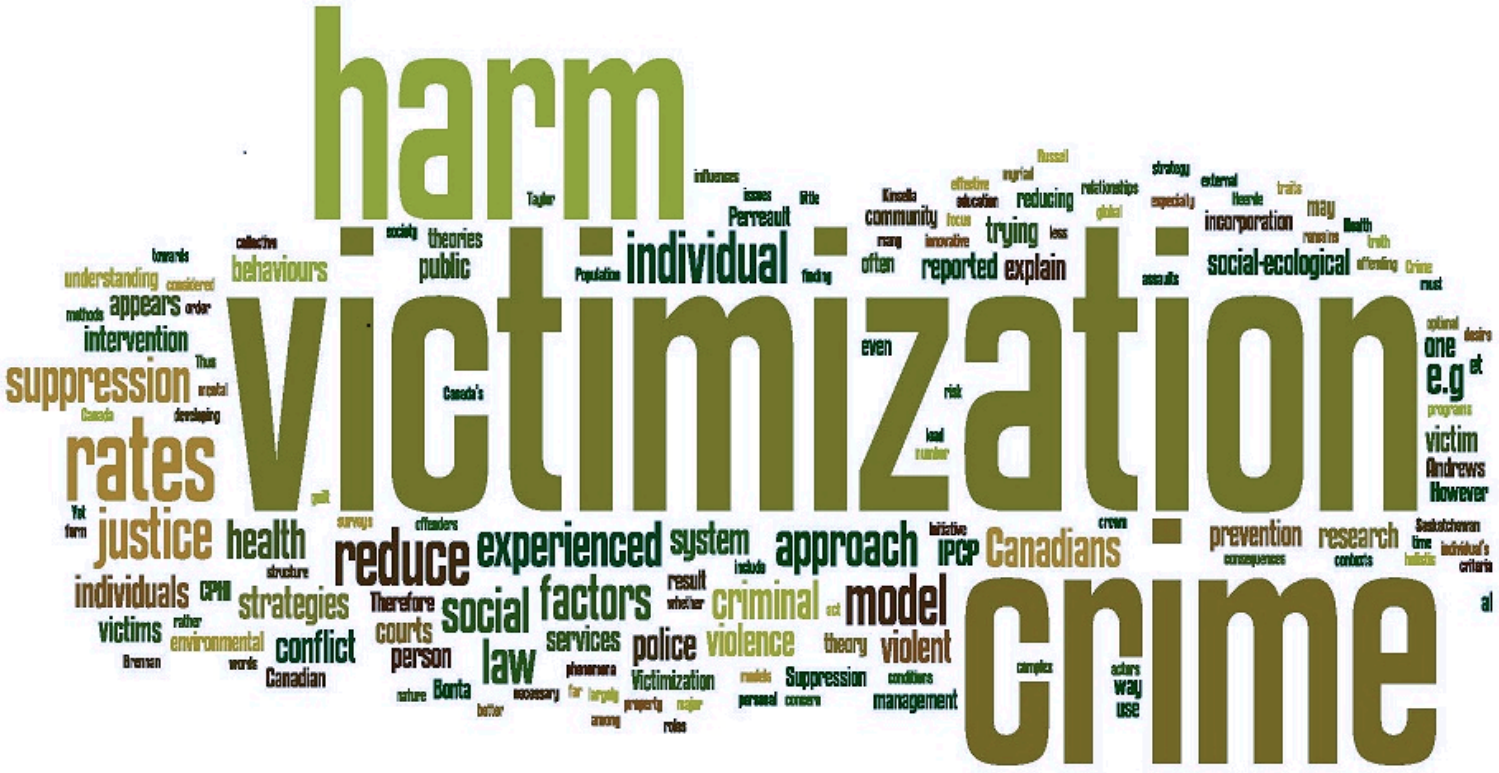
Hitting Crime Where it Hurts: A Holistic Approach to Reducing Victimization



Prepared by:

Andrea J Scheske
Collaborative Centre for Justice and Safety

CCJS
Collaborative Centre for Justice and Safety

University of Regina

March 2015

Hitting Crime Where it Hurts:
Developing a Holistic Approach to Reducing Victimization

Andrea J Scheske

Acknowledgements

I would like to thank Professor Hirsch Greenberg at the University of Regina for his help, guidance, and incredible patience during the completion of this work. Thanks must also be given to Steve Palmer and Heather Holtslander at the Collaborative Centre for Justice and Safety for their help and giving me the opportunity to contribute to an area for which I have incredible passion. Portions of this paper were written in partial fulfillment of the requirements for the degree of Master in Human Rights and Conflict Management at the Scuola Superiore Sant'Anna.

Abstract

This paper seeks to develop a new paradigm in justice to address victimization, crime and the numerous societal ills that follow in their wake in order to inform future policy initiatives and ultimately result in the improvement of the quality of life for many Canadians, particularly groups such as the Canadian Aboriginal peoples. This paper reframes justice to focus on victimization, explore the numerous associated factors involved with victimization and crime, many of which are often overlooked, and discuss the potential for the implementation of Inter-Professional Collaborative Practice (IPCP). IPCP recognizes the interconnectedness of a mutuality of complex factors involved with the provision of healthcare (World Health Organization (WHO) 2010), and has great potential for reducing victimization by targeting these factors. The framework employed will be the social-ecological model of public health. This model allows for an easier understanding and compartmentalization of the factors contributing to victimization and crime and thus presents a great opportunity for its implementation in a justice context.

Keywords: Victimization, Crime, Public Health, Inter-Professional, Collaboration

Table of Contents

List of Tables and Figures

I. Introduction

While writing this thesis proposal, developing my academic skills with respect to research and policy, I deliberately sought out a subject area that would allow me to contribute to the development of innovative strategies to improve quality of life for Canadians. The desire to reduce crime should stem from a desire to reduce harm, but it often appears that crime rates do not actually reflect the harm caused or received. Additionally, there is no adequate strategy to reduce harm that is reflected in the justice system. By seeking dramatic improvements to crime and victimization reduction, all Canadian citizens stand to benefit: less harm perpetrated; less cost to us all. Most notably, marginalized individuals, historically and presently, and those organizations working with them, may find the tools necessary to break the cycle of victimization and offending.

This research identifies pressing questions:

- How can we re-evaluate the organizational roles of prevention, intervention, and suppression?
- What roles should the individual, family, and community have in crime management?
- What models help illustrate the ubiquity of harm and its impact upon other individuals?

This research explores the use of the social-ecological model of public health and the incorporation of Inter-Professional Collaborative Practice (IPCP) to reduce the victimization and crime experienced by Canadians in an effective and meaningful way.

Over the last couple of decades in Canada, crime rates have been trending downwards (Perreault, 2013). In contrast, rates of victimization have not been declining proportionally. In fact, in some categories, such as victimization from robbery or victimization from theft of personal property, rates have even been increasing (Perreault & Brennan, 2009). Thus, it appears that crime rates and victimization rates are somewhat disconnected, and while crime rates are decreasing, the harm experienced by individuals, as evidenced by victimization surveys (Perreault & Brennan, 2009), has remained virtually flat. At a global level, victimization remains a major concern: violent victimization remains high, especially for individuals between the ages of fifteen to forty-nine (WHO, 2014). In 2012, 2.6% of global mortality was attributable to self-

harm, intrapersonal violence, or collective violence (e.g. violence performed by terrorist groups) and the legal interventions attempting to quell this collective violence (e.g. air strikes) (WHO, 2014). Death is not the only dire result of violent victimization. Injuries, deterioration of mental health, poverty, and protracted health consequences, particularly for youth, arise from violent victimization (Perry, 2009). Victimization of individuals, both violent and nonviolent, is a far reaching concern affecting the integrity of our social relationships, with a myriad of negative consequences.

This disconnect, between crime rates and victimization rates, can be explained by how crime is reported; qualified and quantified. For example, a victim is not legally considered a victim under our justice system until there is a finding of guilt. For an act to qualify as a crime it needs to meet a number of criteria. First, the act must be illegal as codified under a set of legislative Acts. Second, the interpretation of whether a law is broken is determined by a number of actors: police who lay a charge; the crown who prosecute the accused; and the courts who determine guilt. Thus, crime requires a finding of a guilty person, without which there is no recognized victim by the justice system. Yet, even if an alleged crime is unreported, there is a person who has suffered harm, that is to say, a victim. Statistics Canada's victimization survey data from 2009 estimates that over 60% of violent victimization, household victimization, and personal property thefts were not reported to police. Some criminal code offenses are notable for low reporting rates: female victims reported domestic violence assaults 28% of the time; and only one in ten non-spousal sexual assaults were reported to the police (Sinha, 2013). Crime rates then seem to be a better reflection of Canada's prosecutorial functions rather than a measure of the harm experienced by Canadians (Russell & Taylor, 2014). Therefore, when trying to understand and define the harm that Canadians experience, victimization rates present as a much better indicator. Unlike crime, victimization surveys are not dependent on the 'offender' criteria for crime. Instead victimization should only depend on whether a person feels some harm has been done. In the words of Weisstubb, "victimization, even more than beauty, is in the eye of the beholder" (1986, p. 318 as cited in Kinsella, 2012).

Victimization eclipses an array of complex phenomena such as substance abuse (Darke, Torok, Kaye, Ross, & McKetin, 2009; Hughes, McCabe, Wilsnack, West, & Boyd, 2010; Kazemian & Le Blanc, 2004), homelessness (Ferguson, Bender, Thompson, Xie, & Pollio, 2011; Heerde, Hemphill, & Scholes-Balog. 2013; Kinsella, 2012), mental health issues (Canadian

Population Health Initiative (CPHI), 2008; Turner, Finklehor, & Ormrod, 2010), parenting (DePadilla, Perkins, Elifson, & Sterk, 2013; Romano, Bell, & Billet, 2011), education (CPHI, 2008; Jakobsen, Fergusson, & Horwood, 2012; Li et al., 2011; Machin, Marie, & Vujić, 2010), and most relevant to interests of government, courts, corrections, and law enforcement: future victimization and conflict with the law (Chen, 2009, Estevez & Emler, 2011, Heerde et al., 2013). These phenomena strongly correlate with crime behaviours largely because, as noted by the Canadian Population Health Initiative, the same social conditions that may increase the chance an individual is victimized are similar or the same as those which can lead to an individual offending (CPHI, 2008; Shaw, 2001). Therefore we can recognize that those who are victims and those that are offenders share common etiological and epistemological conditions.

When trying to reduce harm, the Saskatchewan Ministry of Justice aims to employ prevention, intervention, and suppression strategies (Government of Saskatchewan, 2011). Preventative services take the form of programs which reduce the potential for an individual's likely involvement in crime (e.g. public education). Intervention involves the use of social services to change environmental and behavioural risk factors to reduce criminal behaviours and victimization (e.g. addiction support programs). Suppression, however, attracts the most resources, in part because of historical notions of criminal justice. Alternatives were few and far between with gaols (jails) or executions being the only and simple alternatives. A preoccupation with this form of crime management is echoed in modern society and is often reverberates as 'get tough on crime' ideological arguments used for political advantage. Suppression employs a law and order approach to crime (e.g. arrest and incarcerate). Suppression appears to be the preferred approach to reducing crime and victimization in Canada (Andrews & Bonta, 2010).

However, victimization rates indicate that this strategy does little to reduce the actual harm experienced by Canadians. While perspectives around crime management are changing, often suppression is still perceived by many as the most basic and fundamental component of the criminal justice system, and tends to be seen as 'one solution fits all.' However, despite the prevalence of initiatives which focus on suppression, strategies of this nature are not necessarily optimal. There has been research supporting crime suppression strategies, but they largely show little positive effect, if any effect at all, and are becoming financially unsustainable (Andrews & Bonta, 2010; Cullen, Jonson, & Nagin, 2011; Garland, 2001). Progression towards innovative methods of reducing crime and victimization is slow. While some progress has been made with

the incorporation of intervention-based methods, there remain significant issues for effective implementation (Gondolf, 2011; Noell & Gansle, 2006) and sustainability (Stirman et al., 2012). Likewise, when trying to integrate prevention, intervention, and suppression strategies, there are few existing frameworks incorporating the necessary elements to provide a holistic, person centered service for victims and/or for those in conflict with the law.

Selected criminological theories to explain criminal behaviours include: rational choice, trait, social structure, social process, social conflict, and developmental theories. Each theory contributes to our understanding of crime and deviant behaviour. Yet, there isn't a unified theory that fully accounts for an individual's traits, external influences such as peers, or environmental contexts (Vito & Maahs, 2011). Social structure strain theory has difficulty accounting for entire classes of crime (e.g. white collar crime), heavily focusing on an economic and social contexts at the expense of individual traits or external influences on the commission of a crime (Bryant, 2012). While these theories seek to explain crime and criminality, none do so in a way that comprehensively considers the many risk factors, which may lead an individual into conflict with the law or result in victimization. In the words of Hester and Miller (1995, p. 8), "no one of these models appears to be the whole truth, though each contains truth." Therefore, in order to discern a more holistic approach, an alternative model is considered for this paper: the social-ecological model of public health.

The social-ecological model was selected due to its capacity to synthesize individual, relational, community, and societal factors, especially in combination with a preventive, rather than reactive perspective to reduce harm experienced by Canadians. This model permits a truly integrative approach towards developing an understanding and responding to the multi-variate nature of crime. It encompasses the inclusion of numerous factors, which organically interact with the individual, community, society and the relationships among them. Furthermore, this model considers the optimal balance of resources for prevention, intervention, and suppression services.

The greatest boon the public health model affords us is an understanding of how crime emerges from an intersection of static and non-static factors among an environmental plurality surrounding the issue of crime and victimization. Since the time of Sir Robert Peel (c. 1821), the focus has been on a criminal justice system where actors (i.e. the police, crown, courts, and correctional services) suppress crime. However, the evidence is not in favour of using the police

and courts as a skeleton key when trying to unlock the harm experienced as a result of victimization and conflict with the law (Russell & Taylor, 2014; Andrews & Bonta, 2010). This singular vision approach to reducing crime and victimization is not so different from relying on a single theoretical approach to explain crime. Essentially, victims and offenders are treated as if their behaviours are independent of each other. Using a multi-lense approach such as the social-ecological model it becomes clear that it is no longer enough to use only one tool to explain and intervene in crime and victimization. The justice system's policies and operations must be expanded to include professionals from myriad disciplines that will target factors more broadly related to crime and victimization (Government of Saskatchewan, 2011). One way in which to achieve this is through the incorporation of IPCP.

IPCP is based upon the mutuality of complex factors involved with healthcare provision (WHO, 2010). This paper argues that crime and victimization can be similarly addressed. A major principle of IPCP is that it is 'person-centered.' In justice, this could be expressed as meaningfully involving the individual, and inviting them to become more accountable in seeking healing for experienced harm. This is in addition to drawing upon the capabilities and expertise of professionals across numerous disciplines to find effective solutions to issues of crime and victimization.

However, while this sounds wonderful on paper, it is not a panacea. To properly incorporate IPCP into a justice context a number of obstacles must be overcome. For example, there remain many difficulties implementing IPCP (Russell & Taylor, 2014). How can we deal with inter-professional conflict, improve communication between professionals, and ensure that changes in the bureaucratic structure result in meaningful outcomes that advance harm reduction on the front lines? Even in public health, where collaborative practice has been extensively explored, many issues arise with its actual implementation, and in some instances innovative theory may only lead to ineffectual practice. An example would be how some health promotion strategies resulted primarily in social marketing and health education, but did not implement the substantial policy changes needed to support them (Russell & Taylor, 2014). Despite the current issues with implementation, IPCP presents a narrative for reducing experienced harm when considering the experience of victims and offenders. It is for this reason that this thesis intends to explore how to effectively incorporate IPCP, using a public health model, and create a comprehensive strategy to reduce crime and victimization and direct future research that can

better support the implementation of this framework. To this end, this thesis will discuss the necessity for, and challenges presented by, IPCP's implementation. Furthermore, creating a theoretical foundation for a framework within the halls of justice will, at its core, result in an improved quality of life for Canadians, particularly those belonging to its most vulnerable groups.

In preparing this document a few limitations are kept in mind. Firstly, while this thesis holds that victimization should be at the core of a justice framework, research relating to offenders will also be heavily used, because the extant literature in this area focuses on crime and criminal behaviour, rather than victimization. Secondly, the social-ecological model, while used extensively with violence prevention, has not yet been employed to illustrate crime as a whole, so there may be unexplored limits with regards to how closely this proposal can operate within it. Thus, the different framing of the issue, and the untested potential of the model must be kept in mind when considering this proposal for a new paradigm in Justice and the results of this paper.

