

# Mental health needs of women offenders: Needs analysis for the development of the intensive Intervention Strategy

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This article summarizes some key findings from a study jointly undertaken by Health Services Branch, Research Branch, and the Women Offender Sector of the Correctional Service of Canada. In 1990, a Task Force on Federally Sentenced Women was formed to examine the correctional management of federally sentenced women and to develop a plan responsive to their unique and special needs.<sup>3</sup> Among the Task Force's recommendations was the closing of the Prison for Women (P4W) in Kingston, Ontario,<sup>4</sup> and its replacement with four regional facilities and an Aboriginal Healing Lodge. Between 1995 and 1997, these new institutions were opened. The design of the new institutions reflected the recommendations of the Task Force, specifically promoting concepts associated with community-style living (inmate housing is provided through stand-alone houses clustered behind a main building which contains staff offices, program space, a health care unit, and visiting area). While the new institutions did address the needs of most women, they did not address the needs of some women who needed more intensive mental health treatment (which, at the time, was unavailable at the regional institutions) or the small group of maximum-security offenders who needed more structure and control.<sup>5</sup>

Over the past few years, the priority has been to put into place a comprehensive, realistic and sustainable strategy to meet the needs of those women with intensive mental health needs, as well as addressing the needs and risk of those women classified as maximum-security.<sup>6</sup> To help develop this strategy, a Needs Analysis was required in order to obtain information regarding the mental health, living skills, and security needs of these women and provide further information on treatment and programming needs, staffing, staff training, security, and the nature of the supervision/intervention required.<sup>7</sup> The present article is limited to describing certain findings of the Needs Analysis pertaining to the mental health issues of the target populations.

## Methodology

The criteria for inclusion in the Needs Analysis were designed to include all women with maximum-security classifications, severe mental health concerns, and/or significant problems with daily-living (i.e., those women who cannot function in the community living environment of the regional facilities without considerable additional support and intervention).<sup>8</sup>

Needs Analysis Questionnaires were sent to all institutions housing federal women inmates (10) and completed by all staff and/or members of the inter-disciplinary team working with women in the target populations.<sup>9</sup> To ensure consistency in the completion of the questionnaires, representatives received direction from the national researchers.

The questionnaire covered a broad range of questions (both closed and open-ended) and was designed to provide a comprehensive national picture of the nature of the difficulties experienced by these women and the staff who work with them, as well as corresponding security, programming and staff training needs.

With respect to the mental health needs of the women, the questionnaire elicited information intended to gauge the following: existence and identification of psychiatric diagnosis/diagnoses,<sup>10</sup> the use of psychiatric and other medications, suicide risk, self-injurious behaviour, substance abuse, and other mental health issues/concerns, treatment and related programming needs and requirements.

## Data organization

Data were analyzed using a coding guide; where the coding was not straight forward/self-evident, categories were delineated on the basis of the most frequently occurring responses. The sample was divided into four mutually exclusive sub-groups according to which criteria the women met (see Table 1). Data were also analyzed regionally.

Table 1

Sub-group categorization		
Sub-group label	Number (n)	Description of the sub-groups
<b>Max</b> (Maximum-Security)	20	Those women with maximum-security classification who are <i>not</i> living in a special-needs or mental health unit or treatment centre and do <i>not</i> have significant mental health problems and/or living-skills deficits.
<b>MaxSN</b> (Maximum-security Special Needs)	9	Those women with maximum-security classifications who are living in a special-needs or mental health unit or treatment centre or who have significant mental health problems and/or living skills deficits
<b>SN-Tx</b> (Special Needs-Treatment Centre)	20	Those women with medium- or minimum-security classifications who are living in a special-needs or mental health unit or treatment centre
<b>SN-NonTx</b> (Special Needs-Non Treatment Centre)	25	Those women with medium- or minimum-security classifications who are not in a treatment centre or special needs unit but who have significant mental health problems and/or living-skills deficits

