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MENTAL HEALTH STRATEGY FOR WOMEN OFFENDERS

Jane Laishes
Mental Health, Health Services
December 1997
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The author wishes to express her gratitude to all internal and external stakeholders for their input and feedback during consultations on the development of the Strategy.
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INTRODUCTION

The Mental Health Strategy for Women Offenders provides a framework for the development of all mental health services for women offenders whether they are in a regular regional facility, a maximum security unit or the community. The Strategy parallels the Mental Health Strategy which was developed for male offenders, however it acknowledges the mental health needs of women in general, and of women offenders in particular. It describes the full range of mental health issues and problems faced by women offenders and the intervention and programming required by legislation and policy to address these issues. The Strategy further describes a continuum of mental health care and the inter-connected nature of all programs and services in support of mental well-being for women offenders and the need to address criminal recidivism.

BACKGROUND

"Women in American society have life experiences that differ from men’s in important ways. Many of these - sexual assault, domestic violence, poverty and discrimination - hurt women’s mental and physical health." (American Psychological Association)

The findings of the 1989 Mental Health Survey (in Creating Choices, 1990) commissioned by the Correctional Service of Canada indicate that the types and incidence of mental health problems are different for men and women and that some mental health problems experienced by women offenders can be linked directly to past experiences of early and/or continued sexual abuse, physical abuse and assault.
The research supports the need to provide appropriate mental health services oriented to the specific needs of women offenders.

Overall, women outnumber men in all major psychiatric diagnoses with the exception of Anti-Social Personality Disorder. Differences also exist in the behavioral manifestations of mental illness between men and women. In general, men turn their anger outward while women turn theirs inward and women suffer from approximately twice as much depression as men (federally incarcerated women are three times as likely to be moderately to severely depressed compared to incarcerated men). Men tend to be more physically and sexually threatening and assaultive while women are more self-abusive and suicidal. Women tend to engage in self-mutilating behaviors such as slashing, and verbally abusive and disruptive behaviors (see Appendix A - Gender Differences with respect to Mental Health).

In addition, important mental health differences exist between women in prison and women in general. In a study (Ross 1988) comparing women in prison matched by age and ethnicity to those in the community, women in prison had a significantly higher incidence of mental disorders including: schizophrenia, major depression, substance use disorders, psychosexual dysfunction, and antisocial personality disorder. In addition, studies have shown that incarcerated women have a much higher incidence of a history of childhood sexual abuse and a history of severe physical abuse than women in the general population (see Appendix B - Mental Health Problems of Incarcerated Women Compared with Those of Women in General Population).

*Creating Choices, “The Report of the Task Force on Federally Sentenced Women”,* notes, as a result of research done with women offenders, that there is a strong need for improved access to physical and mental health services. The report includes the
results of a survey of 170 of the 203 women serving federal sentences in 1989 which found that two thirds of the women had children and more than 70% had been single parents part or all of their children’s lives; 80% had been abused, 68% reported physical abuse and 54% reported sexual abuse; and 69% reported that substance abuse had played a major role in their offense or their offending history. Among incarcerated aboriginal women 90% had been physically abused and 61% reported sexual abuse (Shaw 1990).

A study of the mental health needs of 75 women at the Burnaby Correctional Centre found the following:

- 74% were found to have personality disorders;
- 67% reported current substance abuse problems and 87% reported that substance abuse had been a problem at some point in their lives;
- 36% reported childhood physical abuse, 47% reported childhood sexual abuse, 19% reported adult sexual abuse, and 69% reported adult partner physical abuse;
- 29% reported engaging in self-destructive behaviors such as slashing; and
- 24% reported depression.

These findings are also consistent with the findings of other recent studies of the mental health needs of women in jails, detention facilities and prisons in both Canada and the U.S.
RELEVANT POLICY CONSIDERATIONS

The *Corrections and Conditional Release Act (CCRA)* principles identify that correctional policies, programs and practices respect gender, ethnicity, cultural and linguistic differences and be responsive to the special needs of women and aboriginal peoples, as well as to the needs of other groups of offenders with special requirements.

The *CCRA* Section 77.a) further states that the Service shall provide programs designed particularly to address the needs of female offenders and Section 86 states that the Service shall provide every inmate with essential health care (which includes mental health care) by registered professionals and reasonable access to non-essential mental health care (see Appendix C for definitions).