II. Theoretical Framework

Public Health Model

The opening pages briefly introduced the complicated relationship of victims and offenders, their families and communities and ultimately society. The social-ecological model of public health was introduced. While the public health model was originally used as a way to approach and address health issues in populations, some researchers saw potential in using a public health approach to target violence. The public health model, evidence-based and interdisciplinary, focuses on providing positive outcomes for a maximum number of people as opposed to relying on individual levels of analysis (WHO, 2002) (e.g. social causes of crime as opposed to individual causes). Its interdisciplinary nature, including contributions from criminology, psychology, anthropology, epidemiology and many others, is suited to incorporate collaborative efforts of numerous professionals working towards a collective goal, and often with an acute emphasis on preventive strategies (WHO, 2002).

Social Ecological Model

The public health model has a few different designs. Perhaps the most recognizable is the social-ecological model; the model currently employed by the World Health Organization. While the social-ecological model has served to explain certain types of violence: including child abuse

and intimate partner violence (WHO, 2002), it has yet to be used as an overall approach to crime. Despite this, the social-ecological model shows great promise and will be employed as the foundation for this new perspective.

The social-ecological model can recognize the complexity of factors involved in the commission of violent acts. Many of these factors are strongly correlated with increased chances of victimization or other conflicts with the law. The model is comprised of four levels: individual, relationship, community, and societal. Detailed descriptions of each level were set out in the World Report on Health and Violence (WHO, 2002). The individual level identifies personal characteristics which may contribute to the likelihood of a person being victimized or perpetrating violence. Such factors include biological and personal history. The level on relationships identifies how social interactions, such as those an individual might have with peers or family members, could contribute to the likelihood of being a victim or perpetrator of violence. Community refers to the places where relationships develop and individuals spend time. Some community examples are: schools or neighbourhoods which can have characteristics such as poverty. The final level is societal, referring to the overarching aspects such as cultural norms or government policy. The other levels exist in this context. Each level provides an opportunity for intervention by evaluating risk and protective factors. This allows for better prevention strategies to emerge (WHO, 2002). This terminology and framework will be used as a foundation and point of reference throughout this paper to improve structure and clarity.

III. Methodology

The objective of this discussion was to review selected literature, as a precursor to future research, to better understand and frame the problems inherent in the current criminal justice system. The conclusions drawn will be used to inform future research and qualitative and/or quantitative methods. Sources for this paper did not follow a structured or exhaustive search. These key sources are peer-reviewed, covering a variety of topics which contribute to the overall construction of the arguments in this paper. Other sources were occasionally used from: federal and provincial government documents; official national statistics; and recognized international and national organizations. Searches were primarily preformed using the University of Regina Summon page which functions as a search point to access all of the university's collections. Exploratory searches were also conducted using Google Scholar. Searches were based upon

keyword searches across databases to support an inter-disciplinary point of view. Additional information was found through searches or topical browsing from other organizations' websites (Table 1). The documents compiled numbered over 200 which were then reviewed and analyzed in order to extract relevant information. All documentation was in the English language. While this paper argues that victimization should be at the core of a justice system, terminology for both offenders and victims will be used as the extant literature largely focuses on the former.

IV. Literature Review

Victims Not Offenders

Although victimology originated in the 1940s, meaningful investigation of victimhood is a much more recent phenomenon (Walkate, 2013). A victim, by definition, can be any individual who experiences harm as the result of a crime, event, or action. For example, an individual may be victim of a natural disaster. However, the usage of the word 'victim' is most often used as a designation for a person harmed by a criminal act, and so has historically been closely linked to a justice context. With regards to this, Fattah (1997 as cited in McShane, 2013) wrote, "the offence should cease to be regarded as an affront to the state and be viewed as an offence against the individual victim, not as a violation of abstract law but a violation of the rights as a victim." An effort has recently been made to clarify that victims can exist independently of reported and prosecuted crimes; individuals victimized by non-criminal acts are still often overlooked (Victim Services and Crime Prevention Division, 2009). Indeed, while the creation and support of victim services units across Canada have the potential for profound change, the objective explicitly discusses victims in terms of crime and the criminal justice system (Government of Canada: Department of Justice: Victims, 2013) leaving many victims of non-criminal circumstances without sufficient remedy. Therefore, Canada has demonstrably linked victims with crime, yet while all crimes (theoretically) result in the victimization of an individual, not all instances of victimization are the result of a crime.

Likewise, when focusing on the offender, rather than the victim, the determination of the perpetration of a crime then becomes the lynchpin for whether an individual can be legally considered a victim as defined by federal and provincial legislation. There are a number of issues with this definition at the outset. Firstly, not all the ways in which individuals can be victimized are considered criminal acts, and the criminal designation of some other acts has lead to

substantially more harm. Some examples are secondary victimization within the criminal justice system, or criminal sanctions for drug use. Secondly, there remain issues with crime reporting – both by individuals and the police – preventing any remedy and complicating victim data analysis. Finally, focusing on the offender as opposed to the victim can lead to policies and practices which are unable to meaningfully address the heart of the issue – the harm experienced.

There are numerous ways in which an individual can be victimized –crime is one of the better known causes. However, perceptions of crime evolve with time and changes in societal attitudes. Marital rape, for example, has only been a criminal offence in Canada since 1983. The harm experienced by individuals in that situation is now well known, yet, they would not have legally qualified as victims, because the act of marital rape was not a crime. One such topic which showcases harm to an individual, while not being a crime, revolves around re-victimization by the criminal justice system.

Historically, treatment of victims within the criminal justice system has been quite poor (Karmen, 2012; Shoham, Knepper, & Kett, 2010). While there have been efforts made to improve the treatment of victims by the criminal justice system nationally (Department of Justice Canada, 2013) and internationally (United Nations General Assembly, 1985), re-victimization, also referred to as secondary victimization, still remains a reality for many victims (Orth, 2002), notably in sexual assault (Monroe, 2005; Patterson, 2011; Shoham, Knepper, & Kett, 2010) and child custody and divorce proceedings when cases involve intimate partner abuse (Bemiller, 2008; Rivera, Sullivan, & Zeoli, 2012). Also important to note is that involvement with the youth or adult criminal justice system is often associated with maltreatment (Mersky, Topitzes, & Reynolds 2012). This secondary victimization by the courts has been linked to negative effects on victims' self esteem (Orth, 2002) and recovery including higher prevalence of post traumatic stress related symptoms and other psychological distress (Campbell et al., 1999; Orth, 2002; Wemmer, 2013). Low self-esteem and other mental health problems are associated with an increased likelihood of future victimization or offending behaviour (Becker & Kerig, 2011; Butler, 2010; Fanti & Henrich, 2014; Hartinger-Saunders, 2011; McCart et al., 2012; Turner et al., 2010). Yet, this secondary victimization by the criminal justice system, which causes harm to the individual and can contribute to an individual's increased likelihood of future victimization or offending behavior, goes unrecognized. The issue of re-victimization in the criminal justice system thus demonstrates that a reliance on combating crime to reduce harm is actually

insufficient because harm can be caused by the criminal justice process itself in non-criminal contexts. This issue also shows some of the numerous and complex factors involved in crime and victimization, such as self esteem and mental health issues or emergent issues arising from involvement in the criminal justice system including higher likelihood of future offending or victimization. Therefore, the example of secondary victimization has demonstrated that the fixation on crime can lead to more harm to the victimized individuals the system seeks to protect, which is an argument for a victim centered system.

The fixation with criminalization as a means of addressing criminogenic risk factors of offenders and victims has led to further harm in other areas as well such as substance use and abuse. Substance use is co-morbid with factors such as mental health issues, negative childhood experiences, poor education, etc. (Fergusson, Boden, & Horwood, 2008; Zucker, Donovan, Masten, Mattson, & Moss, 2008) which tend to cluster around crime and victimization, again showing the complex nature of the issue. With only a handful of exceptions, current justice systems favour imposing criminal sanctions against substance use (UNODC, 2009), yet the efficacy of this approach is dubious at best, and demonstrably harmful at worst. This is because involvement in the criminal justice system introduces a number of other factors such as the creation of a criminal identity, relationships with criminal associates, and contributes to a stigma upon release (UNODC, 2009). Prisons are also not conducive to dealing with psycho-social issues, often related to substance abuse, and mental health issues when considering the high relapse rates post release (Baillargeon et al., 2009). Recent evidence indicates that decriminalization of illicit substances, coupled with the integration of a health-oriented approach is effective at reducing substance abuse and the myriad of harms that are associated with it (UNODC, 2009). This position is supported by the World Health Organization (WHO, 2014b). Therefore, the issues of substance use as a crime is a clear example which shows that the singular focus on criminalizing self-harming behaviours, and assuming that targeting such crimes will reduce related harm, are not necessarily optimal. The panoply of issues associated with substance abuse could also be more effectively mitigated when the focus is on helping the individual, rather than prosecuting the criminal.

The next major issue is with crime statistics and the reporting of crime to the police. A discrepancy has been observed between crime rates submitted by the police and the rates of victimization reported by the General Social Survey; this is not unique to Canada. Differences

between police reported crime rates and self-reported victimization have been identified internationally as well (Mayhew & van Dijk, 2014). While crime rates have been steadily decreasing since the 1990s (Perreault, 2013), rates of victimization have largely remained stable (Perreault & Brennan, 2010). One factor which could be contributing to this is crime reporting. For Canadians over the age of fifteen, over one quarter of respondents indicated that they were victims of a crime (Perreault & Brennan, 2010). However, the 2009 General Social Survey in Canada indicated that only 31% of crimes were ever reported to police, a decrease from 34% from the previous survey in 2004. Victimization surveys provide a much better picture of the harm experienced (Mayhew & van Dijk, 2014). The reasons for the lack of reporting vary. Perreault and Brennan (2010) noted that 36% of respondents did not consider the event important enough to report, 15% reported dealing with the incident in another way, and a fairly substantial 19% (nearly one fifth) indicated they didn't report because they did not feel the police could do anything about the crime. Police reports are also less than effective for collecting demographic data about who is being victimized. Victimization surveys can readily provide such data (Mayhew & van Dijk, 2014). Therefore, crime rates are a less accurate reflection of the actual harm experienced by individuals, which makes effective harm reduction more difficult.

However, even current victimization surveys only reference victimization from crime, and as discussed previously there are other ways in which people can be victimized. Similarly, victimization surveys do not cover all potential victim populations, such as the homeless, and have difficulty measuring certain trauma such as childhood victimization or drug use or abuse (Mayhew & van Dijk, 2014). To help widen the scope of victimization surveys, one possibility is that data collected by organizations working with more difficult to access populations (e.g. homeless individuals) could be included. So while work must still be done to make surveys of victimization an even stronger tool, victimization rates are already a better representation of experienced harm because of their more accurate counting of victimized individuals and the ability to provide information, such as demographic details, that police reports cannot (Lynch, 2006; Mayhew & van Dijk, 2014). This suggests that focusing attention on victimization gives us a much stronger tool, which can provide more accurate information about the harm experienced by individuals. Acknowledging the gaps in victimization survey techniques can also allow for the contributions from inter-professional perspectives in order to ensure that an accurate picture is painted of individual harm experienced by Canadians.

The other issue with crime statistics is that of police reporting of events. Police and police services are not a monolith, nationally or internationally (Lynch, 2006). There can be significant differences in policy and procedure between them as well as differing targeted priorities and availability of resources (Perreault, 2013; Lynch, 2006). For example, if a police department targets one type of crime, in all likelihood there will be an increase in that particular crime statistically – even though nothing may have actually changed with regards to numbers of individuals harmed. Perreault (2013) notes that impaired driving, prostitution, and drug offences in particular tend to be affected by differences in priority, policy, and procedure by police organizations. Nationally, specific police services may prioritize legislation differently. An example would be targeting a municipal bylaw or provincial statue, especially for minor offences such as mischief (Perreault, 2013). Thus differences between police services can result in crime rates being reported that may be difficult to meaningfully compare (Lynch, 2006). This lack of standardization of police policy, procedure, priority and resources creates fluctuations that are difficult to analyze and to develop appropriate policy responses. While crime rates may fluctuate as a result, victimization rates overtime, generally, do not. This would make it a much more useful metric for investigating and innovating new policy and practices.

Finally, it is important to note that seeking to reduce victimization by solely targeting criminal behaviours can have suboptimal results. Many traditional policing practices (e.g. random preventative patrol), while still often relied upon, have little to no evidence supporting their effectiveness at crime reduction (Telep &Weisburd, 2011; Weisburd & Eck, 2004). While there has been some successful evidence based development regarding strategies for crime reduction (Telep & Weisburd, 2011) most initiatives still start and end with the police and their budgets (Russell & Taylor, 2014). Of course, this is the obvious choice to make when looking at crime rates, because, as previously demonstrated, it is largely the police who are made aware of any crimes – if anyone is at all. The police, however, are not the best suited agency to deal with most aspects of reducing victimization. Russell and Taylor (2014) suggest that the police may be able to make the biggest difference through targeted enforcement or mobilization of different organizations, social service agencies and communities by providing support for social development strategies (e.g. by ensuring a safe space for the community to mobilize within). The perceived primacy of the justice system, even though they are not necessarily the optimal party, likely stems from the focus on ‘crime’ rather than ‘victimization.’ By couching attempts at

reducing potential harm for Canadians in terms of 'victimization reduction' it opens many doors with regards to potential avenues of prevention, intervention, and suppression. It allows a more holistic view of the ways in which people are victimized, and can result in a greater understanding of the parties who are best involved in order to reduce it. Strategies of this nature have been suggested, yet, they still often place the police at the centre (Mazerolle & Ransley, 2005; Weisburd & Eck, 2004). By focusing on victimization reduction as the goal, the police simply become one tool among many, and the most important party is the organization best suited to address the harm experienced by a particular individual. This fits well within the public health framework, where the myriad factors surrounding offenders and victims can all be taken into consideration, as well as the involvement of IPCP wherein the best suited professionals can be involved to address any issues in the most effective manner possible.

There are many issues which arise when couching harm reduction in terms of crime. These are: lack of acknowledgement of non-criminal harm; further harm caused by designating certain acts as crimes; lack of standardized statistical collection of data due to low reporting and differences between police service priorities, as well as suboptimal harm reduction strategies which disregard the myriad issues surrounding crime and victimization, and rely heavily upon the police despite the presence of other agencies better suited to different types of harm reduction. For these reasons, in order to move forward in improving the quality of life for Canadians the focus must first be shifted from crime reduction to victimization reduction. This allows for a more holistic perspective of related factors which in turn allows for a more intuitive incorporation of IPCP.

Factors Associated with Crime and Victimization

With this broader perspective focused on victims and victimization in mind, there are many other avenues to pursue. Numerous factors have been found to contribute to the likelihood of offending behaviour or being victimized later in life. The social conditions which may contribute to crime and victimization cover a vast array of social issues, which have been organized here into: individual, relationship, and community factors in accordance with the social-ecological model. Many of these factors can be closely connected to other known risk factors which are beginning to be incorporated more generally in crime reduction strategies.

When looking at the social issues of victimization or crime there is a major element which must be kept in mind. That is the strong correlation between victimization and offending.

Additionally, the substantial overlap between the populations of perpetrators and victims, with many individuals falling under both categories, is well established in the literature (Chen, 2009; Darke et al., 2009; DePadilla et al., 2013; Estevez & Emler, 2011; Holtfreter, Reisig, Piquero, & Piquero, 2010; Jennings, Piquero, & Reingle, 2011; Latimer, Kleinknecht, Hunt, & Gabour, 2003; Manasse & Ganem, 2009; Shaw 2001). Thus when addressing reductions in victimization, one must equally work to address offending. Victimization and offending behaviour effect and are affected by each other, alongside numerous risk factors (Holtfreter et al., 2010; Jennings et al., 2011; Manasse & Ganem, 2009). One example is victimization leading to higher incidence of substance abuse in sexual minorities (Hughes et al., 2010). Also, after violent victimization, mental health consequences tend to rise. These mental health consequences can even be found in individuals other than the victim (Cornaglia, Feldman, & Leigh, 2014). All of these factors, which can occur concurrently, can potentially exacerbate other conditions (CPHI, 2008) or increase chances of being persistently victimized (Ellonen & Salmi, 2014) which is supported by research which demonstrates that victimization itself is a risk factor for future victimization (Ruback, Clark, & Warner, 2014). Even after controlling for various other factors, violent offending and victimization were still directly linked in a study performed with discharged psychiatric patients (Silver, Piquero, Jennings, Piquero, & Leiber, 2009). Because of the complex array of factors and their highly interconnected nature, this overview will cover offending and victimization together, alongside other factors, organized in accordance with the levels of the social-ecological model.

Individual Level

The first level deals with personal traits, like personal history, that can increase an individual's likelihood of being victimized or coming into conflict with the law. A person's personal history with regards to crime and victimization would fit in here, but since it has already been broadly discussed above it will not be reiterated in full.