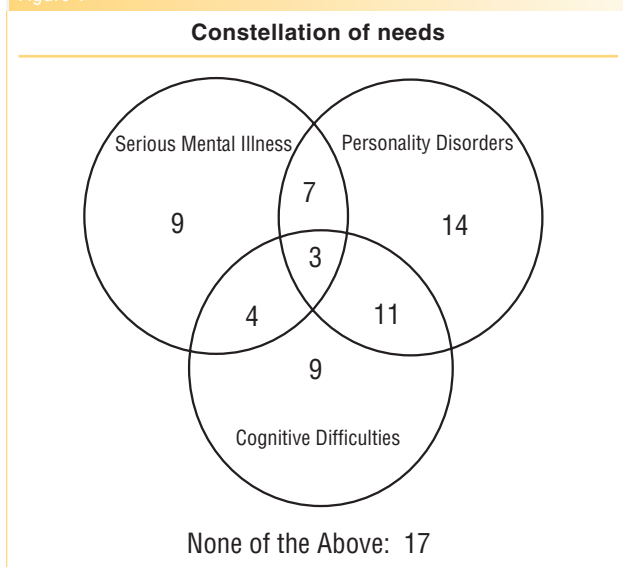
## Results

Seventy-four completed questionnaires were returned.<sup>11</sup> The mean age across the sub-groups was 35.3 (SD = 8.7); 19 women were Aboriginal (25.7%).

### Constellation of needs

Psychiatric diagnoses and information on cognitive functioning were examined to determine a broad constellation of needs, based on: Serious Mental Illness (SMI, e.g., schizophrenia); Personality Disorder (PD, e.g. Borderline Personality Disorder); and/or Cognitive Difficulties, (CD, e.g. low cognitive functioning).<sup>12</sup> The majority of women (77%) could be accounted for in this constellation; almost half (43%) had more than one of the above needs identified (see Figure 1).

Figure 1



### Constellation of needs by sub-groups

In Figure 2, the constellation of needs identified above is further examined in relation to the four sub-groups. Some of the more interesting findings are that for almost half (n = 9) of the Max sub-group, none of the needs in the constellation identified were noted; moreover, no one in this sub-group presented with an SMI. Of the remainder of the Max sub-group, almost one-third (n = 7) were identified as having a personality disorder, comprising the highest

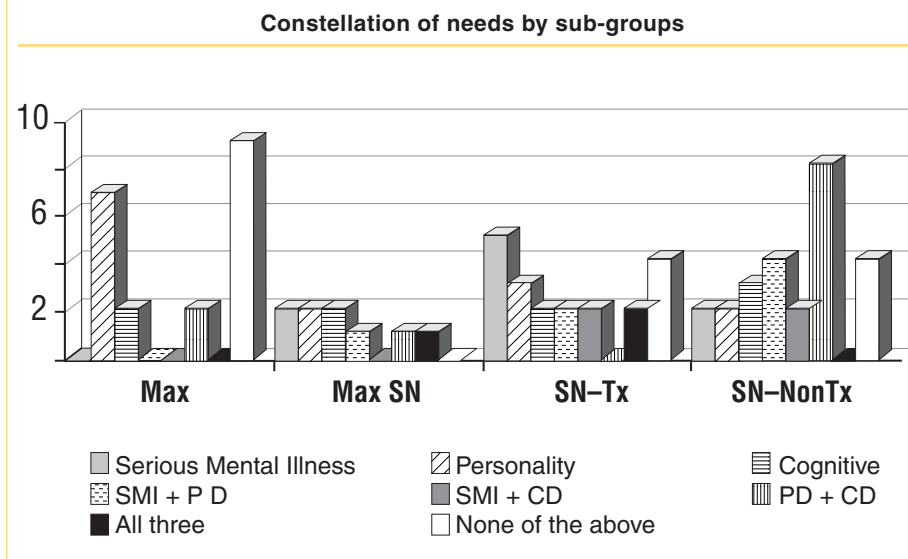
percentage of PDs across any of the remaining sub-groups. Half of the women in the MaxSN group were diagnosed with an SMI or SMI combination. Additionally, half of these women were diagnosed with a PD (Borderline Personality Disorder; BPD). Again, half of the women in the SN-Tx sub-group were diagnosed with an SMI or SMI combination. Additionally one-third were diagnosed with BPD. Finally, in the SN-NonTx sub-group, the highest number of needs were noted: over three-quarters of the sub-group had one or more of these need areas identified, the majority of which were cognitive difficulties and personality disorders (including a high frequency of co-occurrence).