Commissioner’s Directive 850 - Mental Health Services, states that a continuum of essential care for those suffering from mental, emotional or behavioural disorders will be provided consistent with professional and community standards and will include assessment and treatment for those suffering from various mental disorders.

Any mental health strategy must also respond to the specific needs of aboriginal offenders as per the CCRA section 80 and CD 702 - Aboriginal Offender Programs. Further, all components of the strategy must be assessed according to their cultural relevance for aboriginal women offenders.
GENDER SPECIFIC MENTAL HEALTH STRATEGY

In light of the CCRA and resultant policy, mental health programs for women offenders must be based on a comprehensive program of gender appropriate services in recognition of gender differences in the etiology and classification of mental health problems, the prevalence of specific categories of mental illness, and in the psychological and behavioral manifestations of mental health problems.

Many women offenders are from marginalized backgrounds and current situations which may include poverty, abuse and chemical dependency. Programs and services must be holistic insofar as they address the social context of women’s lives and target those areas which have contributed to their criminal behaviour. Therefore, gender appropriate mental health services must respond to the experiences and related mental health needs of incarcerated women which include:

- a history of relationships characterized by physical, emotional and sexual abuse;
- dependent children for whom the woman had primary caretaking responsibility prior to incarceration;
- low education attainment and limited opportunity for employment in adequately paid jobs; and
- significant long-term substance abuse.

Effective correctional programs for all women offenders should also be based on a model of empowerment whereby women gain insight into their situation, identify their strengths, and are supported and challenged to take positive action to gain control of their lives. This process acknowledges and holds women offenders accountable for their actions while recognizing that actions occur within a social context (Kendall, 1993).
For some women offenders with mental health problems, mental health intervention may, in and of itself, address criminality and reduce recidivism, for others it is only once their mental health problems have been addressed that they can actively engage in programming to address other issues. Nevertheless, despite women’s needs for mental health intervention, the need to address women’s criminality and criminal values cannot be overlooked.

GOAL OF MENTAL HEALTH SERVICES FOR WOMEN OFFENDERS

The goal of mental health services for women offenders is as follows:

To develop and ensure a coordinated continuum of care, structured support and remediation programs which permit women offenders to maximize mental-well being and to minimize criminal recidivism through social, emotional, and cognitive skill development.
KEY PRINCIPLES UNDERLYING THE DELIVERY OF MENTAL HEALTH PROGRAMS AND SERVICES FOR WOMEN OFFENDERS

There are a number of principles essential to the development of any and all mental health services for women offenders:

1. **Wellness** - including:
   - holistic program delivery, that is, program delivery that recognizes body, mind, spirit and emotions and their interconnections in a family and community-oriented context
   - the avoidance of labels insofar as these may function to reduce women to only their mental health issues
   - reinforcement of the skills necessary for personal development and independent living in the community versus adaptation to the institutional environment (however, long term offenders will be encouraged to live in the community living style of the institution)
   - that assisting offenders in this goal involves mental health professionals as well as others including aboriginal service providers, community resources, families, etc.

2. **Access (consistent with CCRA section 86)** - reasonable access to appropriate essential and non-essential professional mental health services including:
   - early identification of mental health problems and service needs
   - timely interventions that minimize symptom escalation and prevent acute crisis situations
   - services provided in keeping with community standards
3. **Women-Centered** - the continuum of mental health services must be offered in a gender-specific and gender-appropriate manner such that:
   - only personnel sensitive to women and women's issues are involved
   - programs and services are designed to meet the specific needs of women offenders while acknowledging personal autonomy, connection to others and positive mutually respectful relationships

However, it should be noted that as result of fiscal limitations, women may require transfer to other regions, institutions or community facilities, to maximize treatment options.

4. **Client Participation (a principle of fundamental justice)** - the women offenders must be involved in their assessment and treatment such that:
   - women offenders play as active a role as possible in their treatment planning and in decision-making

5. **Least Restrictive Measures (consistent with CCRA - Principle d)** such that:
   - treatment is based on the least restrictive/intensive form of intervention possible
   - women are housed in the least restrictive environment possible with the lowest level of security required to ensure public safety.

**OTHER ELEMENTS ESSENTIAL TO THE DELIVERY OF MENTAL HEALTH SERVICES FOR WOMEN OFFENDERS**

**Structure and Environment**: The general institutional environment needs to be consistent, predictable, supportive and constructive. The women need to know what the parameters and expectations are. Consistent structure and environment are central
to the success of programming endeavors. Further, the administration and staff must seek to provide a therapeutic, educational and consistent environment throughout the facility.