One of the most well researched traits is gender. The higher likelihood of males becoming involved in offending behaviour is well supported in the literature (CPHI, 2008; Newburn & Stanko, 2013; MacNeil, Stewart, & Kaufman, 2000; Perreault & Brennan, 2010; Sprott, Doob, & Jenkins, 2001), although some research has suggested this does not apply to all types of offending behaviour (Alleyne & Wood, 2014; DePadilla et al., 2013). It must also be considered that most of the studies investigating rates of male offending have been in western nations and a

cross national sample found that the gender link was strongly dependent upon cultural contexts (Antonaccio, Tittle, Botchkovar, & Kranidiotis, 2010). Victimized males also experience more assault and threats, as opposed to females who are more likely to be victimized in non-physical (e.g. verbal), and relational ways (Romano et al., 2011). It has also been suggested that the connection between victimization and re-victimization may differ between males and females (Ruback et al., 2014). Expressions of mental illness as they are related to offending behaviour (Silver, Felson, & Vaneseltine, 2008) and substance use and abuse (Holder, 2006) have also been noted to differ between genders. Therefore, gender is a very important factor to take into account particularly with regards to targeting of preventative measures.

Belonging to a sexual minority has also been associated with higher incidence of childhood victimization (Hughes et al., 2010). Age is negatively associated with crime perpetration, that is to say that youth commit more crime, even in cross-national samples (Antonaccio et al., 2010). Race can also be a factor for offending behaviour, victimization, and criminal justice system involvement (Allen, 2014; CPHI, 2008; Latimer et al., 2003; Perreault, 2012; Shaw, 2001), although demographic disparities may differ depending on the type of crime (Alleyne & Wood, 2014; Latimer et al., 2003). The issues faced by Canadian Aboriginal peoples will be discussed more in depth in the next chapter. Care should be taken to tailor strategies for the appropriate group as offending and victimization experiences may differ between them.

Aggression in youth has been found to be a correlate of delinquency, as well as connected to adolescent and adult violence (CPHI, 2008; Latimer et al., 2003; DePadilla et al., 2013), although the close association with victimization over the long term has been suggested to be unstable (Pouwels & Cillessen, 2012). Aggression has likewise been linked to particular aspects of mental health such as early conduct and self esteem issues (CPHI, 2008) and depression (Sprott et al., 2001). Low self esteem itself has been strongly connected to youth delinquency and victimization (MacNeil et al., 2000; Sprott et al., 2001; Butler, 2010; Fanti & Henrich, 2014; Holtfreter et al., 2010). Beyond this, a myriad of other character traits have been associated with victimization and offending behaviour. Anti-authoritarian attitudes may also be used to justify crime and support the perception that an increase in status is linked to criminal participation in gang related crime (Alleyne & Wood, 2014). Self-reported lack of motivation was also found to be positively correlated to youth delinquency (Latimer et al., 2003). Low self-control was also found to be predictive of cyberdeviance in juveniles (Holt, Bossler, & May, 2011).

Substance use and addiction have also been strongly associated with offending behaviour and victimization in both youth and adults (Alleyne & Wood, 2014; Cartier, Farabee, & Prendergast, 2006; Darke et al., 2009; Estevez & Emler, 2011; Hughes et al., 2010; Kazemian & LeBlanc, 2004). Almost universally, persistent lifetime victimization has also been found in individuals suffering from addictions (Darke et al., 2009). Substance use and addiction have also been associated with mental health issues (CPHI, 2008) and homelessness (Mental Health Commission of Canada (MHCC), 2009).

Mental health issues are strongly associated with offending behaviour, victimization, and other risk factors (Becker & Kerig, 2011; CPHI, 2008; Ellonen & Salmi, 2014; Hartinger-Saunders et al., 2011; McCart et al., 2012; Silver et al., 2008; Turner et al., 2010). Some other associated risk factors are substance abuse (McCart et al., 2012; CPHI, 2008), aggression (Sprott et al., 2001), and homelessness (MHCC, 2009). Homelessness is in itself strongly connected to victimization (Ferguson et al., 2011; Kinsella, 2012; Heerde et al., 2013). Mental health patients with a criminal history are also more likely to have dropped out of school and have used mental health services previously (CPHI, 2008). Silver et al. (2008) also noted that poor mental health appears to be a causal factor for deviant behaviour, and the severity of the behaviour tends to be positively associated with the severity of the mental illness. They also found that mental illness was more closely connected with specific types of offending behaviour: deviant and sexual offending (Silver et al., 2008).

This is only a brief overview of the numerous individual level factors which are associated with offending behaviour and victimization. Some, such as gender, show aspects which should be taken into account when looking to engage with individuals for the purposes of reducing victimization. While others, like aggression, can help us identify individuals who may be more at risk for later offending or victimization. The overview of personal traits, attitudes, substance use, and mental health issues and their interaction with offending behaviour and victimization help demonstrate the complex array of interconnected factors which must be taken into account when working towards harm reduction. As a whole, the factors begin to illustrate the main areas which might be effectively targeted through the implementation of IPCP.

Relationship Level

The relationship level investigates the relationships that an individual has with peers, family, or other close individuals, which may have an impact on an individual's likelihood of

being victimized or coming into conflict with the law. One strongly correlated factor would be the association between having deviant peers and an individual's likelihood to come into conflict with the law (CPHI, 2008; DePadilla et al., 2013; Holt et al., 2011; Latimer et al., 2003). This was even supported in a cross-national sample (Antonaccio et al., 2010). Peer substance abuse has also been predictive regarding a youth's likelihood of delinquency (MacNeil et al., 2000). Having poor quality friendships has been associated with an increase in the likelihood of victimization (Romano et al., 2011). Being the victim of bullying at school has been connected to future egregious behaviour (Sprott et al., 2001) and delinquency, with individuals who considered themselves both bullies and victims reporting the most delinquent behaviour (CPHI, 2008).

Family factors also seem to play a large role in future offending and victimization. Poor parenting, including neglect, punitive practices, rejection, and a lack of appropriate discipline, is a risk factor for offending and victimization and is very well supported in the literature (CPHI, 2008; DePadilla et al., 2013; Farrington et al., 2002; Latimer et al., 2003; Romano et al., 2011; Sprott et al., 2001; Hoeve et al., 2012). Related to peer association, simply living with someone involved in criminal activities was predictive for non-violent crime (DePadilla et al., 2013). Lack of family support (CPHI, 2008; DePadilla et al., 2013), low family involvement (Farrington et al., 2002), family substance abuse (MacNeil et al., 2000), and general maltreatment (Mersky et al., 2012) have all been associated with later offending behaviour. Family disruption and violence were also found to be significant factors for delinquency, and was also cited to be a major contributing factor for homeless individuals when they chose to leave home (Shaw, 2001). Youth in foster care are also more likely to report drug use and psychiatric symptoms as well as much higher rates of offending behaviour (Pilowsky & Wu, 2006; Traube, James, Zhang, & Landsverk, 2012). Childhood physical punishment has also been associated with both victimization from and perpetration of social aggression (Björkqvist & Österman, 2014). Aggression has also been found to result from parental rejection and punitive parenting practices (CPHI, 2008, Sprott et al., 2001). Aggression itself is associated with offending behaviour (CPHI, 2008; DePadilla et al., 2013; Latimer et al., 2003). This evidence makes it clear that one of the main areas in which attention could be focused is in the family and household domain.

This is only a small number of factors found at the relationship level. The literature makes it clear that both deviant peers and parenting are major factors implicated in an

individual's likelihood of being victimized or participating in criminal behavior. These areas should therefore be a major focus when investigating potential preventative measures for victimization reduction.

Community Level

The community level investigates the different settings in which individuals spend their time and where relationships can form. Educational factors have been associated with the potential for an individual to participate in offending behaviour (CPHI, 2008; Fitzgerald, 2009; Groot & van den Brink, 2001; Jakobsen et al., 2012; ; Latimer et al., 2003; Liljeberg, Eklund, Fritz, & af Klinteberg, 2010; Li et al., 2011; Machin et al., 2010; Shaw, 2001; Sprott et al., 2001). Low educational aspirations were found to be associated with increased property violations (CPHI, 2008; Machin et al., 2010; Sprott et al., 2001). There have also been associations found between educational attainment and mental health (Johnston, Propper, Pudney, & Sheilds, 2011) which was reflected in a survey of mental health patients with a criminal history (CPHI, 2008). Educational attainment has also been negatively associated with the likelihood of offending behaviour (CPHI, 2008; Jakobsen et al., 2012) with higher levels of education leading to reductions in various common crimes such as assault (Groot & van den Brink, 2001). However, individuals with higher education do seem to have more permissive attitudes towards crime, and are more likely to commit fraud (Groot & van den Brink, 2011). Individuals who perceived poor treatment by educators, or simply did not like school were more likely to participate in delinquent acts involving property (CPHI, 2008). An individual's failure to attend school (i.e. truancy or dropping out) has also been associated with delinquency (CPHI, 2008; Jakobsen et al., 2012; Shaw, 2001) School involvement has also been shown to lower the risk of engaging in substance use (Li et al., 2011).Experiencing non-victim adversity (e.g. a death in the family) and, surprisingly, increased participation in school activities both increased likelihood of victimization (Romano et al., 2011). The latter was presumed to increase the chances of being victimized due to the increased social exposure of the individual. Certain educational factors such as poor quality schooling (Shaw, 2001), failing out of school (CPHI, 2008) and suspensions (CPHI, 2008) were associated with offending behaviour. Failing out of school was also associated with mental health issues (CPHI, 2008).

Perhaps surprisingly, socio-economic status has both substantial evidence for and against its association with offending and victimization. This has been elaborated upon by the findings

that socio-economic status is highly sensitive to cultural context, suggested by its inconsistent association with crime perpetration in a cross-national sample (Antonaccio et al., 2010). Sometimes access to certain substances in a neigbourhood can contribute to the severity or types of crime. For example, methamphetamine use has been associated with a higher possibility of violent offending (Darke et al., 2009), and in general many offenders and victims report drinking at the time of the offense (Kazemian & Le Blanc, 2004).

Neighbourhood violence and disorder, which may increase the chance of deviant peers, can contribute to the development of an identity which condones violence (DePadilla et al., 2013). The presence of many youth who are in trouble with the law (Alleyne & Wood, 2014; Howell, 2011; Shaw, 2001) as well as heightened criminal activity overall (Howell, 2011) are associated with both crime and victimization. This is particularly true for gangs, wherein individuals are more likely to get involved with a gang, or participate in gang related violence if there is an existing gang presence (Alleyne & Wood, 2014; Howell, 2011). Victimization can also increase because of the tendency for youth to victimize people they already know – usually members of their neighbourhood or community (Shaw, 2001). There are also positive associations between the density of alcohol establishments and some crime outcomes: public consumption, underage consumption, vandalism, nuisance crime, and driving under the influence (Toomey et al., 2012). There are also positive associations between the density of alcohol establishments and violent crime (Toomey et al., 2012b). Widespread use of firearms and drugs in a community are also a risk factor for youth (Howell, 2011). Poor housing has been positively correlated with delinquency for youth living in poor neighbourhoods (Farrington et al., 2002). A lack of training and work opportunities has also been found to be a major risk factor for youth (Shaw, 2001).

This has only been a brief review of the various community level factors which are associated with crime and victimization. Out of the many touched upon, the key factor from this selected review of the literature could certainly be seen as education. While the literature presented here once again helps to acknowledge the complex array of factors which surround crime and victimization they also begin to show us which factors seem to arise the most often across levels, such as association with deviant peers. Acknowledging these main factors can help to determine what types of professionals would best be involved when incorporating IPCP.

Societal Level

Some of the major issues at a societal level have already been discussed, and so will only be mentioned briefly. One relevant example would be the effects of drug policy and its implications for associated mental health issues, substance abuse, and crime. Another mentioned in this paper is the likelihood of individuals with mental health issues to be incarcerated – policy seeing them in facilities where their treatment options are few and less effective. Some social and cultural factors will be more widely discussed in the next chapter, focusing on a vulnerable population: Canadian Aboriginal peoples.

Vulnerable Population: Canadian Aboriginal Peoples

Many of the issues touched upon in the correlates of crime and victimization disproportionately affect Canada's most vulnerable populations. One substantial population is Canadian Aboriginal peoples. Aboriginal is a blanket term which encompasses three broadly differentiated groups as set out in the Canadian Constitution: the Inuit, Métis and First Nations peoples. They comprise 4.3% of the Canadian population, and 15.6% of Saskatchewan's population (Employment and Social Development Canada, 2014). This population is also increasing rapidly with a growth of 20.1% between 2006 and 2011 (Employment and Social Development Canada, 2014), with estimates suggesting that the aboriginal population aged twenty to twenty-nine will grow by 40% in Canada and will comprise 30% of Saskatchewanians by 2017. These same estimates suggest that, in Saskatchewan by 2017, 37% of youth will identify as Aboriginal (Statistics Canada, 2005).

Arising from historical colonization practices, treatment of these peoples has been very poor. This poor treatment was strongly perpetuated by the Residential Schooling System. This system was designed to eliminate aboriginal languages and cultures by separating individuals from their families and communities (Rice, 2011). The youth sent to these schools often suffered psychological, physical, and sexual abuse (Rice, 2011; Gough, Schlonsky, & Dudding, 2009; Leach, 2010), with some estimates suggesting up to 75% of students experienced sexual abuse and even higher rates of physical abuse (Rice, 2011). These schools operated for approximately one hundred years with the last school closing only in 1998. This means that three generations of many aboriginal families may not have been raised by their own families or in their own communities. It is doubtful that any aboriginal community is unaffected by the harms of this practice due to the profound and widespread inter-generational trauma (Rice, 2011). Some

effects resulting from this practice are alienation from mainstream education systems, cultural disconnection, poorer physical and mental health, fewer economic opportunities, isolation, increased levels of substance abuse, and loss of parenting skills (Brzozowski, Taylor-Butts, & Johnson, 2006; Gough et al., 2009; Leach, 2010; Pendakur & Pendakur, 2011; Wilson & MacDonald, 2010). It is unsurprising then that many of these individuals are exposed to numerous conditions which can influence their likelihood of being victimized or participating in offending behaviour at rates far higher than most of the Canadian population.

In 2005, approximately one third of Aboriginals lived on reserves (Statistics Canada, 2005) while one half of First Nations specifically lived on reserve (Government of Canada, 2006). Many reserves have substantial issues with poverty, isolation, and substance abuse. There are also issues with health and social support infrastructure which are consistently poor or absent, particularly for those in remote northern reserves (Gough et al., 2009). While rates of police reporting are comparable to non-Aboriginal populations, rates of violent victimization for Aboriginal individuals are approximately three times higher (Brennan, 2011). On reserves, crime rates have also been found to be three times higher, both for youth and overall, and eight times higher for violent crime (Brzozwski et al., 2006). Both on reserve and off reserve Aboriginal persons are more likely to be victimized – 37% versus 26% for the non aboriginal population. This risk is especially high regarding sexual assaults of youth (Perreault, 2011). Spousal abuse is also particularly high with 24% of women and 18% of men reporting some experience of spousal abuse (Guirguis-Younger, MacNeil, & Hwang, 2014)

Alongside the other issues associated with substance use, discussed in the previous section, substance use and abuse remains a substantial issue for Aboriginal populations (Canadian Centre on Substance Abuse, 2007; Gone & Trimble, 2012). Twenty five percent of Aboriginals surveyed reported having a personal issue with alcohol, 33% reported there was an issue with alcohol in their home or family, and 75% indicated that they felt there was a problem with alcohol use in their community (Government of Canada, 2006). Substance use can be a factor in the development or exacerbation of mental health issues and conversely, mental health issues can also be a risk factor for substance use (Government of Canada, 2006). The experience of trauma has also been linked to alcohol use disorders in aboriginal populations (Boyd-Ball, Manson, Noonan, & Beals, 2006). Substance use is also closely associated with perpetration of crimes wherein there is an Aboriginal victim (Perreault, 2011).

Mental health issues are also a concern within Aboriginal populations, in addition to the associates discussed in the previous section. Aboriginal populations demonstrate one of the highest rates of high psychological distress and experience selected mental disorders and substance dependence at two to five times the rates of other ethnic subgroups (Caron & Liu, 2010). By comparison to white Canadians, off-reserve Aboriginals were 42% more likely to experience high psychological distress (Caron & Liu, 2010). Aboriginals experience higher rates of suicide, alcoholism and depression (Kirmayer, Brass, & Tait, 2000) with First Nation's peoples experiencing major depression at rates twice that of the overall national average (Government of Canada, 2006). Post-traumatic stress is also disproportionately experienced by Aboriginal individuals (Gone & Trimble, 2012). Aboriginal youth have also been found to commit suicide at higher rates than non-Aboriginal youth (MHCC, 2012). Individuals identifying as Aboriginal are also more likely to be mental health in-patients with a criminal history (CPHI, 2008) and there is also evidence that suggests that poverty exacerbates mental health issues in Aboriginal populations (Caron & Liu, 2010).