### Other findings: Substance abuse, suicide, self-injury

The majority of women (75%) were identified as having a significant substance abuse problem. For about one third (35%) of those with a substance abuse problem, this presented serious challenges within the institution (e.g., using, trafficking). Of those with a substance abuse problem, there was 70% co-occurrence with a psychiatric diagnosis (PD, SMI).

Almost half the women were identified as at risk for suicide;<sup>13</sup> of these women, two-thirds had attempted suicide in the past two years. With respect to the sub-groups, suicidal risk appeared highest for MaxSN (89%). Similarly, half of the women were identified as having a history of self-injury. Self-injurious behaviour was reported more often for women with maximum-security classifications (either Max or MaxSN): 58% compared to 35%. Furthermore, self-injurious behaviour was identified as a current concern for 25% of the women, with no differentiation across sub-groups.

Figure 2



When staff were asked for their opinion regarding the women's treatment needs, the most frequently identified type of treatment need was psychological, including the need for individual counselling. Other treatment needs frequently identified were: treating deficits in skills/coping abilities which included things such as interpersonal skills and daily living skills; psychiatric treatment needs where medication management was required; treatment

A great deal of variability was noted in the responses to questions relating to interpersonal skills. While this is a subjective assessment that can be influenced by the quality of the relations between the women and the staff; staff identified the majority of the women as having difficulties, the most common being: creating conflict; interpersonal difficulties; antisocial behaviours; and impulsive behaviours.

Three-quarters of the women were identified as experiencing difficulties in activities associated with daily-living. Common difficulties identified included: emotional/behavioural (coping, problem solving, impulsivity); self-care (personal hygiene, eating); household; and motivational/organizational (e.g., initiating activities; organizing the steps in completing a task). Across the sub-groups the greatest difficulties were in emotional/behavioural; the SN-NonTx group had the most difficulties across all of the categories.

Staff identified approximately 70% of these women as having a mental health or treatment issue(s) that fell outside of any DSM-IV category. Among the more commonly identified issues were: emotion dysregulation, past trauma issues and serious medical conditions (e.g., Hepatitis C, asthma, epilepsy; HIV / AIDS).<sup>14</sup> In terms of the different sub-groups, emotion regulation and past trauma issues were more commonly reported for women in the SN-NonTx group; eating disorders and emotion regulation were more commonly reported for women in the Max group; and serious medical conditions were more commonly reported for women in the SN-Tx group.

to address substance abuse; and treatment to address anger management issues.

The findings relating to programming revealed that approximately one-quarter of the women require programs adapted to their cognitive level (this need was highest for SN groups and considerably lower for the Max group). The majority were identified as being capable of participating in group programming; however there were differences again across the sub-groups, with MaxSN identified as least likely to be able to function in groups and requiring more individual programming.

Finally, the staff identified various areas for additional and specialized training. Among the most frequently identified areas were: Dialectical Behaviour Therapy (DBT); mental health awareness; and crisis intervention. Other suggestions included, substance abuse; therapeutic skills; responding to suicide/self-injury; Aboriginal awareness; understanding abuse/trauma; and anger management training.

### Conclusion

On September 3, 1999 Solicitor General Lawrence MacAulay announced the *Intensive Intervention Strategy for Women Offenders*. The *Strategy* addresses the complex needs and risks of the populations included in the Needs Analysis. In brief, the *Strategy* delineates specialized housing environments to accommodate the women within the regional facilities — Structured Living Environments have been built to accommodate medium-and minimum-security women with significant mental health difficulties and Secure Units are

being created to better accommodate maximum-security women. Both environments offer 24-hour staff supervision and support, as well as specialized programming delivered through an inter-disciplinary team. Within the context of an effective therapeutic environment, the two primary treatment models being implemented in the Structured Living Environments are: DBT — to address emotion and behaviour dysregulation and other interpersonal skill needs; and Psychosocial Rehabilitation (PSR) — to address the daily-living and coping skills needs for women who are identified as lower

cognitively functioning. These interventions will also be available for women in the Secure Units.