Facilities should be designed to incorporate other factors known to promote wellness, including natural light, fresh air and space.

**Bridging:** Bridging services between institutions, and institutions and the community are vital to decreasing recidivism and the gaps in service provision to women offenders. In addition, regular facilities must be able to support and build on the changes made in specialized treatment programs. Bridging services should be developed to support the gains made in treatment especially since many of those with mental health problems are revoked not as a result of new charges, but because of mental health issues e.g. non-compliance with psychotropic medications resulting in a deterioration of overall functioning.

Continuity of care could be provided through one to one therapy, group therapy focusing on relapse prevention issues, and linkages to community resources. These services would fill the gap and create a transitional stage for women leaving prison. Social workers would be well suited to this role.

**Coordination of Mental Health Service Providers:** All mental health service providers, including those on contract, must be involved in ongoing consultation, to share relevant offender information, conduct appropriate assessments, undertake treatment planning, monitor progress, and ensure continuity of care. Coordination and consultation are also important to ensure that mental health service providers, as well as other institutional staff, are not isolated which can lead to early burn-out.
For aboriginal women and other who are open to aboriginal culture, medicine activities including sweats, fasts, cedar baths, drumming/dancing, and ceremonies should be available.

**Role of the Psychologist:** Given the degree of mental health concerns in the women offender population, the psychologist should play a key role in the management of individual cases to aid in case management, behaviour management, program delivery and in striving toward the creation of a treatment supportive milieu. Given that psychologists are involved in the identification of each woman's needs, they should also play a role in assigning women to appropriate programs, whether these are mental health or other programs that would support mental wellness in a holistic context.

**Integration/Information Sharing:** Management must ensure that the model of mental health delivery integrate all related activities that are part of the continuum, and ensure that the psychologist play a role in decisions with respect to those programs that address such issues as sexual abuse and substance abuse even though these programs may not fall under the rubric of mental health programs per se. Further, mental health services must be integrated into each woman's correctional plan and the Case Management Officer must play a role in the coordination and delivery of each woman's mental health treatment plan. The sharing of mental health information with the woman's entire case management team, within the limits of confidentiality, is essential to ensure effective monitoring of her progress.

**Elder Services:** For aboriginal women offenders, Elders are to be considered as an integral part of the mental health services team. Easy access to the services of Elders should be available, with provision for necessary ceremonies and teachings. Mental health programs for aboriginal women should be developed and delivered by
aboriginal organizations or individuals with demonstrated awareness of the concerns and needs of aboriginal women.

**Offender Involvement:** Offenders should be involved in program development and delivery to the extent possible. There are a number of groups that offenders could reasonably and effectively be trained to facilitate with positive impacts on their self-esteem.

**Critical Mass:** Group size will need to be considered in program delivery. Although most programs are designed for 8 to 12 participants, given the small number of women inmates in each facility, some mental health programs may have fewer participants.

**Staff Training/Education:** Ongoing staff training and education in the mental health problems faced by incarcerated women and appropriate intervention is essential to the creation of an atmosphere of understanding and acceptance for this population and to enhancing staff confidence and skills. However, only staff who possess a strong desire to work with women with mental health needs should be recruited.

Regular support and feedback to staff is essential when working in an often stressful and demanding environment. Ongoing training is also essential to the maintenance of appropriate boundaries between staff and inmates. Further, staff training should include education on aboriginal medicine, teachings and ceremonies and possibly participation in aboriginal ceremonies.

**Crisis Resolution:** Creative approaches to crisis resolution or intervention should be sought. These could include not only the involvement of the mental health staff but
also visits with family and other inmates during critical periods when the women may require a great deal of support. The inclusion of Elders in this process, for aboriginal women offenders, should always be considered.

**Transfers:** Transfers in and out of mental health treatment environments must be managed in a such a way that the potential adaptation difficulties for the woman being transferred are minimized and responded to.

**Employment:** The development of useful employment skills and attitudes for those with mental health problems who are incarcerated and within a similar bridging process, as described earlier, is extremely important. These skills would also enhance self-esteem, a crucial mental health issue. Without these skills women are likely to be released into continuing poverty, thus reinforcing some of the dynamics underlying their criminogenic behaviour.