The Aboriginal population is also overrepresented in correctional facilities, making up 21.4% of those incarcerated across Canada (Sapers, 2012). Saskatchewan in particular has one of the most disproportionate incarceration rates: Aboriginals comprise 1,260 per 100,000 population by comparison to 49 per 100,000 for non-Aboriginals (Owusu-Bempah et al., 2014). In the prairie region as a whole, Aboriginal offenders make up 43% of the offender population (Sapers, 2012). Aboriginal populations also lose approximately six times as many years being incarcerated as non aboriginals (Owusu-Bempah et al., 2014). Aboriginal offenders are twice as likely to return to custody, and are more likely to be involved in self harm (Sapers, 2012). Aboriginals are also more likely to be mental health in-patients with a criminal history (i.e. forensic patients) (CPHI, 2008). This issue only seems to be escalating with the population of incarcerated Aboriginal individuals rising 40% – compared to only 2% for non-aboriginals (Sapers, 2012). This is particularly problematic considering the numerous negative consequences associated with an individual's involvement in the criminal justice system (Baillargeon et al., 2009; UNODC, 2009).

Women who identify as Aboriginal are particularly vulnerable in Canada. They are three times more likely to self report spousal violence victimization and more likely to report fear for their life or injury as a result of the victimization (Perreault, 2011). The rate of violent

victimization in general for aboriginal women is also three times higher than non-aboriginal women (Brennan, 2011). The high rates of murdered or missing Aboriginal women and girls are indicative of these high violent victimization rates which recently resulted in the request for an inquiry by the UN special rapporteur on the rights of indigenous peoples (Anaya, 2014). Alongside high rates of victimization, the rates of Aboriginal women's involvement in the criminal justice system is rising drastically (Sapers, 2012). They make up 85% of admissions to sentenced custody in Saskatchewan and Manitoba (Mahony, 2011). These incarcerated women have also been shown to disproportionately exhibit substance abuse issues, which have been linked to experiences of trauma. The discrepancy was particularly high for alcohol abuse (Derkzen, Booth, Taylor, & McConnell, 2012). Aboriginal woman are also more likely to experience chronic disease than Aboriginal men (Bourassa, McKay-McNabb, & Hampton, 2005). Their overall health outcomes are also much poorer (Bourassa et al., 2005; Guirguis-Younger et al., 2014). Aboriginal women also experience more difficulty in providing necessities for their children such as food, clothing and housing (UATF, 2007).

Aboriginal youth are also highly vulnerable within the Canadian context. Despite only 5% of children in Canada being Aboriginal, they make up 30 to 40% of the children living in out-of-home care (Trocmé, Knoke, & Blackstock, 2004). Placement in the child welfare system has been correlated with greater mental disorder and disability (Gough et al., 2009) as well as substance use and higher rates of offending behaviour (Pilowsky & Wu, 2006; Traube et al., 2012). Foster care has also been associated with homelessness in Aboriginal populations, with Aboriginal populations disproportionately represented among Canadian homeless (Klodawsky, Aubry, & Farrell, 2006). Approximately 10% of Canada's homelessness identify as Aboriginal (Leach, 2010).

Aboriginal youth are also highly overrepresented within the correctional system. Despite only comprising 7% of all Canadian youth, aboriginal youth make up 39% of the youth in correctional facilities. Female Aboriginal youth, an especially vulnerably population, make up 49% of the female youth correctional population (Perreault, 2013). Aboriginal youth are also at a higher risk of victimization than non-Aboriginal populations (Brennan, 2011). First Nation's youth in particular are five to six times more likely to commit suicide (MHCC, 2012) and report higher levels of drug use (Latimer et al., 2003).

Overall, the lived experiences of these individuals are rife with individual, relationship,

community, and societal factors that are correlated to both crime and victimization. These people represent a percentage of the Canadian population which is often ignored, even though in certain regions of Canada they represent a substantial proportion of the population. The difficulties disproportionately experienced by the Aboriginal population, especially Aboriginal women and children, again demonstrate a complex array of factors which have been strongly associated with both crime and victimization, and can be much better illustrated through the use of the public health framework. In using IPCP through the public health model, this paper will envision a way to alleviate these conditions in order to dramatically improve the quality of life for this vulnerable population.

Canadian Criminal Justice

The Canadian criminal justice system has its roots largely in English and French law systems in place since the 17th and 18th centuries (Department of Justice Canada, 2005). While the Aboriginal populations native to Canada also had traditions and laws regarding societal norms and expectations, these systems were largely pushed out with the imposition of English law (Griffiths & Verdun-Jones, 1994; Department of Justice Canada, 2005). Despite the heavy influences from its neighbours (e.g. the United States of America) and colonizers, Canada developed a criminal justice system distinct from these other parties. The Constitution Act of 1867 was where it was consolidated, wherein the enactment of criminal laws, and the procedures for dealing with them, became an exclusive power of the federal government. Justice and the courts (except for the Supreme Court of Canada) are administered under provincial jurisdiction; however the federal government also provides justice services in the form of the Royal Canadian Mounted Police (RCMP), which can act federally, provincially, or municipally. The 1892 Criminal Code, which has undergone numerous revisions, is the authoritative work containing substantive offences and procedures for the administration of justice, although there are also other federal statutes. All legislation is subject to the 1982 Canadian Charter of Rights and Freedoms, and this is enforceable by the courts if legislation conflicts with the guaranteed rights and freedoms outlined within. Both crown counsel, who prosecute, and criminal court judges are appointed by provincial and federal governments.

Treatment of offenders, and the Canadian correctional system - Correctional Service of Canada - was largely influenced by France, England and the United States. From the 1700s to the

1930s punishment and penitence formed the basis for the majority of correctional policy and practices. In the 17th and 18th centuries there was a lack of uniformity, but common was the reliance upon capital and corporal punishment, and an emphasis on shame and humiliation. There was very little focus on what could be causing the criminal behaviour (Griffiths & Verdun-Jones, 1994). Incarceration became more widespread in the 1800s with the Penitentiary Act of 1868, and incarceration still remains a substantial component of the criminal justice system (Andrews & Bonta, 2010), yet conditions were very poor and they remained as such into the early 20th century (Griffiths & Verdun-Jones, 1994). Children were also sent to these adult penitentiaries as late as 1888 (Griffiths & Verdun-Jones, 1994). Today, youth may only be sent to adult correctional facilities if sentenced as an adult. While there has been great improvement since then, the conditions of prisons and the negative effects they can have on incarcerated individuals are still a matter of concern (UNODC, 2009). During the mid to late 1800s significant developments were made in perception and policy regarding young offenders – wherein there was an emphasis on the family as both a cause and cure of potential crime, and preventative efforts were implemented to that end. Likewise, there also were reforms for youth courts and youth correctional facilities – unfortunately the implementation was often poor (Griffiths & Verdun-Jones, 1994).

Canadian policing traditions largely were imported from England (Griffiths & Verdun-Jones, 1994): Sir Robert Peel is widely recognized as the 'father of modern policing' (Kappeler & Gaines, 2015) and he introduced the 1829 Metropolitan Police Act, which, once passed, allowed Peel to create the Metropolitan Police of London (Scott, 2010); different from the disparate groups of locally governed constables and night-watchmen which had previously been responsible for policing, the Metropolitan Police of London were the first paid constables (Kappeler & Gaines, 2015). The actions of the police were envisioned to follow Peel's Principles, drafted by Maynes and Rowan, the appointed commissioners of the department (Kappeler & Gaines, 2015; Scott, 2010), which among them included stated purposes to prevent crime and disorder, acknowledge the power of public opinion on their actions (and their actions on public opinion), well as maintain a positive relationship with the public, avoid the use of force, work only within the extent of their role, and use a lack of crime as a measure of success, rather than police visibility (Dempsey & Forst, 2013). An awareness of these principles, and their influence on modern policing, exists even today (Scott, 2010).

Although the first Canadian police force was established in Toronto in 1835, prior to confederation in 1867, policing practice was diverse and largely uncontrolled (Griffiths & Verdun-Jones, 1994). Police, and up until the 1860s sometimes Hudson Bay Company agents, were expected to play various roles including jailor, bailiff, sanitary inspector, tax collector and various other roles and duties in addition to policing duties which generally involved the prevention of conflict, maintenance of moral order, and apprehension of criminal individuals. While this is largely no longer the case, the RCMP in remote locations are sometimes still expected to play numerous roles (Griffiths & Verdun-Jones, 1994). It was after Confederation in 1867, and the establishment of the RCMP that provincial police forces were developed (Griffiths & Verdun-Jones, 1994).

Today, policing falls to federal, provincial and municipal jurisdictions. Within their jurisdiction police enforce all laws in the Criminal Code, provincial statues, municipal laws, and sometimes federal statutes (Griffiths & Verdun-Jones, 1994). Eighty percent of eligible communities are additionally covered by the First Nations Policing Program which is a collaborative policing program designed to provide more specialized services suited to the needs of many different First Nations communities (Kiedrowski, 2013). The development of formal agencies to administer law and order started a trend of shifting responsibility away from the community (Griffiths & Verdun-Jones, 1994). In addition to apprehending offenders and maintaining order, police are now also responsible for crime prevention, traffic control, non-emergency response, and information dissemination on various crime reports (Griffiths & Verdun-Jones, 1994). There is also often pressure for police to assume even more roles, and what exactly they should be responsible for is still somewhat uncertain, especially in the eyes of the public. However the police are not best suited for all of these roles – particularly for the prevention of crime and disorder (Russell & Taylor, 2014) and many of the 'traditional' policing practices (e.g. patrol) are largely ineffective for prevention (Telep & Weisburd, 2011; Weisburd & Eck, 2004). The police are often those mostly likely to first encounter social problems such as homelessness or substance abuse (Griffiths & Verdun-Jones, 1994), however they are less able to deal with these issues in effective ways due to the incident driven perspective of Canadian policing (Russell & Taylor, 2014). Transitioning to a risk-driven perspective presents, and indeed requires, the implementation of a more holistic system in justice. One such way in which this could be done is through the implementation of IPCP, which is best implemented when

crime and other issues leading to victimization can be reframed using the social-ecological model.

In summary, Canada's criminal justice background draws from a number of different traditions with roots in numerous cultures. While there has both historically and recently been some attempt to account for more preventative methods of reducing crime and victimization, practice largely involved arrest and incarceration. The police are the individuals most often exposed to the harm experienced by Canadian citizens, however they are not necessarily the individuals best suited to deal with it. Police also suffer from a lack of clarity in what their roles are, resulting in them being expected to deal with numerous issues that they are not best suited to. This paper seeks to change the way we look at Justice, bucking the previous trends which have long ruled the landscape of Canadian Justice.

Best Practice Literature

For IPCP one of the more important elements is the emphasis on empirically supported practice. Despite the myriad strategies attempted across sectors, not everything attempted – even those with the best of intentions – result in a positive outcome. This can be detrimental if these attempts use valuable organizational resources. Therefore this paper will discuss a selected literature review highlighting some of the most well supported risk factors correlated to crime: parenting, substance abuse, mental health issues, education and crime and victimization. Deviant peers, while a very notable risk factor, will not be discussed in depth, as the best way to prevent a youth from associating with deviant peers, would be to prevent those youth from coming into conflict with the law themselves by involving them in proactive activities. This can be accomplished by using empirically supported methods.

In the literature, parenting issues have largely been addressed through interventions. Interventions have been shown to improve childrens' cognitive, social and emotional development, as well as school readiness in a cross-national review of previous studies (Engel et al., 2011). Standardized programs have been found to improve both parenting skills and child outcomes, even when additional complicating factors are involved such as mental health problems or substance abuse (Akai et al., 2008; Chand, Farruggia, Dittman, Chu, & Sanders, 2013; Engel et al., 2011; Gardner, Burton, & Klimes, 2006; Henggeler & Schoenwald, 2011; Suchman et al., 2010). Additionally, they can help reduce inequalities which can arise from poverty, poor health, or limited educational opportunities (Engel et al., 2011). Although, research

suggests that interventions must focus specifically on increasing parental skills, as improvements only in confidence or mood of the parents were not associated with positive child outcomes (Gardner et al., 2006). Some of the positive outcomes for parents have been found to include higher levels of child supervision and parental support (Akai et al., 2008; Chand et al., 2013), fewer 'negative parenting practices' such as hitting (Gardner et al., 2006), increased parental attachment (Suchman et al., 2010), and improved family cohesion (Chand et al., 2013). Functional family therapy, which treats issues as symptoms of family dysfunction, has also been an effective intervention for youth in conflict with the law (Henggeler & Schoenwald, 2011). Despite these positive results, often parenting programs are not promoted multisectorally such as during substance abuse treatments (Arria et al., 2013), which could be one way to reach more at risk individuals (Engel et al., 2011). The quality of a parental intervention can be improved in a number of ways, some of the most effective interventions included: systematic training of workers, providing feedback on parental practice, involvement of both the community and the family, and a structured and evidence based curriculum (Engel et al., 2011). For youth already in conflict with the law, program success has also been improved by rehabilitative strategy, behavioural intervention techniques, staying in the youth's natural environment, individual tailoring, focusing on high risk factors, and targeting high risk offenders (Henggeler & Schoenwald, 2011). These interventions are often constrained by a lack of financial resources so engaging governments or organizations to provide further funding should be a goal (Arria et al. 2013; Engel et al., 2011).

For combating substance abuse a health oriented approach has been found to be more effective than criminal sanctions both for the substance abuse itself and also for the reduction of some of the related social harms (Chandler, Fletcher, & Volkow, 2009; McSweeney, Stevens, Hunt, & Turnbull, 2007; Uchtenhagen et al., 2008), which improves outcomes for both the individual and their community. By using a public health model for substance abuse it permits the acknowledgement of other elements such as: negative family or social experiences, negative childhood experiences, mental disorders, poor education, and individual personality or biological pre-dispositional factors which have all been associated with substance abuse (Dick et al., 2006; Fergusson et al., 2008; Merikangas et al., 2009; Zucker et al., 2008). Reductions in drug dependency and related crime are also more substantial with treatment, rather than incarceration (Gerstein & Harwood, 1990; Guydish, Wolfe, Tajima, & Woods, 2001; Prendergast, Podus,

Finney, Greenwell, & Roll, 2006; UNODC, 2009). Some alternative treatments which are effective are education, drug dependence treatment and aftercare, rehabilitation and social reintegration, and drug courts (UNODC, 2007; Prendergast et al., 2006). Combinations of both clinical and social interventions provided by multi-professional teams are highly recommended (UNODC, 2009).

Once an individual engages with and commits to the mental health system, outcomes are generally positive, but getting individuals to initially engage or commit remains difficult. The main difficulties that have been identified in attempting to reach out to individuals with mental health issues are stigma (Gamm, Stone, & Pittman, 2010; Gulliver, Griffiths, & Christiensen, 2010; Loch, 2011), lack of awareness of mental health issues (Gamm et al., 2010; Gulliver et al., 2010; Mojtabai et al., 2011), and the desire for these individuals to deal with their problem on their own (Gulliver et al., 2010; Mojtabai et al., 2011; van Beljouw et al., 2010). In order to improve mental health outcomes the literature suggests utilizing patient empowerment, activation, and engagement in order to improve individual self-help (accessing use of an established program), and encourage initial participation and attendance (Alegria et al., 2008; van Beljouw, 2010; den Boer, 2004; Gopalan, 2010; Spek et al., 2006). Reminder phone calls directly from the therapist (Shoffner et al., 2007), the usage of web based appointment scheduling systems (Tambling, Johnson, Templeton, & Melton, 2007), home based therapy (Slesnik & Prestopnik, 2004; Thompson, Bender, Windsor, & Flynn, 2009), and text message reminders (Downer, Meara, da Costa, & Sethuraman, 2006) have also been found to increase the likelihood of an individual engaging with and/or attend their appointments. In order to bring more individuals into contact with the mental health system efforts should also be taken to make mental health care more accessible (Chan, 2010; de Girolamo et al., 2011) especially for groups in rural areas (such as remote reserves) where mental health care access is often poor (Gamm et al., 2010).

Early intervention have been shown to reduce severity and persistence of mental health disorders as well as preventing secondary disorders, which is why quickly engaging individuals is of such great import (de Girolamo et al., 2011; Joa et al., 2008; Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2010). Some methods, like motivational interviewing, where the interviewee is encouraged to strengthen their resolve to overcome ambivalence and facilitate change, have been found effective for individuals already in conflict with the law (McMurran,

2009). Collaboration and multidisciplinary practices integrated into partnerships (Chan, 2010; de Girolamo et al., 2011; Gopalan, 2010; McKay et al., 2010) as well as informational campaigns (Engel et al. 2011; Joa et al., 2008; Kovandzic et al., 2010) have been found to be effective in maximizing outreach and efficiency. Involvement and encouragement of family, community, or other social support has also been suggested to improve engagement and outcomes (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009; Gulliver et al., 2010; French, Reardon, & Smith, 2003; Frazier, Abdul-Adil, Atkins, Gathright, & Jackson, 2007).

