilities, understanding that their role extends to the overall health and wellbeing of clients, considering factors like housing, cultural connection and safety. Despite these insights and regular engagement in support of client health, formal education and training related to health and wellbeing was an exception to the rule among legal actors.

We highlight structural and relational features that the DCC's legal actors view as critical in enabling the court to act to support client wellness. The court's location, wraparound services and courtroom design play a significant role in enhancing its ability to address health needs. Building on, and supported by these structural factors, inter-professional respect and trusting relationships among DCC personnel enable collaborative problem-solving to address client health needs through facilitated information-sharing and expedited processes. Our research builds on the therapeutic jurisprudence literature that indicates that actions such as treating clients with dignity and involving them in decision-making – both of which are actions facilitated by the DCC's structures and relationships – can be key factors in court effectiveness (Goldberg, 2011; Wexler, 2005; Wexler, 2010).

Existing studies on community courts, including the DCC, have focused narrowly on recidivism rates and employ recidivism as a metric of evaluation (Digney, 2022; Somers et al., 2014). Our research suggests that such a metric does not fully capture the court's mandate, activities or impact. The question of evaluation is a complex one. What does it mean for the DCC or for a DCC client to be successful? What is the "realistic ideal," given the complex needs and circumstances of DCC clients? How can this be measured or counted? Can criminal justice adopt a "harm reduction" perspective, acknowledging improvements such as reduced crime rates or severity and safer substance use practices? It is essential to develop a measurement system that recognizes these subtle yet significant changes, providing a more comprehensive view of what "success" looks like for the DCC and its clients. Finally, as a study focused on legal actors, our research does not provide insight into the most arguably critical and vulnerable population – DCC clients, most of whom come before the court repeatedly. There is notably little knowledge about the client experience of the DCC and how they might assess their DCC experience and its impact on their health and wellbeing, including experiences with wraparound services and health support.

CONCLUSION

Our research reveals at least three critical needs. First, if legal actors view client health and wellbeing as part of their role, and routinely act to support client health, education and training support should be offered in this area – both to the current DCC personnel and, ideally, integrated more broadly into legal training. Second, a nuanced metric is needed to assess the DCC's impact, including its efforts to address the often health-related root causes of criminal behaviour. Third, more research is needed to explore the client's perspective of DCC engagement to assess longitudinal impacts on health and wellbeing.

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CONFLICT OF INTEREST DISCLOSURES

The authors have no conflicts of interest to declare.

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