**Creative Approaches:** Creative approaches should be explored wherever possible including relaxation techniques, conflict resolution, body work (i.e. acupuncture, therapeutic massage, etc.), wilderness challenge, story writing, journalling, drama, art therapy, pet therapy, meditation, Tai Chi, role plays, peer counselling, mentor programs, etc.

**Linkages:** The role of other activities and interests such as physical exercise, hobbies, intellectual and spiritual activities, and contact with family and friends will be encouraged for their significant contribution to women’s mental well-being. Further, contact with family and friends can play a crucial role in helping the women retain the gains made during incarceration. As well, programs for women should be designed to support the ongoing relationships between mothers and their children.
Diversity: A proactive effort should be made to increase the diversity of the mental health staff to reflect the diversity of the prison population, including differences in ethnicity, sexual orientation and language.

Capability: Programs should be culturally appropriate and geared to women’s literacy levels. Programs must also be able to address the needs of low-functioning women, with the possibility of groups specifically targetting the needs of these offenders.

Support/Reference Materials: The development of a reference section in the inmate library comprised of books related to the program areas for supplementary reading should be considered, as well as educational videos on a variety of topics including substance abuse, parenting skills and stress management.

Limitations: Fiscal realities may override other considerations for women with mental health needs insofar as women requiring intensive care in regions without a specific program may have to be transferred to another region thereby compromising the aim of allowing women to serve their sentence nearest to their home community.

Further, resourcing difficulties, such as securing staff with the appropriate expertise, may also place limitations on what can be developed in any particular location or region.
ESSENTIAL ELEMENTS IN A WOMEN’S MENTAL HEALTH CONTINUUM OF CARE

Based on their experiences and needs, a continuum of mental health care to address the needs of women and their criminality should include the following elements as found in Appendix D and listed below:

1. **Assessment Services**

   All women will undergo a standardized mental health assessment resulting in a written report as part of a multi-disciplinary and comprehensive intake process. This process will specifically address the needs and realities of women and be culturally sensitive (CD 840 - Psychological Services). The assessment will also integrate mental health needs with other correctional objectives into a single, comprehensive treatment plan. The assessment will determine the level and intensity of mental health intervention required, as well as the women’s willingness to participate in any form of treatment. If a woman appears to have serious mental health problems she may be referred to a psychiatrist or other specialists for further evaluation and assessment.

   Women who have had previous mental health intervention will be encouraged to allow the psychologist and others to access this information. The assessment report should be shared with case management to ensure a team approach to the management of a woman’s case from the beginning of her sentence.

2. **Intensive Care**

   **Organic Disorders:** Intensive care may be required to assess and treat women with acute mental disorders (psychosis, schizophrenia). The treatment goal is symptom stabilization and this level of treatment should occur in an intensive residential setting.
such as a secure hospital in the community. Joliette Institution has an arrangement
with Institute Phillippe Pinel to treat women requiring intensive care.

**Other Disorders:** Intensive care may also be required for those non-psychotic women
with long-standing emotional and behavioural problems, as previously noted. An
Intensive Healing Program for women experiencing these difficulties has been
developed at the Regional Psychiatric Centre in the Prairies as described below.
Other intensive care programs may be developed in future based on identified needs.

**The Intensive Healing Program:**
In recognition that some women inmates had mental health needs beyond the capacity
for intervention available in the new facilities, CSC hired Dr. Margo Rivera from
Kingston Psychiatric Hospital to undertake an analysis of 26 women inmates who
were thought to have mental health needs that could not be addressed under existing
service levels in the new facilities. Dr. Rivera’s report entitled, “Giving Us A
Chance” - Needs Assessment: Mental Health Resources for Federally Sentenced
Women in the Regional Facilities, recommended that an intensive healing program be
developed by CSC to address the needs of those women who exhibited a combination
of *all or most* of the following behaviours: persistent and severe self-destructive
behaviour, identity disturbance, depression, difficulty controlling anger, severe
dissociation, problems in intimate relationships, suicidality, severe anxiety, low self-
esteeem, and severe substance abuse. These women have traditionally been the most
difficult to manage and their behaviours are often an impediment to programming
aimed at reducing the risk of recidivism.