Some educational interventions, such as mentoring (Lampley & Johnson, 2010; Pecora, 2014) and using a positive manner to inform parents of their child's successful attendance, have been found to be effective for improving educational outcomes, (McConnell & Kubina, 2014; Wilson, Tanner-Smith, & Lipsey, 2011). This holds true for children in foster care (Forsman & Vinnerljung, 2012; O'Brien, 2010; Pecora, 2014). One study has suggested that community based and shorter duration programs tend to be effective for school dropout (Wilson et al., 2011). Development of supportive environments, such as the inclusion of child care, community services, and school restructuring programs have also shown good results for reducing drop outs (Wilson et al., 2011). To help improve mental health and education outcomes, there has also been a lot of support for mental health services integrated into education for the purposes of removing barriers and stigma, which may have discouraged children from attending (Chan, 2010; Frazier et al., 2007; Pecora, 2014; Romano, Babchishin, Marquis, & Frechette, 2014) especially for maltreated children (Romano et al., 2014).

Another way in which we can reduce potential victimization and crime is through evidence based strategies in policing. There has been support for strategies like problem-oriented-policing (POP), hot-spots policing, strategies employing inter-agency working groups (Braga & Weisburd, 2012; Weisburd & Eck, 2004) and suggestions that a main role for the police could be in mobilization of social service agencies, organizations, and communities to address social development (Russell & Taylor, 2014). Studies have also shown that some very commonly employed aspects of policing such as random patrols do little to actually impact crime (Weisburd & Eck, 2004). However, a number of strategies have been found in the literature to help reduce crime much more efficiently. In general, focused police efforts tend to be more beneficial than general ones such as those that target known risk factors (Russell & Taylor, 2014; Telep & Weisburd, 2012; Weisburd & Eck, 2004). Hot-spot policing, which targets small geographic

areas, seems to have an impact on crime rates (Braga, Papachristos, & Hureau, 2012; Telep & Weisburd, 2012; Weisburd & Eck, 2004). Combining hot spots policing and POP has also been found to be very effective (Telep & Weisburd, 2012). POP on its own has also shown moderate positive results for crime reduction and involves officers scanning, analyzing, responding to and then assessing strategies which are tailor made for the place and problem (Telep & Weisburd, 2012). Evidence suggests that POP works best when the officers and departments are fully engaged and committed to using the program (Telep & Weisburd, 2012). Unfortunately this is not common in practice (Cordner & Biebel, 2005), possibly because there are expectations for POP to have immediate results, or because of piling too great a workload on officers which can lead to less time and consideration of each issue – hampering officer effectiveness (Telep & Weisburd, 2012). A study has suggested focused deterrence seems to have positive effects particularly for violent crime when it works to address criminogenic conditions which underlay the emergent issues (Braga & Weisburd, 2012). Others still, such as developing personal contacts in community policing, improving perceived legitimacy of police, and undifferentiated arrest for domestic violence do show some effect, although the connection is not as strong (Weisburd & Eck, 2004). They seem to have more of an impact on reducing fear, improving satisfaction, and reducing victimization (Telep & Weisburd, 2011).

Therefore, it becomes clear after a selected review of the literature that many potential solutions exist for some of the major correlated factors of crime and victimization. Many other options presented here, with positive benefits, have not been widely instituted. Some results also suggest a number of ways in which improvement can be sought such as in the reduction of mental health stigma, and in retooling the role of police. However there is little multisectoral outreach, which was suggested by a few studies, which could allow for greater outreach and effectiveness. This would be one of the things that the incorporation of IPCP could contribute to in a meaningful way.

The Current Status of IPCP

Inter professional collaborative practice has been developed largely within the health sector, but has also been employed by mental health and educational organizations. Inter professional collaboration is when two or more workers from different professional backgrounds work together with an individual, a family and/or a community to provide holistic and high quality care that addresses a number of issues that cross various jurisdictions (WHO, 2010).

Stakeholders are numerous and diverse: educators, students, regulators, practitioners, and employers (Canadian Interprofessional Health Collaborative (CIHC), 2010; WHO, 2010). Collaborative practice has generally been found to support improved systems and outcomes in the health sector (WHO, 2010). One study also found that collaborative partnerships were effective for crime prevention in disadvantaged communities (Choi & Choi, 2012). National Interprofessional Competency Framework (CIHC, 2010) for Canada covers, in depth, Inter-Professional Education (IPE) and identifies six competency domains: inter-professional communication, patient/ family/community-centered care, role clarification, team functioning, collaborative leadership, and inter-professional conflict resolution. Five key characteristics for the integration of these competencies were also noted: variable complexity, additive nature, integrative nature, continual development, and evolution depending upon context (CIHC, 2010). This framework affords the possibility of a unified language and concept for IPCP in Canada and supports the contextualization, acknowledgement of variable problem complexity and quality improvement approaches of which IPCP is a part (Bainbridge, Nasmith, Orchard, & Wood, 2010; CIHC, 2010). Numerous studies have provided insight into different factors which can facilitate or act as a barrier to IPCP's implementation, particularly in light of the key competencies.

One of the main factors is IPE, which is when two or more students from different professions are brought together to learn about, from, and with each other in order to facilitate collaborative practice in the workplace and improve outcomes (WHO, 2010). IPE should ideally occur to provide individuals with the appropriate attitudes, knowledge and skills which would allow them to work with individuals from other disciplines, such as how to maintain relationships with other professionals (Anderson, 2013; Johnson & Freeman, 2014; Pfaff et al., 2014). The World Health Organization has recognized that quality IPE is necessary to prepare a workforce for collaborative practice, and that high quality IPE leads to good collaborative practice (WHO, 2010). This is supported by numerous other studies which support IPE's inclusion within pre-service academic instruction (Anderson, 2013; Gagnon et al., 2010; Gould, Lee, Berkowitz, & Bronstein, 2014; Johnson & Freeman, 2014; Legare et al., 2010). IPE is especially important because current professional and academic preparation often encourages professionals to work within their 'silos' with IPE's integration seen more of an 'add on' rather than a fundamental part of the discipline's program (Anderson, 2013; Johnson & Freeman,

2014). This can make professionals more likely to encounter barriers, such as misunderstanding of roles, terminology, or effective collaborative practice (Anderson, 2013). IPE can contribute to skills and attitudes, which will lead to beneficial team functioning (WHO, 2010) and collaborative leadership (CIHC, 2010). Strong commitment for training is also required, not only by the professionals (and students), but also from their supporting faculty, departments, universities or colleges, communities, and administration (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011; Johnson & Freeman, 2014). This commitment is needed to ensure that trainers do not solely pay lip service to the idea of IPCP without properly mentoring, because this lack of appropriate mentoring can be a barrier to IPE (Rice et al., 2010).This commitment is necessary both in order to implement measures to provide quality training (e.g. changing curricula), but also to ensure that there is appropriate infrastructure and sufficient resources, whether human, financial or otherwise to do so (Bridges et al., 2011; WHO, 2010; Xyrichis & Lowton, 2007).

Resource availability can also be a substantial factor for the implementation of IPCP and is a major barrier (Gaboury, Bujold, Boon & Moher, 2009; Legare et al., 2010; San Martin-Rodriguez et al., 2009; WHO, 2010; Xyrichis & Lowton, 2007). Resources in this case can refer not only to infrastructure, but also to financial, material, human, spatial, and even temporal resources. Infrastructure, that is physical spaces to meet, should also be taken into consideration even with regards to their layout (Xyrichis & Lowton, 2007; WHO, 2010). The numerous other resources and their potential to either facilitate or increase difficulty in implementation of IPCP will be discussed throughout this section.

Another huge barrier, both for IPCP and IPE, is time constraints, or perceived time constraints (Anderson, 2013; Gould et al., 2014; Lalonde, 2006; Legare et al., 2010; Legare, Ratte, Gravel, & Graham, 2008). However, there has not been substantial research indicating that greater involvement of certain Inter-Professional practices, such as the focus on patient/family/community-centered care, necessarily increases time spent (Legare et al., 2010; Legare et al., 2008; Stacey, O'Connor, Graham, & Pomey, 2006; Whelan et al., 2006) with one study noting that after training nurses to provide decision coaching and support, not only did their skills improve but the time spent communicating with the patient did not increase (Stacey et al., 2006). Some professionals even suggested that shared responsibilities save time (Chong, Aslani, & Chen, 2013; Legare et al., 2010). Some communication innovations such as

smartphone use in IPCP have been suggested to reduce time constraints, but they may add complexity in turn (Lo, Wu, Morra, Lee, & Reeves, 2012).

Role clarification is one of the six competency domains outlined by the CIHC, and is a major factor in the implementation of IPCP and IPE (Bridges et al., 2011; Gaboury et al., 2009, Gabrielsson, Looi, Zingmark, & Savenstedt, 2014; Johnson & Freeman, 2014; Legare et al., 2010). Lack of clarity about roles results in substantial barriers often due to a misunderstanding of other professionals' responsibilities, frustration with the jargon used by other disciplines, or even differences of opinion on shared concepts (Anderson, 2013). A lack of clarity on roles can prevent someone from taking advantage of another's strengths to increase efficiency (Anderson, 2013; Bridges et al., 2011). Some of the issues around roles are: identity, expertise, territory & power (Rose, 2009) with power in particular being an influential factor for IPCP.

Power imbalances can provide a barrier to the implementation of IPCP (Legare et al., 2010). These imbalances can arise from gender stereotypes, social status, personal connection to the patient, and symbolic power arising from a particular profession (Gabrielsson et al., 2014; Legare et al., 2010; San Martin-Rodriguez et al., 2005). The decision making power of patients is also something that must be acknowledged (Gabrielsson et al., 2014). Power differentials will need to be acknowledged and negotiated on the way to an outcome with power being shared among collaborators (Rose, 2009; Legare et al., 2010; Salhani & Coulter, 2009). Of course, in order to overcome such a barrier individuals must be willing and motivated to do so – motivation for the implementation of IPCP being a major facilitator (Legare et al., 2010; San Martin Rodriguez et al., 2005). Willingness involves trust between parties as well as mutual respect and communication (San Martin Rodriguez et al., 2005), all of which can contribute to more beneficial team functioning and collaborative leadership practices.

Regarding power, the involvement of the patient/family/community is one of the core competencies outlined by the National Inter-professional Competency Framework. The patient and their family (and significant others) should play a distinct and active role which includes collaboration with the inter-professional team (Legare et al., 2010). However, in practice at least one study has shown that often times the patients are barely involved in treatment decisions (Gagnon et al., 2010). This relationship should involve mutual respect and trust, not only between professionals, but also between the professionals and the patient (Legare et al., 2010). The inter-professional team in this role is well suited to initiating decision making and acting as a

decision coach (Legare et al., 2010). Difficulties arise, particularly in mental health, wherein the stigma against mental health and some individuals' lack of competency to participate were perceived to be barriers to shared decision making (Chang et al., 2013). One way in which the patient can be more effectively engaged is through the use of participant decision aids (Gagnon et al., 2010; Lalonde et al., 2006; Lalonde et al., 2004; Legare et al., 2010; Nannenga et al., 2009) although there hasn't been much exploration of a decision aid for psychiatric treatment (Chang et al., 2013). Decision aids as a whole have been found to improve relationships between professionals and their patients (Nannenga et al., 2009). The involvement of the patient, and the development of good relationships between them and collaborating professionals, is also important for beneficial team functioning (CIHC, 2010). Another barrier was with professionals deciding for patients (without their input) whether the patients would want to participate or would benefit from IPCP (Legare et al., 2008). Future interventions should address the patient directly rather than relying upon professional perception of a patient's willingness to participate (Legare et al., 2008). The involvement of the patient/family/community is one of the fundamental and supporting competencies outlined in the National Inter-professional Competency Framework, and as such should be one of the primary considerations and is always relevant (CIHC, 2010).

Interprofessional communication is also an influential factor for the implementation of IPCP and IPE in order to facilitate collaboration (Gaboury et al., 2009; Legare et al., 2010; Lo et al., 2012; San Martin Rodriguez et al., 2005). Communication is important because of its ubiquitous presence – it can influence everything about collaborative practice, such as knowledge dissemination and conflict resolution, and as such is always relevant (CIHC, 2010). However, at least one study has noted that communication in IPE training is only employed at a minimal level due to a general lack of communication between collaborators, and that before communication techniques can be employed communication must be properly established (Rice et al., 2010). Communication issues can often result from attempting to communicate over large distances, or from profession centric attitudes (Johnson & Freeman, 2014). Smartphones have been used to improve communication issues over spatial boundaries, but they also increased complexity of the communications (Lo et al., 2012). This increased complexity also introduced some conflict issues regarding appropriate use of particular communication methods (Lo et al., 2012). Other communication methods like texting have helped to improve citizen

communication with police officers, with the subtlety of the method of communication helping to allay the fears an individual might have for reporting (Firman, 2012). The importance of communicating with the patient/family/community must also be acknowledged (Johnson & Freeman, 2014). Communication between collaborators is also particularly important to establish collaborative leadership, which can change depending on the specifics of a particular patient's case (CIHC, 2010).

Conflict resolution is also a major factor when trying to implement IPCP. IPE would be a beneficial starting point for ensuring strong conflict resolution within IP teams. Some of the major sources of conflict between professionals were lack of role and responsibility clarification as well as accountability (Brown et al., 2011). There are also a number of barriers which can exacerbate these conflicts such as: lack of motivation to overcome it, unequal power, lack of time or excessive work load, and on occasion the avoidance of an issue to avoid emotional discomfort (Brown et al., 2011). By educating students not only on role responsibilities, but also on issues such as: ethical obligation to consult, seeking of supervision, maintenance of relationships with other professionals, and development of productive attitudes, a substantial amount of conflict may be avoided as the students will be more capable of productive Inter-Professional work (Johnson & Freeman, 2014; WHO, 2010). Even with solid implementation of IPE, conflict is generally a given in teamwork environments (Brown et al., 2011), although constructive debate, which could be helpful in a collaborative partnership, should not be confused with conflict. Some other factors which may contribute to a reduction in conflict and more effective collaboration are: interventions by team leaders, and conflict management protocols which can be developed by the team, mutual and respectful treatment of collaborators, motivation to resolve conflicts, and strong communication (Brown et al., 2011; Gaboury et al., 2009; Legare et al., 2010; Lo et al., 2012; San Martin Rodriguez et al., 2005).

It becomes clear from this overview of the literature, that while IPCP has a substantial amount of research, most notably within health care, issues with the implementation remain. IPCP was envisioned to confront the complex needs of modern day care issues (WHO, 2010), something which is similarly necessary when implementing Justice through a Social-Ecological approach. However the challenge remains at increasing capability without introducing needless complexity. Particular care must be taken to ensure that appropriate means of assessment are developed and employed in order to avoid excessive bureaucracy (Page, 2004; Thannhauser,

Russell-Mayhew, & Scott, 2010). The literature suggests that the incorporation of well constructed and supportive IPE could effectively overcome many of the major barriers to IPCP such as cross-discipline communication issues and conflict management. Other concerns, such as time constraints, need more research to clarify if an issue actually exists. The most difficult barrier is limited resources, which can only be improved by convincing governments and the public that the incorporation of IPCP into Justice is the best way forward in order to effectively reduce crime and victimization in Canada.

V. Conclusion

This thesis asserts that addressing only crime while ignoring related elements is not the most effective means of reducing crime. Reducing crime is best achieved through reducing victimization, and victimization – when extended outside its restrictive crime related context – is shown to be an issue which affects society on a number of levels and requires diverse means to address. This diversity allows and invites the incorporation of IPCP to best address victimization on all levels in order to effect a substantive change in the lives of Canadians, particularly for vulnerable groups such as the Canadian Aboriginal peoples.

A few questions were raised during the course of this work that will now be addressed. Firstly, after looking at the literature, how can we re-evaluate the roles for different organizations? The literature indicated a clear reliance on policing and corrections as the first and foremost means of dealing with crime, yet these systems are often less capable of providing substantive preventative actions and are largely employed during intervention and suppression. While these systems provide a service which is vital to the successful functioning of the criminal justice system, they do little to help those who are victimized by other means (e.g. mental health) as such actions are often outside of their purview. There were a few substantial correlates of crime and victimization such as: parenting, education, mental health, deviant peers, previous victimization or offending behavior, and substance abuse. In order to address these factors, measures must be taken by professionals across a diverse range of disciplines, ideally collaborating together towards the overall goal of reducing harm. This means a much greater focus should be placed on services provided by groups such as educational institutions, child and family services, mental health services, and addictions services. While the actions and efforts taken by police and corrections should not be diminished, they should be understood in the

context of also working towards a reduction in harm, and therefore victimization, rather than the definitive means by which to solve the issue of crime and victimization. Additionally, improvement of existing victimization surveys should be considered, not only to broaden their scope, but also to ensure they are reaching as many individuals as possible including often unrepresented groups like homeless individuals.