In summary, the Needs Analysis provided useful information to assist in addressing the mental health needs of the target populations, including the choice, design and implementation of the primary treatment interventions (DBT and PSR). Furthermore, information from the Needs Analysis was also used to develop the *Institutional Functioning Scale*, which will assist in the progress and outcome evaluation of both environments. ■

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<sup>3</sup> Correctional Service of Canada (1990). *Creating Choices: The Report of the Task Force on Federally Sentenced Women*. Ottawa, ON: Author.

<sup>4</sup> P4W opened in 1934 and in 1990 was the only federal penitentiary for federally sentenced women inmates in Canada.

<sup>5</sup> Each house accommodates 6 to 10 women and includes communal living space, a kitchen, dining area, bathrooms, a utility/laundry room and access to the grounds. The women in each house are responsible for all their daily living needs, such as cooking, cleaning and laundry.

<sup>6</sup> In September 1996, an interim decision was made to remove all maximum-security women from the Service's new regional facilities for women because the community-living design of the regional facilities was not meeting the needs of this population either in terms of security or programming and the enhanced units at the regional facilities were designed for short-term stays, not long-term accommodation. Maximum-security women have been regionally accommodated at the Prison for Women (now closed) or in separate and distinct units at existing facilities for men: Saskatchewan Penitentiary, Regional Psychiatric Centre - Prairies (Saskatchewan), Regional Reception Centre (Quebec) and Springhill Institution (Nova Scotia). In the Pacific Region, all female inmates are accommodated at the Burnaby Correctional Centre for Women under an Exchange of Services Agreement.

<sup>7</sup> Previous reports on women with special needs and/or maximum-security classifications include: McDonagh, D. (1999). *Federally Sentenced Women Maximum Security Interview Project: "Not Letting the Time Do You"*. Ottawa, ON: Correctional Service of Canada. Morin, S. (1999) *Federally Sentenced Aboriginal Women in Maximum Security: What Happened to the Promises of "Creating Choices"?* Ottawa, ON: Correctional Service of Canada. Warner, A. (1998) *Implementing Choices at Regional Facilities: Program Proposals for Women Offenders with Special Needs*. Ottawa, ON: Correctional Service of Canada.

<sup>8</sup> Staff were requested to complete the questionnaires on all women incarcerated in their institutions July 1<sup>st</sup>, 1999 who met the following criteria:

<sup>1</sup> Currently classified as maximum-security.

<sup>2</sup> Currently living in a special-needs or mental-health unit or a treatment centre (due to severe mental health problems and/or low cognitive functioning and deficits in basic living skills). [Regardless of security classification.].

<sup>3</sup> Women who, although they are not currently classified as maximum-security, have had a maximum-security classification within the last calendar year. [Results have not been included in present report.].

<sup>4</sup> Women who, although they are not currently living in a mental-health unit or treatment centre, have significant mental health problems and/or living-skills deficits such that the women cannot function in the community living environment without considerable additional support and intervention.

<sup>9</sup> Questionnaires were sent to the following facilities and units: Nova Institution, Springhill Institution, Établissement Joliette, Centre régional de réception, Grand Valley Institution, Prison for Women, Edmonton Institution for Women, Okimaw Ohci Healing Lodge, Regional Psychiatric Centre, Saskatchewan Penitentiary, and Burnaby Correctional Centre for Women.

<sup>10</sup> American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV)*. Washington, DC: Author.

<sup>11</sup> In total 90 questionnaires were returned; 16 of these questionnaires considered inmates who had a maximum-security classification in the past 12 months but were no longer classified maximum-security.

<sup>12</sup> SMI includes major psychotic diagnoses such as schizophrenia, major depression, bipolar or dissociative disorder; PD most frequently identified was Borderline Personality Disorder (BPD); Cognitive difficulties were identified by either a DSM IV diagnosis indicating low cognitive functioning or an answer of yes to the question "Is this women's cognitive functioning below normal?"

<sup>13</sup> This figure is an overall indicator of risk as determined by staff and is based on current ideation or attempts (current is considered to have occurred within the past two years) or past risk.

<sup>14</sup> Emotion dysregulation comprised issues such as mood lability and anger management. For the purposes of our analyses, past trauma issues included both family violence as well as abuse experienced in a woman's family of origin. Serious medical conditions such as Hepatitis C, asthma, epilepsy, HIV/AIDS or other serious medical conditions were also considered as a mental health issue insofar as the emotional toll experienced by women with these conditions.