An Intensive Healing Program for women experiencing these difficulties was
designed by CSC (no similar program has ever previously been offered either in CSC
or to incarcerated women in any jurisdiction), and has been operational at the
Regional Psychiatric Centre in the Prairies since September 1996. Treatment focuses on understanding and transforming the thoughts and behaviours that are the source of the women’s problems (cognitive-behavioural therapy). Key to reinforcing these transformations are the acquisition of new skills and coping strategies. This happens both formally through the program components and informally through interactions and the positive role modelling of behaviour by staff (therapeutic community). Emphasis is placed on the present rather than the past, and on understanding the dynamics of interpersonal experiences that occur within the program. Built into the Intensive Healing Program is a comprehensive evaluation component which involves staff and inmates.

Treatment includes a number of complimentary aspects:

- A Therapeutic Community Approach
- Individual Counselling
- Group Programs
- Pharmacotherapy (prescription medication as necessary)

3. Intermediate Care

Intermediate care is designed to allow inmates with significant mental health problems to live in the general population by providing daily targetted intensive treatment services in either one-to-one counselling, treatment groups or a combination of interventions. However, group intervention targetted at this population is unlikely in some institutions given the small numbers.

The role of the mental health team (comprised of the psychologist, Elder or Native Liaison Worker, nurse, and possibly the psychiatrist, primary worker, case management officer, and chaplain) established in every institution (CD - 850) will be
to oversee the women requiring this level of care. They will identify needs and service requirements, and monitor and document the clinical progress of individual inmates on a regular basis. It may be advisable to have one member of the mental health team assigned as the coordinator of the mental health aspects of the case for every woman requiring this level of care to ensure appropriate monitoring.

Interventions can include:

- Symptom stabilization and management
- Psychosocial rehabilitation programs
  - social and interpersonal skills training
  - cognitive skills training
  - life skills including education and employment skills
- Therapeutic groups*
  - medication education and support - to enhance medication compliance
  - survivors of abuse
  - eating disorders
  - self-destructive behaviour
  - anger and stress management
- Dual disorders treatment (mental health and substance abuse)
- Comprehensive treatment planning
- Relapse prevention

*Groups with a psychoeducational focus, appear to be the preferred option, that is, those that make the psychological connections in an educational way versus probing into the women's individual traumas.
Follow-up and relapse prevention for those with serious problems who were in the Intensive Healing Program will be essential to ensure that changes made in treatment are supported and maintained.

4. Ambulatory Care

Ambulatory care includes therapeutic groups, prevention, maintenance, relapse prevention and psycho-educational services designed to provide both therapy directed at specific ongoing issues e.g. eating disorders, and short term interventions to women experiencing significant psychological distress related to situational phenomenon that may impair their ability to function on a temporary basis e.g. death in the family, losing a custody hearing or interpersonal conflict on the living unit.

Ambulatory care will take place in addition to other programming. The services offered will be coordinated by the Mental Health Team. The individual plan for a woman may be developed between the woman and her psychologist or primary worker, in conjunction with the Mental Health Team.

Treatment can include:

- Crisis resolution
- Targetted group treatment programs
  - anger and stress management
  - conflict resolution
  - survivors of abuse and trauma*
  - substance abuse
  - eating disorders
  - self-esteem
  - parenting skills
  - self-destructive behavior
-relapse prevention
-Elders therapeutic circle meetings

* The survivors of abuse and trauma group is one of the Core Programs offered in the Women’s facilities. It is also listed here because this group may play an integral role in addressing women’s mental well-being.

Some institutions have provided these groups based on the needs of a number of inmates at a point in time. Nova Institution currently offers a voluntary substance abuse group that is open for any woman wishing to attend and it has been very successful.

As with intensive care, follow-up and relapse prevention for those with serious problems who were in the Intensive Healing Program will be essential in ambulatory care to ensure that changes made in treatment are supported and maintained.

Women requiring intensive care could participate in the group treatment programs dependent on their suitability for group work, the numbers of women, group dynamics and operational considerations.

5. Psychotherapy/Counselling Services

Psychological and individual counselling services will be offered on a voluntary basis to women who are ready to deal with personal issues on a one-on-one basis by the psychologist (CD 840 - Psychological Services). The role of counselling is a critical one for women dealing with various personal and other traumatic issues that they do not feel able to deal with in other ways. The psychologists work with the women to increase their awareness of how past issues are affecting current behaviour and to increase their coping skills with a view to enhancing mental well-being and reducing recidivism. If the issue is one for which an appropriate group exists, the woman may
be encouraged to deal with this issue by attending the group. However, the small size of some facilities may mitigate against participation in therapeutic groups due to issues of confidentiality.* Psychotherapy and counselling may also be an important adjunct for those involved in the group components of intermediate or ambulatory care.