Secondly, what roles exist for the individual, family, and community in crime management? After reading through this paper, crime management would be better understood as victimization reduction. The literature for IPCP emphasizes the importance of involving the individual in decision making and care decisions, yet research on the matter has shown that actual implementation is poor. This is problematic because, fundamentally, if an individual does not wish to comply or participate with a particular strategy used by a professional it is likely they simply will not. What good is the medicine if the patient will not take it? Implementation of IPE in numerous programs likely to filter into areas related to victimization reduction would be ideal, as good quality IPE leads to better implementation of IPCP. This is no small undertaking and would require substantial change and participation, not only by organizations, but also by educational and training institutions. More research must be done to determine whether IPCP has a detrimental impact upon time costs, as current research is not definitive. Communication with individuals, families, and communities can also add necessary information and insight and further contextualize the problem, which is an important element discussed by the CIHC. For individuals, decision aids have been shown to be helpful, yet difficultly remains when considering mental health issues, as occasionally the patient's competency is unclear. More research should be done on the development of psychiatric decision aids and their potential contribution to mental health care. The literature also suggests that multisectoral interventions should be implemented in greater numbers in order to improve intake into programs, which is a suggestion which would benefit greatly from the involvement of IPCP.

In the section on best practices, the role of the family, whose involvement is a major element of IPCP, was discussed. Research has shown that family involvement, often parental involvement, has positive outcomes on youth in numerous areas, even when dealing with complicated factors such as mental health issues and substance abuse. Involving the family is a way to improve outcomes potentially beyond what could be achieved through simply interacting

with the individual. It also provides the opportunity to aid further understanding or improve family relationships, which are major factors related to crime and victimization on their own.

Communities, understood in accordance with the social-ecological model of health which suggests they are places where people develop relationships and spend their time, are ripe for outreach opportunities. The involvement of the community is also a tenet of IPCP. In the literature, supportive communities lead to positive benefits in the reduction of many factors associated with crime and victimization. Some examples include improved educational outcomes and better understanding of mental health, leading to reductions in stigma. Supportive communities can provide an environment where individuals feel freer to engage in existing services. For this reason communities merit involvement in victimization reduction initiatives as they can not only encourage further support, but also bolster positive outcomes.

Thirdly, what models exist to help illustrate the ubiquity of harm and its impact upon other individuals? The socio-ecological public health model has been used effectively with regards to understanding violence and its correlates. It permits for a broad understanding of the phenomena and its correlates across various levels: individual, relationship, community, and societal, which were discussed at length in this paper. This model is optimistically being extended within this paper to account for all types of crime and victimization, rather than just violence.

This paper proposes an entirely new paradigm around crime and victimization. A paradigm based upon the socio-ecological model of public health that puts victimization at the centre with crime as a contributing factor on the same level as substance abuse, education, parenting, and mental health. This model would better allow for preventative work in advance of crime commission, while still addressing, and even improving, intervention and suppression strategies. By dissociating victimization from crime, harmful situations such as poor parenting or mental health issues can be addressed faster and more effectively as opposed to the current system which often relies upon criminal behavior to indicate a need for intervention. This radical change in focus would suggest a need to rework the infrastructure and organizational balance surrounding crime to account for the complexity of its correlates. Numerous organizations, such as child and family services, would understandably play a much larger role when reframing the issue in terms of victimization reduction, which invites the incorporation of IPCP. This shift must be accompanied not only by changes in the bureaucratic structure, but also in IPE and

training for future professionals to further encourage and develop collaborative skills across professional divides. Further research on specific topics, as discussed within this paper should also be undertaken.

References

Akai C. E., Guttentag C. L., Bagget K. M., Noria C. C. W., & The Centre for the Prevention of Child Neglect. (2008). Enhancing parenting practices of at-risk mothers. *Journal of Primary Prevention*, 29, 223-242.

Alegria M., Polo A., Gao S., Santana L., Rothstein D., Jiminez A., Hunter M. L., Mendieta F., Oddo V., & Normand S. L. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, 46(3), 247-256.

Allen M. (2014). Police-reported hate crime in Canada, 2012. *Juristat*, component of Statistics Canada catalogue no. 85-002-X.

Alleyne E. & Wood J. L. (2012). Gang-related crime: The social, psychological and behavioural correlates. *Psychology, Crime & Law*, 19(7), 611-627. doi:10.1080/1068316X.2012.658050

Anaya J. (2014). Report of the special rapporteur on the rights of indigenous peoples, James Anaya. Addendum: The situation of indigenous peoples in Canada. 4 July 2014, A/HRC/27/52/Add.2. Available from: <http://unsr.jamesanaya.org/docs/countries/2014-report-canada-a-hrc-27-52-add-2-en.pdf>

Anderson E. M. (2013). Preparing the next generation of early childhood teachers: The emerging role of interprofessional education and collaboration in teacher education. *Journal of Early Childhood Teacher Education*, 34(1), 23-35. doi: 10.1080/10901027.2013.758535

Andrews D. A. & Bonta J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*, 16(1), 39-55.

Antonaccio O., Tittle C. R., Botchkovar E., & Kranidiotis M. (2010). The correlates of crime and deviance: Additional evidence. *Journal of Research in Crime and Delinquency*, 47(3), 297-328. doi: 10.1177/0022427810365678

Arria A. M., Mericle A. A., Rallo D., Moe J., White W. L., Winters K. C., & O'Connor G. (2013). Integration of parenting skills education and interventions in addiction treatment. *Addiction Medicine*, 7(1), 1-7.

Baillargeon J., Penn J. V., Knight K., Harzke A. J., Baillargeon G., & Becker E. A. (2009). Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Administration and Policy in Mental Health*, 37(4), 367-374. doi:10.1007/s10488-009-0252-9

Bainbridge L., Nasmith L., Orchard C., & Wood V. (2010). Competencies for interprofessional collaboration. *Journal of Physical Therapy Education*, 24(1), 6-11.

Becker S. P. & Kerig P. K. (2011). Posttraumatic stress symptoms are associated with the frequency and severity of delinquency among detained boys. *Journal of Clinical Child & Adolescent Psychology*, 40(5), 765-771. doi: 10.1080/15374416.2011.597091

Bemiller M. (2008). When battered mothers lose custody: A qualitative study of abuse at home and in the courts. *Journal of Child Custody*, vol. 5, no. 3-4, pp. 228-255. DOI: 10.1080/15379410802583742

Björkqvist K. & Österman K. (2014). Does childhood physical punishment predispose to a "Victim Personality"? *Pediatrist and Therapeutics*, vol. 4, no. 1, pp.190-192. DOI: 10.4172/2161-D665.1000190

Bourassa C., McKay-McNabb K., & Hampton M. (2005). Racism, sexism and colonialism: The impact on the health of aboriginal women in Canada. *Canadian Woman Studies*, 24(1), 23-30.

Boyd-Ball A. J., Manson S. M., Noonan C., & Beals J. (2006). Traumatic events and alcohol use disorders among american indian adolescents and young adults. *Journal of Traumatic Stress*, 19(6), 937-947.

Braga A. A., & Weisburd D. L. (2012). The effects of focused deterrence strategies on crime: A systematic review and meta-analysis of the empirical evidence. *Journal of Research in Crime and Delinquency*, 49(3), 323-358. doi: 10.1177/0022427811419368

Braga A., Papachristos A., & Hureau D. (2012). Hot spots policing effects on crime. *Campbell Systematic Review,* 8. doi: 10.4073/csr.2012.8

Brennan S. (2011). Violent victimization of aboriginal women in the Canadian provinces, 2009. *Juristat*, component of Statistics Canada catalogue no. 85-002-X.

Bridges D. R., Davidson R. A., Odegard P. S., Maki I. V., & Tomkowiak J. (2011). Interprofessional collaboration: Three best practice models of interprofessional education. *Medical Education Online 2011,* 16(6035). doi: 10.3402/meo.v16i0.6035

Brown J., Lewis L., Ellis K., Stewart M., Freeman T. R., & Kasperski M. J. (2011). Conflict on interprofessional primary health care teams – can it be resolved? *Journal of Interprofessional Care*, 25, 4-10. doi: 10.3109/13561820.2010.497750

Bryant C. D. (Ed.) (2011). *The Routledge Handbook of Deviant Behaviour*. Routledge: New York: New York.

Brzozowski J. A., Taylor-Butts A., Johnson S. (2006). Victimization and offending among the aboriginal population in Canada. *Juristat*, Statistics Canada, catalogue no. 85-002-XIE, 26(3).

Campbell R., Sefl T., Barnes H. E., Ahrens C. E., Wasco S. M. & Zaragoza-Diesfeld Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology*, 67(6), 847-858. doi: 10.1037/0022-006X.67.6.847

Canadian Centre on Substance Abuse. (2007). Substance abuse in Canada: Youth in focus. *Canadian Centre on Substance Abuse*, Ottawa, ON. Available from: < http://www.ccsa.ca/Resource%20Library/ccsa-011521-2007-e.pdf>

Canadian Interprofessional Health Collaborative (CIHC). (2010). A national interprofessional competency framework. Available from: <www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf>

Canadian Population Health Initiative (CPHI). (2008). Improving the health of Canadians: Mental health, delinquency & criminal activity. *Canadian Institute for Health Information*. Available from: <http://www.cmha.ca/public_policy/improving-the-health-of-canadians-mental-health-delinquency-and-criminal-activity/>

Caron J. & Liu A. (2010). A descriptive study of the prevalence of psychological distress and mental disorders in the Canadian population: Comparison between low-income and non-low-income populations. *Chronic Diseases in Canada*, 30(3).

Cartier J., Farabee D., & Prendergast P. J. (2006). Methamphetamine use, self-reported violent crime, and recidivism among offenders in California who abuse substances. *Journal of Interpersonal Violence*, 21(4), 435-445. doi: 10.1177/0886260505285724

Chan M. (2010). Mental health and development: Targeting people with mental health conditions as a vulnerable group. *World Health Organization*. Available from: <www.who.int/mental_health/policy/development/mh_devel_targeting_summary_2010_en.pdf>

Chand N., Farruggia S., Dittman C., Chu J. T. W., Sanders M. (2013). Promoting positive youth development through a brief parenting intervention program. *Youth Studies Australia*, 32(1), 29-36.

Chandler R. K., Fletcher B. W., Volkow N. D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association*, 201(2), 183 – 190.

Chen X. (2009). The link between juvenile offending and victimization: the influence of risky lifestyles, social bonding, and individual characteristics. *Youth Violence and Juvenile Justice*, 7(2), 119-135. doi: 10.1177/1541204008328799

Choi C. G. & Choi S. O. (2012). Collaborative partnerships and crime in disorganized communities. *Public Administration Review*, 72(2), 228-239. doi: 10.111/j.1540-6210.2011.02498.x

Chong W. W., Aslani P., & Chen T. F. (2013). Shared decision-making and interprofessional collaboration in mental healthcare: A qualitative study exploring perceptions of barriers and facilitators. *Journal of Interprofessional Care*, 27(5), 373-379. doi: 10.3109/13561820.2013.785503

Cordner G. & Biebel E. P. (2005). Problem-oriented policing in practice. *Criminology & Public Policy,* 4, 155-180. doi: 10.1111/j.1745-9133.2005.00013.x

Cornaglia F., Feldman N. E., & Leigh A. (2014). Crime and mental wellbeing, *IZA Discussion Paper, no. 8014.*Available from: <http://hdl.handle.net/10419/96730>

Cullen F. T., Jonson C. L., Nagin D. S. (2011). Prisons do not reduce recidivism: The high cost of ignoring science. *The Prison Journal,*9(3), 48s-65s.

Darke S., Torok M., Kaye S., Ross J., & McKetin R. (2009). Comparative rates of violent crime among regular methamphetamine and opioid users: offending and victimization. *Addiction*, 105, 916-919. doi: 10.1111/j.1360-0443.2009.02872.x

de Girolamo G., Dagani J., Purcell R., Cocchi A., & McGorry P. D. (2012). Age of onset of mental disorders and use of mental health services: Needs, opportunities and obstacles. *Epidemiology and Psychiatric Sciences*, 21(1), 47-57. doi: 10.1017/S2045796011000746

Dempsey J. & Forst L. (2013). *An Introduction to Policing* (7th ed.). Cengage Learning: USA.

den Boer P. C., Wiersma D. & van den Bosch R. J. (2004). Why is self-help neglected in the treatment of emotional disorders? A meta analysis. *Psychological Medicine,* 34, 959-971.

DePadilla L, Perkins MM, Elifson KW & Sterk CE (2013). Adult criminal involvement: A cross-sectional inquiry into correlates and mechanisms over the life course. *Criminal Justice Review*, 37(1). doi: 10.1177/0734016811432921

Department of Justice Canada (2005). Canada's System of Justice. Available from: <www.justice.gc.ca/eng/csj-sjc/just/img/courten.pdf>

Department of Justice Canada (2013). "Making the criminal justice system more responsive to victims." Safeguarding the future and healing the past. Available from: <http://www.justice.gc.ca/eng/rp-pr/cp-pm/cr-rc/dig/vict.html>

Derkzen D., Booth L., Taylor K., & McConnell A. (2013). Mental health needs of federal female offenders. *Psychological Services*, 10(1), 24-36. doi: 10.1037/a0029643

Dick D M., Bierut L., Hinrichs A., Fox L., Bucholz K. K., Kramer J., Kuperman S., Hesselbrock V., Schuckit M., Almasy L., Tischfield J., Porjesz B., Begleiter H., Burnberger Jr. J., Xuei X., Edenberg H. J., & Foroud T. (2006). The role of GABRA2 in risk for conduct disorder and alcohol and drug dependence across deveopmental stages. *Behaviour Genetics*, 36(4), 577-590. doi: 10.1007/s10519-005-9041-8

Downer S. R., Meara J. G., da Costa A. C., & Sethuraman K. (2006). SMS text messaging improves outpatient attendance. *Australian Health Review*, 30(3), 389-396.

Ellonen N. & Salmi V. (2011). Poly-Victimization as a life condition: Correlates of poly-victimization among Finnish children. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, 12(1), 20-44. doi: 10.1080/14043858.2011.561621

Employment and Social Development Canada. (2014). Canadians in Context – Aboriginal Population.. Available from: <www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=36>

Engel P. L., Fernald L. C. H., Alderman H., Behrman J., O'Gara C., Yousafzai A., Cabral de Mello M., Hidrobo M., Ulkuer N., Ertem I., Iltus S. & The Global Child Development Steering Group. (2011). Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries. *Lancet*, 378, 1339-1353. doi: 10.1016/S0140-6736(11)60889-1

Estévez E. & Emler N. P. (2011). Assessing the links among adolescent and youth offending, antisocial behaviour, victimization, drug use, and gender. *International Journal of Clinical and Health Psychology*, 11(2), 269-289.

Fanti K. A. & Henrich C. C. (2014). Effects of self-esteem and narcissism on bully and victimization during early adolescence. *Journal of early Adolescence*, doi: 10.1177/0272431613519498

Farrington D. P., Loeber R., Yin Y., & Anderson S. J. (2002). Are within-individual causes of delinquency the same as between-individual causes? *Crimina Behaviour and Mental Health*, 12(1), 53-68.

Fattah E. A. (1997). "From crime policy to victim policy: The need for a fundamental policy change," in McShane M. & Williams F. P. (Eds.), *Victims of crime and the victimization process.* 2013. Routledge: New York: New York.

Ferguson K. M., Bender K., Thompson S., Xie B., & Pollio D. (2011). Correlates of Street-Survival Behaviours in Homeless Young Adults in Four U.S. Cities. *American Journal of Orthopsychiatry*, 81(3), 401-409.

Fergusson D. M., Boden J. M., & Horwood L. J. (2008). The developmental antecedents of illicit drug use: Evidence from a 25-year longitudinal study. *Drug and Alcohol Dependence*, 96, 165-177. doi: 10.1016/j.drugalcdep.2008.03.003

Firman J. R. (2012). Commentary on "Collaborative partnerships and crime in disorganized communities." *Public Administration Review*, 72, 239-240. doi: 10.1111/j.1540-6210.2011.02555.x

Fizgerald R. (2009). Self-reported violent delinquency and the influence of school, neighbourhood and student characteristics. *Crime and Justice Research Paper Series*, Canadian Centre for Justice Statistics, Catalogue no. 85-561-M, no. 17.

Forsman H. & Vinnerljung B. (2012). Interventions aiming to improve school achievements of children in out-of-home care: A scoping review. *Children and Youth Services Review*, 34, 1084-1091. doi: 10.1016/j.childyouth.2012.01.037

Frazier S. L., Abdul-Adil J., Atkins M. S., Gathright T., & Jackson M. (2007). Can't have one without the other: Mental health providers and community parents reducing barriers to services for families in urban poverty. *Journal of Community Psychology*, vol. 35, no.4, pp. 435-446.