* Some research suggests that it is possibly contraindicated to be undertaking intensive therapeutic work on issues such as sexual abuse inside prison.

6. Aboriginal Components/Elder Services

The importance of access to Elder Services for the healing and mental well-being of aboriginal women cannot be over-stated. At the Healing Lodge contact with Elders is viewed as the most integral part of their mental health services and an Elder is always available. Traditional mental health services in the form of counselling offered by a psychologist, and psychiatric services are also available. There appears to be an easy integration of traditional mental health services with Elder services and women are encouraged to take the best of what each has to offer.

All staff working with women offenders should be trained and sensitized on the importance of Elder services to the healing process of aboriginal women and should ensure as much access to Elders as possible. Further, the Elders should be part of the Mental Health team in every institution to ensure an integration of their expertise.

7. Other Program Components

Suicide and Self-Injury:

It is essential that each institution develop a comprehensive strategy to prevent suicide and reduce the incidence of self-injury including ongoing training of frontline staff in understanding self-injury and suicide attempts as these specifically relate
to women, and appropriate intervention. Self-injurious behaviour must be viewed as a mental health issue and not a security issue unless there are extenuating circumstances, such as the involvement of weapons. Given that there are now some studies that support the view that self-injury and aggression are linked for those with personality disorders, staff should pay close attention to incidents of self-injury amongst these inmates (Swinton and Hopkins, 1996).

**Low-Functioning Women:**

There are a number of women with mental health problems, especially in the Atlantic region, who may also be considered of low intellectual functioning. These women have been identified as mainly high need and low risk, and likely require intensive case management and supportive services to function effectively in the regional facilities (Whitehall, 1995).

Low functioning women may require intervention for needs outside the realm of therapeutic counselling and formal programs in order for them to be able to make progress on basic skills of living. The assistance of an Occupational Therapist or Social Worker may be well suited to address the needs of this population. Regions with enough low-functioning women may wish to consider designating one of the houses for this group with 24 hour supervision by staff with training in living skills. The goal would be eventual reintegration into one of the other houses or the community.

**Sex Offenders:**

Research on women sex offenders is scarce, and mental health disorders are seldom identified as a significant issue for this group. Nevertheless, because many of these women appear to function on a marginal level and because of their needs for intervention to address mental wellness, this group is included in the Strategy.
As of February, 1996 there were 9 federally incarcerated women whose major
admitting offense was sexual and 12 on bail, day parole, full parole, and statutory
release (Syed & Williams, 1996). Thus there are proportionally very few women sex
offenders as compared to men.

There are a variety of types of female sex offenders and their treatment and
supervision needs will vary depending upon personal characteristics, the nature of
their sexual offending, and their particular release plans. Treatment efficacy will
depend on the accuracy of the match between the intervention and the specific needs
of the offender. While it is important that women sex offenders take responsibility
for their offenses, it is also important not to overlook the treatment needs that may
arise from their own victimization experiences (substance abuse, dissociation, self-
injury, sexual abuse). The treatment of women incarcerated for sexual offenses
requires specialized knowledge and the necessary training and supervision should be
sought for those working with this population.

Peer Support:
Peer support is a key component of the mental health continuum to provide women
with access to counselling, support and comfort from other inmates when in crisis.
As outlined in the Prison For Women's (PFW) Peer Support Team Guidelines, peer
counsellors will be trained to be,

...“used in a preventative capacity (e.g. if there is a reason to believe that a
woman is experiencing some difficulty that is likely to escalate; if a woman is
vulnerable and living unit tension increases); for follow up counselling after
the initial crisis has passed; and for crisis intervention.”
Training of the Trainers in an updated version of the PFW peer support program has been offered to staff in all facilities for women offenders and program implementation is now underway.

Some institutions have found that a modified version of peer support is more appropriate for a small institution. Nova has therefore implemented a buddy system whereby women with needs are matched with women with skills.

**Other Programs:**

In addition to those programs specifically targetting mental wellness or mental health needs, women may also require programs directed at other issues such as social skills and cognitive skills. However, as previously noted, it is essential that all programs and services be inter-connected.

The role of employment in developing skills leading to financial independence and a gratifying work life in the community is a significant factor in women’s mental health empowering them to feel in control and take control of their lives. To this end, employment programs are an essential adjunct to comprehensive mental health programs.

8. **Community Services**

Offenders with mental health needs should be linked to community services to ensure treatment effects are maintained and to reduce the risk of recidivism.

Program activities can include:

- Education and promotion of self-management skills
- Establishment of linkages with appropriate community institutions such as mental health agencies, supportive housing, employment,
social assistance, substance abuse services, and aboriginal communities/services.

Again, variations are likely, for example, because of the limited resources and small size of Nova institution, the psychologist has gone out into the community to do the bridging work herself. However, a staff person, likely the Community Reintegration Manager, must be assigned to monitor and coordinate the links between women with mental health needs and the community. Strategies for encouraging community agency involvement with the reintegration of incarcerated women will require development.

MONITORING AND EVALUATION

Programs for mental health intervention and treatment must be developed based on the best and most current treatment consistent with the principles reiterated in this document.

All programs must be set up with the intent of ongoing monitoring and periodic evaluation. It is the responsibility of every mental health professional who delivers a program to ensure that the program is fully evaluated using both qualitative and quantitative measures and feedback from the participants. This will require that evaluation criteria, evaluation methods and data collection requirements be identified prior to the program start. Programs and services are to be evaluated for their overall ability to meet the needs of offenders, to adhere to the principles noted earlier, for their effectiveness, and for their ability to contribute to our knowledge of “what works” with women offenders. This could include:
• Workshops evaluated by a brief form completed by participants recording their opinion of the quality and usefulness of the presentation.

• Classes evaluated by pre- and post- tests assessing the knowledge gained by participants.

• Treatment groups evaluated by pre- and post- group measures of depression, anxiety, locus of control, self-esteem, and appropriate self-assertion, as well as forms completed by participants giving their subjective opinions of the helpfulness of the groups.

Evaluation procedures should be refined and updated as the programs/interventions develop.

MANAGEMENT RESPONSIBILITIES

Although each institution need not provide on-site access to all components of the continuum, each institution must provide reasonable and appropriate access for offenders to all levels of care. Each institution must also ensure that their mental health program is managed by a registered mental health professional (CCRA Section 85).

Standing Orders should reflect:

1. the level and range of care
2. appropriate management and monitoring of mental health programs
3. mechanisms for horizontal communications and a “team approach” to ensure integration and consistency etc.
4. a process to ensure that continuous, effective aboriginal awareness training for staff takes place.
Management must also ensure that the mental health professionals, psychologists, social workers, etc. who are hired are highly skilled and knowledgeable and have the appropriate qualifications and experience to work effectively with incarcerated women.

It is understood that the implementation of a comprehensive mental health system will require time for staff members to engage in detailed planning and appropriate response development. Each facility will need to determine which program components in intermediate and ambulatory care should be prioritized for development and implementation more rapidly than others. Further, additional resources will need to be allocated to women’s mental health in order to effectively implement the necessary mental health interventions. The challenge of meeting the mental health needs of women offenders will require constant innovation and evaluation as well as collaboration with our community partners.
**APPENDIX A**

**GENDER DIFFERENCES WITH RESPECT TO MENTAL HEALTH**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Women are twice as likely to be diagnosed with depression. Incarcerated women are three times more likely.</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Women are more likely to be assessed with symptoms of schizophrenia.</td>
</tr>
<tr>
<td>Sexual/Physical Abuse</td>
<td>Higher reported rates of both for women.</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Higher reported rates for women.</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>Incarcerated women: 29%. Incarcerated men: 57%</td>
</tr>
<tr>
<td>Personality Disorder / Anxiety</td>
<td>Women are more likely to be diagnosed with both.</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Women more likely to have a co-existing psychiatric disorder, and experience more serious physical consequences of drug and alcohol use.</td>
</tr>
<tr>
<td></td>
<td>Women in prison are as likely as men to have a history of substance abuse but more likely than male inmates to have used hard drugs such as cocaine and heroin and to have taken drugs intravenously.</td>
</tr>
<tr>
<td>Mental Health Treatment in the Community</td>
<td>A 1995 study at Prison for Women (PFW) found that federally incarcerated women were 3 times as likely to have received mental health treatment in the community compared to men.</td>
</tr>
</tbody>
</table>