French R., Reardon M., & Smith P (2003). Engaging with a mental health service: Perspectives of at-risk youth. *Child and Adolescent Social Work Journal,* 20(6), 529-548.

Gaboury I., Bujold M., Boon H. & Moher D. (2009). Interprofessional collaboration within Canadian integrative healthcare clinics: Key components. *Social Science & Medicine*, 69, 707-715. doi: 10.1016/j.socscimed.2009.05.048

Gabrielsson S., Looi G. E., Zingmark K., & Savenstedt S. (2014). Knowledge of the patient as decision-making power: Staff members' perceptions of interprofessional collaboration in challenging situations in psychiatric inpatient care. *Scandinavian Journal of Caring Science.* doi: 10.1111/scs.12111

Gagnon S., Labrecque M., Njoya M., Rousseau F., St-Jacques S., & Legare F. (2010). How much do family physicians involve pregnant women in decision about prenatal screening for down syndrome? *Prenatal Diagnosis*, 30, 115-121. doi: 10.1002/pd.2421

Gamm L., Stone S., & Pittman S. (2010). Mental health and mental disorders – a rural challenge: A literature review. *Rural Healthy People 2010.* Available from: <http://sph.tamhsc.edu/centers/rhp2010/08Volume2mentalhealth.pdf>

Gardner F., Burton J., & Klimes I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry*, 47(11), 1123-1132. doi: 10.1111/j.1469-7610.2006.01668.X

Garland D. (2001). *The Culture of Control*. University of Chicago Press: USA.

Gerstein D. R. & Harwod H. J. (1990). A study of the effectiveness and financing of public and private drug treatment systems . *Treating drug problems,* 1. National Academy Press, Insitute of Medicine: Washington DC.

Gondolf E. W. (2011). The weak evidence for batterer program alternatives. *Aggression and Violent Behaviour*, 16, 347-353.

Gone J. P. & Trimble J. E. (2012). American indian and alaska native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, 8, 131-160. doi: 10.1146/annurev-clinpsy-032511-143127

Gopalan G., Goldstein L., Klingenstein K., Sicher C., Blake C. & McKay M. M. (2010). Engaging families into child mental health treatment: Updates and special considerations. *Journal of Academic Child Adolescent Psychiatry*, 19(3), 182-196.

Gough P., Schlonsky A., & Dudding P. (2009). An overview of the child welfare systems in Canada. *International Journal of Child Health and Human Development*, 2(3), 357-372.

Gould P. R., Lee Y., Berkowitz S., & Bronstein L. (2014). Impact of a collaborative interprofessional learning experience upon medical and social work students in geriatric health care. *Journal of Interprofessional Carei,* 1-2. doi: 10.3109/13561820.2014.962128

Government of Canada. (2006). The human face of mental health and mental illness in Canada. Catalogue no. HP5-19/2006E. Available from: <www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf>

Government of Canada: Department of Justice. (2013). *Victims*. Available from: <http://www.justice.gc.ca/eng/cj-jp/victims-victimes/index.html>

Government of Saskatchewan. (2011). Building Partnerships to Reduce Crime. Available from: <http://www.justice.gov.sk.ca/PCS-Partnerships>

Griffiths C. T. & Verdun-Jones S. N. (1994). *Canadian Criminal Justice* (2nd ed.) Harcourt Brace & Company, Canada Inc. USA.

Groot W. & van den Brink H. M. (2010). The effects of education on crime. *Applied Economics,* 42(3), 279-289. doi: 10.1080/00036840701604412.

Guirguis-Younger M., MacNeil R., & Hwang S. W. (eds.) (2014). *Homelessness & health in Canada*. University of Ottawa press, Canada.

Gulliver A., Griffiths K. M., & Christensen H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *Bio Med Central Psychiatry*, 10(113). doi: 10.1186/1471-244X-10-113

Guydish J., Wolfe E., Tajima B., & Woods W. J. (2001). Drug court effectiveness: A review of California evaluation reports, 1995-1999. *Journal of Psychoactive Drugs*, 33(4), 369-378. doi: 10.1080/02791072.2001.10399922

Hartinger-Saunders R. M., Rittner B., Wieczorek W., Nochajski T., Rine C. M., & Welte J. (2011). Victimization, psychological distress and subsequent offending among youth. *Child Youth Service Review*, 33(11), 2375-2385. doi: 10.1016/j.childyouth.2011.08.009

Heerde J. A., Hemphill S. A., & Scholes-Balog K. E. (2014). 'Fighting' for survival: A systematic review of physically violent behaviour perpetrated and experienced by homeless young people. *Aggression and Violent Behaviour*, 19, 50-66. doi:10.1016/j.avb.2013.12.002

Henggeler S. W. & Schoenwald S. K. (2011). Evidence-based interventions for juvenile offenders and juvenile justice policies that support them. *Social Policy Report*, 25(1).

Henggeler S. W., Schoenwald S. K., Borduin C. M., Rowland M. D., & Cunningham P. B. (2009). *Multisystemic therapy for antisocial behaviour in children and adolescents* (2nd ed.). The Guildford Press: USA.

Hester R. K. & Miller W. R. (1995) *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* (2nd ed.). Allyn & Bacon: Needham Heights: Massachusetts.

Hoeve M., Stams G. J. J. M., van der Put C. E., Dubas J. S., van der Laan P. H. & Gerris J. R. M. (2012). A meta-analysis of attachment to parents and delinquency. *Journal of Abnormal Child Psychology*, 40(5), 771-785. doi: 10.1007/s10802-011-9608-1

Holder H. D. (2006). "Racial and gender differences in substance abuse: What should communities do about them?" In Miller W. R. & Carroll K. M. (eds.) *Rethinking substance abuse: What the science shows and what we should do about it*. Guilford Press: USA.

Holt T. J., Bossler A. M., & May D. C. (2011). Low self-control, deviant peer associations, and juvenile cyberdeviance. *The Journal of the Southern Criminal Justice Association*, 37(3), 378-395. doi: 10.1007/s12103-011-9117-3

Holtfreter K., Reisig M. D., Piquero N. L., & Piquero A. R. (2010). Low self-control and fraud: offending, victimization, and their overlap. *Criminal Justice and Behaviour*, 37(2), 188-203. doi: 10.1177/0093854809354977

Howell J. C. (2010). Gang prevention: An overview of Research and Programs. *Juvenile Justice Bulletin*, U.S. Department of Justice. Available from: <http://books.google.ca/books?id=fnKIRcyqEq0C&printsec=frontcover#v=onepage&q&f=false>

Hughes T., McCabe S. E., Wilsnack S. C., West B. R., & Boyd C. J. (2010). Victimization and substance use disorders in a national sample of heterosexual and sexual minority women and men. *Addiction*, 105(12), 2130-2140. doi: 10.1111/j.1360-0443.2010.03088.x

Jakobsen I. S., Fergusson D., & Horwood J. L. (2012). Early conduct problems, school achievement and later crime: Findings from a 30-year longitudinal study. *New Zealand Journal of Educational Studies*, 47(1), 123-135.

Jennings W. G., Piquero A. R., & Reingle J. M. (2011). On the overlap between victimization and offending: A review of the literature. *Aggression and Violent Behaviour*, 17, 16-26. doi: 10.1016/j.avb.2011.09.003

Joa I., Johannessen J. O., Auestad B., Friis S., McGlashan T., Melle I., Opjordsmoen S., Simonsen E., Vaglum P., Larsen T. K. (2008). The key to reducing duration of untreated first psychosis: Information campaigns. *Schizophrenia Bulletin*, 34(3), 466-472.

Johnson K. F. & Freeman K. L. (2014). Integrating interprofessional education and collaboration competencies (IPEC) into mental health counselor education. *Journal of Mental Health Counseling*, 36(4), 328-344.

Johnston D. W., Propper C., Pudney S., & Shields M.A. (2011). Child mental health and educational attainment: Multiple observers and the measurement error problem, Discussion Paper No. 5874. Available from: <http://ftp.iza.org/dp5874.pdf>

Kappeler V. E. & Gaines L. K. (2015). *Community policing: A contemporary perspective* (6th ed.). Routledge, USA: NY.

Karmen A. (2012). *Crime victims: An introduction to victimology* (8th ed.) Wadsworth Cengage Learning: USA: Belmont CA.

Kazemian L. & Le Blanc M. (2004). Exploring patterns of perpetration of crime across the life course: Offense and offender-based viewpoints. *Journal of Contemporary Criminal Justice*, 20(4), 393-415. DOI: 10.1177/1043986204269378

Kiedrowski, J. (2013). Trends in Indigenous policing models: An international Comparison. *Compliance Strategy Group, Ottawa*. Available from: < http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/trnds-ndgns-plc-mdl/trnds-ndgns-plc-mdl-eng.pdf>

Kinsella C. (2012). Re-locating fear on the streets: Homelessness, victimisation and fear of crime. *European Journal of Homelessness*, 6(2), 121-136.

Kirmayer L. J., Brass G. M., & Tait C. L. (2000). The mental health of aboriginal peoples: Transformations of identity and community. *Canadian Journal of Psychiatry*, 45, 607-616.

Klodawsky F., Aubry T., & Farrell S. (2006). Care and the lives of homeless youth in neoliberal times in Canada. *Gender, Place & Culture: A Journal of Feminist Geography*, 13(4), 419-436. doi: 10.1080/09663690600808577

Kort-Butler, L. A. (2010). Experienced and vicarious victimization: Do social support and self-esteem prevent delinquent responses? *Sociology Department, Faculty Publications*. Paper 192. Available from: < http://digitalcommons.unl.edu/sociologyfacpub/192>

Kovandzic M., Chew-Graham C., Reeve J., Edwards S., Peters S., Edge D., Aseem S., Gask L., & Dowrick C. (2011). Access to primary mental health care for hard-to-reach groups: From 'silent suffering' to 'making it work.' *Social Science & Medicine,* 72, 763-772. doi:10.1016/j.socscimed.2010.11.027

Lalonde L., O'Connor A. M., Drake E., Duguay P., Lowensteyn I., & Grover S. A. (2004). Development and preliminary testing of a patient decision aid to assist pharmaceutical care in the prevention of cardiovascular disease. *Pharmacotherapy*, 24(7), 909-922.

Lalonde L., O'Connor A. M., Duguay P., Brassard J., Drake E., & Grover S. A. (2006). Evaluation of a decision aid and a personal risk profile in community pharmacy for patients considering options to improve cardiovascular health: The OPTIONS pilot study. *International Journal of Pharmacy Practice*, 14, 51-62. doi: 10.1211/ijpp.14.1.0007

Lampley JH & Johnson KC (2010). Mentoring at-risk youth: Improving academic achievement in middle school students. *Nonpartisan Education Review*, vol. 6, no. 1.

Latimer J., Kleinknecht S., Hung K., & Gabor T. (2003). The correlates of self-reported delinquency: An analysis of the national longitudinal survey of children and youth. *Research and Statistics Division: Department of Justice Canada*. Available from: <http://canada.justice.gc.ca/eng/rp-pr/fl-lf/famil/rr03_yj2-rr03_jj2/rr03_yj2.pdf>

Leach A .(2010). The roots of aboriginal homelessness in Canada. *Parity*, 23(9), pp. 12-13. Available from: < www.homelesshub.ca/ResourceFiles/Parity_Vol23-09.pdf>

Legare F., Ratte S., Gravel K., & Graham I. D. (2008). Barriers and facilitators to implementing shared decision-making in clinical practice: Update of a systematic review of health professionals' perceptions. *Patient Education and Counseling*, 73, 526-535. doi: 10.1016/j.pec.2008.07.018

Legare F., Ratte S., Stacey D., Kryworuchko J., Gravel K., Graham I. D., & Turcotte S. (2010). Interventions for improving the adoption of shared decision making by healthcare professional (Review). *Cochrane Database of Systematic Reviews 2010*, no. 5. Art. No.: CD006732. DOI: 10.1002/14651858.CD006732.pub2

Li Y., Zhang W., Liu J., Arbeit M. R., Schwartz S. J., Bowers E. P., & Lerner R. M. (2011). The role of school engagement in preventing adolescent delinquency and substance use: a survival analysis. *Journal of Adolescence*, 34, 1181-1192. DOI:10.1016/j.adolescence.2011.07.003

Liljeberg J. F., Eklund J. M., Fritz M. V., & af Klinteberg B. (2011). Poor school bonding and delinquency over time: Bidirectional effects and sex differences. *Journal of Adolescence*, 34, 1-9. doi: 10.1016/j.adolescence.2010.03.008

Lo V., Wu R. C., Morra D., Lee L., & Reeves S. (2012). The use of smartphones in general and internal medicine units: A boon or a bane to the promotion of interprofessional collaboration? *Journal of Interprofessional Care*, 26, 276-282. doi: 10.3109/13561820.2012.663013

Loch A. A. (2012). Stigma and higher rates of psychiatric re-hospitalization: Sao Paulo public mental health system. *Revista Brasileira de Psiquiatria*, 34(2), 185-192.

Lynch J. P. (2006). Problems and promise of victimization surveys for cross-national research. *Crime and Justice*, 34(1), 229-287. doi: 10.1086/502670

Machin S., Marie O., & Vujić S. (2010) The crime reducing effect of education. *CEP Discussion Paper No 979.* Available from: <http://cep.lse.ac.uk/pubs/download/dp0979.pdf>

MacNeil G., Stewart J. C., & Kaufman A. V. (2000). Social support as a potential moderator of adolescent delinquent behaviours. *Child and Adolescent Social Work Journal*, 17(5), 361-379. doi: 10.1023/A:1007555014397

Mahony T. H. (2011). Women and the criminal justice system. In: *Women in Canada: A gender-based statistical report* (6th edition, Catalogue no. 89-503-X). Ottawa, ON: Statistics Canada.

Manasse M. E. & Ganem N. M. (2009). Victimization as a cause of delinquency: The role of depression and gender. *Journal of Criminal Justice*, 37, 371-378. doi: 10.1016/j.jcrimjus.2009.06.004

Mayhew P. & van Dijk J. (2014) International Crime Victimization Survey. *Encyclopedia of Criminology and Criminal Justice*, 2602-2614. doi: 10.1007/978-1-4614-5690-2_444

McCart M. R., Zajac K., Kofler M. J., Smith D. W., Saunder B. E., & Kilpatrick D. G. (2012). Longitudinal examination of ptsd symptoms and problematic alcohol use as risk factors for adolescent victimization. *Journal of Clinical Child & Adolescent Psychology*, 41(6), 822-836. doi: 10.1080/15374416.2012.717872

McConnell B. M. & Kubina R. M. (2014). Connecting with families to improve students' school attendance: A review of the literature. *Preventing School Failure: Alternative Education for Children and Youth*, 58(4), 249-256. doi: 10.1080/1045988X.2013.821649

McKay M. M., Gopalan G., Franco L. M., Kalogerogiannis K., Umpierre M., Olshtain-Mann O., Bannon W., Elwyn L., & Goldstein L. (2010). It takes a village to deliver and test child and family-focused services. *Research on Social Work Practice*, 20(5), 476-482.

McMurran M. (2009). Motivational interviewing with offenders: a systematic review. *Legal and Criminological Psychology*,14, 83-100.

McSweeney T., Stevens A., Hunt N., & Turnbull P. J. (2007). Twisting arms of a helping hand? Assessing the impact of 'coerced' and comparable 'voluntary' drug treatment options. *British Journal of Criminology*, 47, 470-490. doi: 10.1093/bjc/az1087

Mental Health Commission of Canada (MHCC). (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB: Author.

Merikangas K. R., Li J. J., Stipelman B., Yu K., Fucito L., Swendsen J., & Zhang H. (2008). The familial aggregation of cannabis use disorders. *Addiction*, 104, 622-629. doi: 10.111/j.1360-0443.2008.02468.x

Mersky J. P., Topitzes J., & Reynolds A. J. (2012). Unsafe at any age: Linking childhood and adolescent maltreatment to delinquency and crime. *Journal of Research in Crime and Delinquency*, 49(2), 295-318. doi: 10.1177/0022427811415284

Ministry of Public Safety and Solicitor General. (2009). *Victims of crime: Victim service worker handbook* (2nd ed.). Available from: <http://www.pssg.gov.bc.ca/victimservices/shareddocs/victim-service-worker-victims-of-crime.pdf>

Mojtabai R., Olfson M., Sampson N., Jin R., Druss B., Wang P. S., Wells K. B., Pincus H. A., & Kesser R. C. (2011). Barriers to mental health treatment: Results from the national comorbidity survey replication (NCS-R). *Psychological Medicine*, 41(8), 1751-1761. doi: 10.1017/S0033291710002291

Monroe L. M., Kinney L. M., Weist M. D., Dafeamekpor D. S., Dantzler J., & Reynolds M. W. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. *Journal of Interpersonal Violence*, 20(7), 767-776. doi: 10.1177/0886260505277100

Nannenga M. R., Montori V. M., Weymiller A. J., Smith S. A., Christianson T. J. H., Bryant S. C., Gafni A., Charles C., Mullan R. J., Jones L. A., Bolona E. R., & Guyatt G. H. (2009). A treatment decision aid may increase patient trust in the diabetes specialist. The *Statin* choice randomized trial. *Health Expectation*, 12, 38-44. doi: 10.1111/j.1369-7625.2008.00521.x

Noell G. H. & Gansle K. A. (2006). Assuring the form has substance: Treatment plan implementation as the foundation of assessing response to intervention. *Assessment for Effective Intervention*, 32(1), 32-39.