## APPENDIX B

MENTAL HEALTH PROBLEMS OF INCARCERATED WOMEN COMPARED TO THOSE OF WOMEN IN GENERAL POPULATION

<table>
<thead>
<tr>
<th></th>
<th>Women in general pop.</th>
<th>Women Inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>1.1% lifetime prevalence</td>
<td>7% lifetime prevalence</td>
</tr>
<tr>
<td>Major Depression</td>
<td>8.1%</td>
<td>19%</td>
</tr>
<tr>
<td>Substance Use Disorders - Alcohol</td>
<td>4.3%</td>
<td>36%</td>
</tr>
<tr>
<td>Substance Use Disorders - Drugs</td>
<td>3.8%</td>
<td>26%</td>
</tr>
<tr>
<td>Psychosexual Dysfunction</td>
<td></td>
<td>70%</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>1.2%</td>
<td>29%</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>20 - 54%</td>
<td>47 - 90%</td>
</tr>
<tr>
<td>Physical abuse in adult intimate relationships</td>
<td>27%</td>
<td>69%</td>
</tr>
</tbody>
</table>

APPENDIX C

The Correctional Service of Canada shall ensure the provision of essential health services for an inmate including mental health and general health care.

Criteria

Essential Health Services

Inmates shall have access to screening, referral and treatment services.

Essential services shall include:

I emergency health care (i.e., delay of the service will endanger the life of the inmate);

II urgent health care (i.e., the condition is likely to deteriorate to an emergency or affect the inmate's ability to carry on the activities of daily living);

III mental health care provided in response to disturbances of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life. This includes the provision of both acute and long-term mental health care services; and

IV dental care for acute dental conditions where the inmate is experiencing swelling, pain or trauma; preventive treatment (i.e., necessary fillings, extractions, etc.) subject to the motivation displayed by the inmate to take an active part in the process; and removable dental prostheses as recommended by the institutional dentist. All other dental care will be initiated and funded by the inmate.

Inmates shall have reasonable access to other health services (i.e., conditions not outlined above) which may be provided in keeping with community practice. The provision of these services will be subject to considerations such as the length of time prior to release and operational requirements. In support of providing essential health services, emphasis will be placed on health promotion/illness prevention.

From: Standards for Health Services, 1995
**APPENDIX D**

**WOMEN'S MENTAL HEALTH CONTINUUM OF CARE**

<table>
<thead>
<tr>
<th>ASSESSMENT SERVICES</th>
<th>NON-MENTAL HEALTH PROFESSIONALS</th>
<th>AMBULATORY CARE</th>
<th>INTERMEDIATE CARE</th>
<th>INTENSIVE CARE</th>
<th>COMMUNITY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>treatment planning</td>
<td>suicide prevention</td>
<td>individual counselling</td>
<td>symptom stabilization</td>
<td>off-site hospitalization for symptom stabilization and treatment</td>
<td></td>
</tr>
<tr>
<td>psychiatric referral</td>
<td>self-help</td>
<td>crisis resolution</td>
<td>psychosocial rehabilitation</td>
<td>Intensive Healing Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>peer support</td>
<td>therapeutic groups</td>
<td>therapeutic groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>referral</td>
<td>prevention / maintenance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>other programs e.g. substance abuse</td>
<td>psycho-educational groups</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- covers all levels of care
- programs offered by community agencies
- Aboriginal Services
- bridging services

bridging services  bridging service
REFERENCES


Many of the men and women who cannot get mental health treatment in the community are swept into the criminal justice system after they commit a crime. In the United States, there are three times more mentally ill people in prisons than in mental health hospitals, and prisoners have rates of mental illness that are two to four times greater than the rates of members of the general public. Offenders who need psychiatric interventions for their mental illness should be held in secure facilities if they have committed serious crimes, but those facilities should be designed and operated to meet treatment needs. Society gains little from incarcerating offenders with mental illness in environments that are, at best, counter-therapeutic and, at worst dangerous to their mental and physical well-being. Our vision for the Mental Health Strategy is of a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma. Over the 10 years of the Strategy, we will work on achieving parity between mental and physical health. The scale of the challenge to achieve parity is considerable. We will work with the Scottish Prison Service and partners to improve the mental health of prisoners, including supporting young offenders. Social Security: Our overarching aim is to create a social security system in Scotland that is based on dignity, fairness and respect. This will be a system that helps to support those who need it and when they need it.