O'Brien, C. P. (2011). Evidence-based treatments of addiction. *Focus*, 9(1), 107-117.

Orth U. (2002). Secondary victimization of crime victims by criminal proceedings. *Social Justice Research*, 15(4), 313-325. doi: 10.1023/A:1021210323461

Owusu-Bempah A., Kanters S., Druyts E., Toor K., Muldoon K. A., Farquhar J. W., & Mills E. J. (2014). Years of life lost to incarceration: Inequities between aboriginal and non-aboriginal Canadians. *Bio Med Central Public Health,* 14(585). doi: 10.1186/1471-2458-14-585

Page S. (2004). Measuring accountability for results in interagency collaboratives. *Public Administration Review*, 64(5), 591-606.

Patterson D. (2011). The linkage between secondary victimization by law enforcement and rape cast outcomes. *Journal of Interpersonal Violence*, 26(2), 328-347. doi: 10.1177/0886260510362889

Pecora P. J. (2012). Maximizing educational achievement of youth in foster care and alumni: Factors associated with success. *Children and Youth Services Review*, 34, 1121-1129. doi: 10.1016/j.childyouth.2012.01.044

Pendakur K. & Pendakur R. (2011). Aboriginal income disparity in Canada. *Canadian Public Policy*, 37(1), 61-83.

Perreault S. & Brennan S. (2010) Criminal Victimization in Canada, 2009. *Juristat*. 30(2), Statistics Canada Catalogue no. 85-002-X.

Perreault S. (2011). Violent victimization of aboriginal people in the Canadian provinces, 2009, *Juristat*, component of Statistics Canada catalogue no. 85-002-X.

Perreault S. (2013). Police-reported crime statistics in Canada, 2012. *Juristat,* 34(1). Statistics Canada Catalogue no. 85-002-X.

Perreault S. (2014). Admissions to youth correctional services in Canada, 2011/2012. *Juristat*, catalogue 85-002-X.

Perry I. (2009). Violence: A public health perspective. *Global Crime*, 10(4), 368-395.

Pfaff K. A., Baxter P. E., Jack S. M., & Ploeg J. (2014). Exploring new graduate nurse confidence in interprofessional collaboration: A mixed methods study. *International Journal of Nursing Studies*, 5, 1142-1152. doi: 10.1016/j.ijnurstu.2014.01.001

Pilowsky D. J. & Wu L. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *Journal of Adolescent Health*, 38(4), 351-358. doi: 10.1016/j.jadohealth.2005.06.014

Pouwels J. L. & Villessen A. H. N. (2012). Correlates and outcomes associated with aggression and victimization among elementary-school children in a low-income urban context. *Journal of Youth and Adolescence*, 42(2), 190-205. doi: 10.1007/s10964-012-9875-3

Prendergast M., Podus D., Finney J., Greenwell L., & Roll J. (2006). Contingency management for treatment of substance use disorders: A meta-analysis. *Addiction*, 101, 1546-1560. doi: 10.1111/j.1360-0443.2006.01581.x

Rapee R. M., Kennedy S. J., Ingram M., Edwards S. L., & Sweeney L. (2010). Altering the trajectory of anxiety in at-risk young children. *American Journal of Psychiatry*, 167(12), 1518-1525.

Rice J. (2011). Indian residential school truth and reconciliation commission of Canada. *Cultural Survival Quarterly*, 35(1). Available from: < https://www.culturalsurvival.org/publications/cultural-survival-quarterly/canada/indian-residential-school-truth-and-reconciliation-c>

Rice K., Zwarenstein M., Conn L. G., Kenaszchuk C., Russell A., & Reeves S. (2010). An intervention to improve interprofessional collaboration and communications: A comparative qualitative study. *Journal of Interprofessional Care*, 24(4), 350-361. doi: 10.3109/13561820903550713

Rivera E. A., Sullivan C. M., & Zeoli A. M. (2012). Secondary victimization of abused mothers by family court mediators. *Feminist Criminology*, 7(3), 234-252. doi: 10.1177/1557085111430827

Romano E., Babchishin L., Marquis R., & Frechette S. (2014). Childhood maltreatment and educational outcomes. *Trauma, Violence, & Abuse*, 1-20. doi: 10.1177/1524838014537908

Romano E., Bell T., & Billet J. (2011). Prevalence and correlates of mutiple victimization in a nation-wide adolescent sample. *Child Abuse & Neglect*, 35, 468-479. doi: 10.1016/j.chiabu.2011.03.005

Rose J. (2011). Dilemmas of inter-professional collaboration: Can they be resolved? *Children & Society*, 25, 151-163. doi: 10.1111/j.1099-0860.2009.00268.x

Ruback R. B., Clark V. A., & Warner C. (2014). Why are crime victims at risk of being victimized again? Substance use, depression, and offending as mediators of the victimization – revictimization link. *Journal of Interpersonal Violence*, 29(1), 157-185. doi: 10.1177/0886260513504626

Russell H. C. & Taylor N. E. (2014). New directions in community safety: Consolidating lessons learned about risk and collaboration. *Ontario Working Group on Collaborative, Risk-Driven Community Safety.* Ontario Association of Chiefs of Police. Available from: <http://www.oacp.on.ca/Userfiles/StandingCommittees/CommunityPolicing/ResourceDocs/OWG%20New%20Directions%20in%20Community%20Safety.pdf>

Salhani D. & Coulter I. (2009). The politics of interprofessional working and the struggle for professional autonomy in nursing. *Social Science & Medicine,* 58, 1221-1228. doi: 10.1016/j.socscimed.2009.01.041

San Martin-Rodriguez L., Beaulieu M., D'Amour D., & Ferrada-Videla M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, 1, 132-147.

Sapers H. (2012). Annual Report of the Office of the Correctional Investigator 2011-2012. *Office of the Correctional Investigator*. Available from: <www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20112012-eng.aspx>

Scott J. E. (2010). Evolving strategies: A historical examination of changes in principles, authority and function to inform policing in the twenty-first century. *The Police Journal*, 83(2), 126-163. doi: 10.1358/pojo.2010.83.2.490

Shaw M. (2001). Investing in youth: International approach to reducing crime and victimization. *International Centre for the Prevention of Crime*. Available from: <www.ibrarian.net/navon/paper/Investing_in_Youth___International_Approaches_to_.pdf?paperid=4998693 >

Shoffner J., Staudt M., Marcus S., & Kapp S. (2007). Using telephone reminders to increase attendance at psychiatric appointments: findings of a pilot study in rural Appalachia. *Psychiatric Services*, 58(6), 872-875.

Shoham S. G., Knepper P., & Kett M. (eds.) (2010). *International handbook of victimology*. Taylor and Francis Group: USA: Boca Raton FL.

Silver E., Felson R. B., & Vaneseltine M. (2008). The relationship between mental health problems and violence among criminal offenders. *Criminal Justice and Behaviour*, 35(4), 405-426. doi: 10.1177/0093854807312851

Silver E., Piquero A. R., Jennings W. G., Piquero N. L., & Leiber M. (2009). Assessing the violent offending and violent victimization overlap among discharged psychiatric patients. *Law and Human Behaviour*, 25(1), 49-59. doi: 10.1007/s10979-009-9206-8

Sinha M. (2013). Measuring violence against women: Statistical Trends. Component of Statistics Canada catalogue no. 85-002-X, *Juristat*. Available from: <http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11766-eng.pdf>

Slesnik N. & Prestopnik J. L. (2004). Office versus home-based family therapy for runaway, alcohol abusing adolescents: Examination of factors associated with treatment attendance. *Alcohol Treatment Quarterly*, 22(2), 3-19.

Spek V., Cuijpers P., Nyklicek I., Riper H., Keyzer J., & Pop V. (2007). Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: a meta-analysis. *Psychological Medicine*, 37, 319-328.

Sprott J. R., Doob A. N., & Jenkins J. M. (2001). Problem behaviour and delinquency in children and youth. *Juristat*, Statistics Canada, Catalogue no. 85-002-XPE, 21(4).

Stacey D., O'Connor A. M., Graham I. D., & Pomey M. (2006). Randomized controlled trial of the effectiveness of an intervention to implement evidence-based patient decision support in a nursing call centre. *Journal of Telemedicine and Telecare 2006,* 12, 410-415.

Statistics Canada (2005). Projections of the Aboriginal populations, Canada, provinces and territories 2001 to 2017. Catalogue no. 91-547-XIE. Ottawa.

Stirman S. W., Kimberly J., Cook N., Calloway A., Castro F., & Charns M. (2012) The sustainability of new programs and innovations: a review of the empirical literature and recommendations for future research. *Implementation Science* 7(17).

Suchman N. E., DeCoste C., Castiglioni N., McMahon T. J., Rounsaville B., & Mayes L. (2010). The mothers and toddlers program, an attachment-based parenting and intervention for substance using women: Post-treatment results from a randomized clinical pilot. *Attachment & Human Development*, 21(5), 482-504.

Tambling R. B., Johnson L. N., Templeton G. B., & Melton M. S. (2007). Using web-based technology to facilitate client engagement. *Contemporary Family Therapy*, 29(3), 177-183.

Telep C. W. & Weisburd D. (2012). What is known about the effectiveness of police practices in reducing crime and disorder? *Police Quarterly,* 14(4), 331-357. doi: 10.1177/1098611112447611

Thannhauser J., Russell-Mayhew S., & Scott C. (2010). Measures of interprofessional education and collaboration. *Journal of Interprofessional Care*, 24(4), 336-349. doi: 10.3109/13561820903442903

Thompson S. J., Bender K., Windsor L. C., & Flynn P. M. (2009). Keeping families engaged: The effects of home-based family therapy enhanced with experiential activities. *Social Work Research*, 22(2), 121-126.

Toomey T. L., Erickson D. J., Carlin B. P., Lenk K. M., Quick H. S., Jones A. M., & Harwood E. M. (2012b). The association between density of alcohol establishments and violent crime within urban neighborhoods. *Alcohol: Clinical and Experimental Research,*36(8), 1468-1473. doi: 10.1111/j.1530-0277.2012.01753.x

Toomey T. L., Erickson D. J., Carlin B. P., Quick H. S., Harwood E. M., Lenk K. M., & Ecklund A. M. (2012). Is the density of alcohol estalishments related to nonviolent crime? *Journal of Studies on Alcohol and Drugs*, 73(1), 21-25.

Traube D. E., James S., Zhang J., & Landszverk J. (2012). A national study of risk and protective factors for substance use among youth in the child welfare system. *Addictive Behaviour*, 37(5), 641-650. doi: 10.1016/j.addbeh.2012.01.015

Trocmé N., Knoke D., & Blackstock C. (2004). Pathways to overrepresentation of aboriginal children in Canada's child welfare system. *Social Service Review*, 78(4), 577-600. doi: 10.1086/424545

Turner H. A., Finklehor D., & Ormrod R. (2010). Child mental health problems as risk factors for victimization. *Child Maltreatment*, 15(2), 132-143. doi: 10.1177/1077559509349450

Uchtenhagen A., Stevens A., Berto D., Frick U., Hunt N., Kerschl V., ...& Werdenich W. (2008).Evaluation of therapeutic alternatives to imprisonment for drug-dependent offenders. Findings of a comparative European multi-country study. *Heroin Addiction and Related Clinical Problems*, 10(2), 5-10.

United Nations General Assembly. (1985). *Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power: resolution / adopted by the General Assembly*, 29 November 1985, A/RES/40/34. Available at: <http://www.refworld.org/docid/3b00f2275b.html>

United Nations Office on Drugs and Crime. (UNODC) (2007). Handbook of basic principles and promising practices on alternative to imprisonment. *Criminal Justice Handbook Series*.

United Nations Office on Drugs and Crime. (UNODC) (2009). From coercion to cohesion: Treating drug dependence through health care, not punishment. Discussion paper. Available from: <http://www.unodc.org/documents/lpo-brazil//noticias/2013/04/Coercion_Ebook.pdf>

Urban Aboriginal Task Force (UATF). (2007). Final Report. Available from: <http://ofifc.org/sites/default/files/docs/UATFOntarioFinalReport.pdf>

van Beljouw I., Verhaak P., Prins M., Cuijpers P., Prenninx B., Bensing J. (2010). Reasons and determinants for not receiving treatment for common mental disorders. *Psychiatric Services*, 61(2), 250- 257.

Vito J. F. & Maahs J. R. (2012) *Criminology: Theory, Research, and Policy*. Jones and Bartlett Learning Canada: Mississauga: Ontario.

Walklate S. (2013). *Victimology: The victim and the Criminal justice process*. Routledge. New York: New York.

Weisburd D. & Eck J. E. (2004). What can police do to reduce crime, disorder, and fear? *The Annals of the American Academy of Political and Social Science*, 593, 42-65. doi: 10.1177/0002716203262548

Wemmers J. (2013). Victims' experiences in the criminal justice system and their recovery from crime. *International Review of Victimology*, 19(3), 221-233. doi: 10.1177/0269758013492755

Whelan T., Sawka C., Levine M., Gafni A., Reyno L., Willan A., …& Bodendorfer I. (2003). Helping patients make informed choices: A randomized trial of a decision aid for adjuvant chemotherapy in lymph node-negative breast cancer. *Journal of the National Cancer Institute*, 95(8), 581-587.

Wilson D. & Macdonald D. (2010). The income gap between aboriginal peoples and the rest of Canada. *Canadian Centre for Policy Alternatives*. Available from: <www.policyalternatives.ca/sites/default/files/uploads/publications/reports/docs/Aboriginal%Income%Gap.pdf>

Wilson S. J., Tanner-Smith E., & Lipsey M. W. (2011). Dropout prevention and intervention programs: Effects on school completion and dropout among school-aged children and youth. *Journal of the Society for Social Work and Research*, 4(4), 357-372.

World Health Organization (WHO). (2002). World report on violence and health. Krug E. G., Dahlberg L. L., Mercy J. A., Zwi A. B., & Lozano R. (Eds.). Available from: <http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf?ua=1>

World Health Organization (WHO). (2010). Framework for Action on Interprofessional education & Collaborative Practice. Available from: <http://www.who.int/hrh/resources/framework_action/en/>

World Health Organization (WHO). (2014) Global Health Estimates 2014 Summary Tables: Deaths by cause, Age and Sex, 2000-2012. Available from: <http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html >

World Health Organization (WHO). (2014b). Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. Available from: < http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1>

Xyrichis A. & Lowton K. (2007). What fosters or prevents interprofessional teamworking in primary or community care? A literature review. *International Journal of Nursing Studies*, 45, 140-153. doi: 10.1016/j.ijnurstu.2007.01.015

Zucker R. A., Donovan J. E., Masten A. S., Mattson M. E., & Moss H. B. (2008). Early developmental processes and the continuity of risk for underage drinking and problem drinking. *Pediatrics*, 121(4), S252-S272. doi: 10.1542/peds.2007-2243B

Table 1

Canadian Centre on Substance Abuse	http://www.ccsa.ca/Pages/default.aspx
Canadian Interprofessional Health Collaborative	http://www.cihc.ca/
Canadian Mental Health Association	http://www.cmha.ca/
Ministry of Justice – Government of Saskatchewan	http://www.justice.gov.sk.ca/
Department of Justice Canada	http://www.justice.gc.ca/eng/
Employment and Social Development Canada – Indicators of Well-Being in Canada	http://www4.hrsdc.gc.ca/
Mental Health Commission of Canada	http://www.mentalhealthcommission.ca/
Office of the Correctional Investigator Canada	http://www.oci-bec.gc.ca/index-eng.aspx
Public Health Agency of Canada	http://www.phac-aspc.gc.ca/index-eng.php
Public Safety Canada	http://www.publicsafety.gc.ca/index-eng.aspx
Statistics Canada	http://www.statcan.gc.ca/start-debut-eng.html
United Nations General Assembly	http://www.un.org/en/ga/
United Nations Office on Drugs and Crime	http://www.unodc.org/
United Nations Special Rapporteur: James Anaya	http://unsr.jamesanaya.org/
Ontario Federation of Indigenous Friendship Centres	http://ofifc.org/
World Health Organization	http://www.who.int/en/