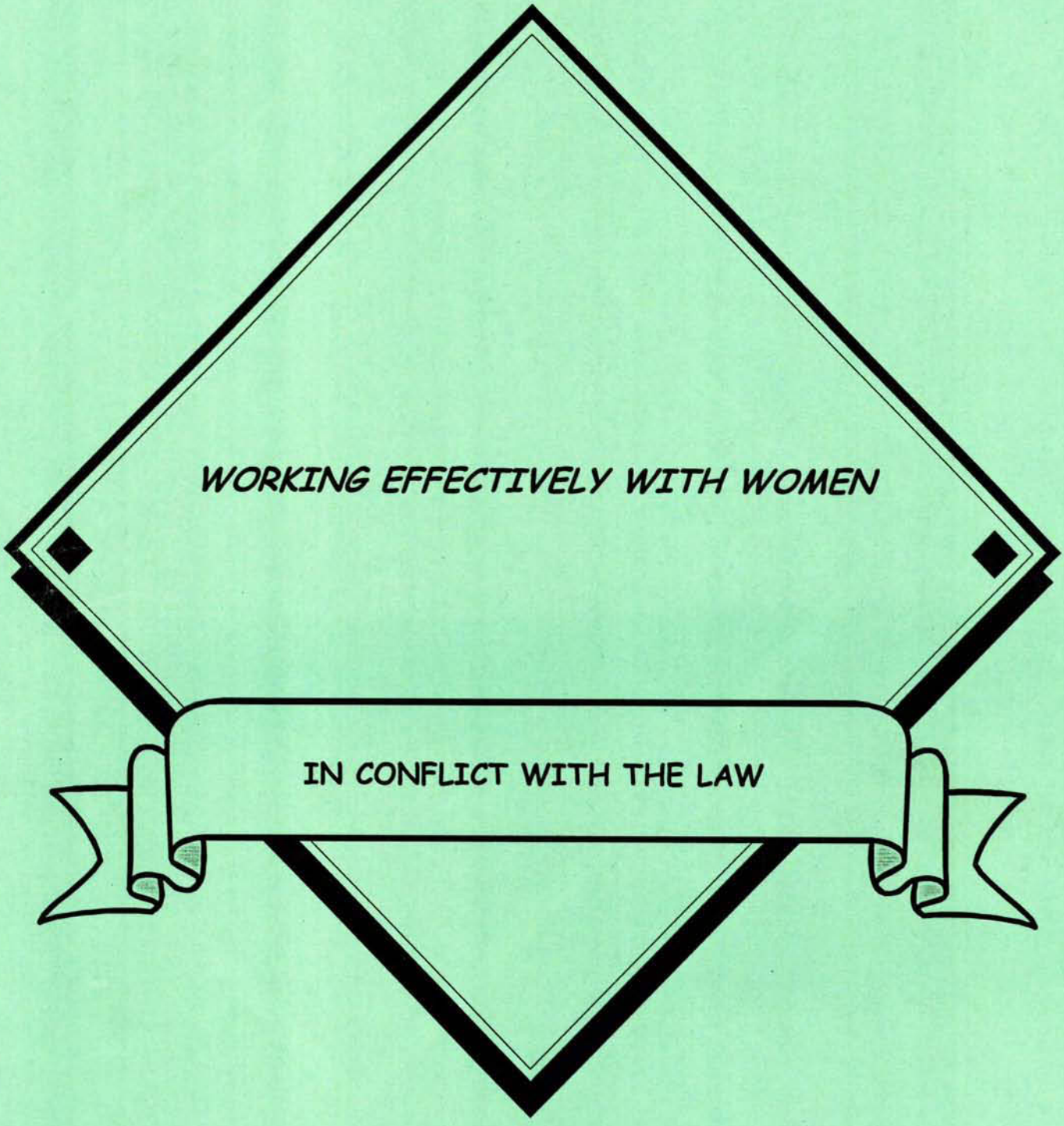

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WORKING EFFECTIVELY WITH WOMEN IN CONFLICT WITH THE LAW

PREFACE

We have all heard that "necessity is the mother of invention". This manual received its inspiration from the staff who met during the summer of 1996 and those who responded to surveys identifying the special training needs of those who work with female offenders. The group generally felt that there are special rewards as well as special challenges for those working with the female offender group and noted a dearth of practical information to help them deal with the issues they commonly encountered. It was felt that a distance learning tool such as a self-study manual would best meet the identified needs. Recognizing the challenges of cross-gender supervision and the valuable insights of the group lead to the development of a "Protocol on Cross Gender Supervision".

Thanks to Nelson Cardoza, Institutional Training Officer at the Metro West Detention Centre, Charlene Marshall, Social Worker at the Vanier Centre for Women, Gord Mairs, Staff Training and Security Officer at the Vanier Centre for Women and Arlene Smith, Correctional Officer from Barrie Jail, who worked on both committees.

The development of a training vehicle was undertaken with the recommendations of the Task Force Report, "Women's Voices, Women's Choices" providing a guiding light. One of their key recommendations was that "the Ministry should ensure that all staff are committed to women's healing and self-development. Awareness and training programmes should involve developing sensitivity and awareness of issues related to gender, race, ethnicity, sexual orientation and disabilities." It is hoped that the material will heighten sensitivity and awareness in these areas.

A special thanks to all the contributors of the articles for their time and expertise, particularly to Catherine Maunsell, Program Coordinator at the Vanier Centre for Women, who was persuaded to write three articles. Also thanks to Joan Winchell, Executive Director of the Peel-Halton Elizabeth Fry Society and to Terri Menagh, Classification Officer at Quinte Detention Centre, for their editorial comments and to Lisa Nuttall for her computer skills. This manual would not have been possible without the support of Neil McKerrell, Assistant Deputy Minister and Louie DiPalma, Director, Adult Institution Operations, who have sponsored the female offender reform project.

Finally, no project comes to fruition without the determination of a key individual to move the agenda forward, increase insight and provide constructive learning opportunities. The publication of this manual was no exception and we were fortunate to have Priscilla Reeve spearheading this important initiative. For those of you who don't know Priscilla, her determination and commitment to achieving positive results is unwavering. All of her efforts to coordinate the expertise of correctional staff and external experts in this project has led to the completion of this very worthwhile manual.

The line drawings were especially created for the manual by young women in custody at the Vanier Centre, Brampton and Harmony House, London, as an expression of their feelings about being in conflict with the law.

Loretta Eley, Manager, Female Offender Programme Reform

WORKING EFFECTIVELY WITH WOMEN IN CONFLICT WITH THE LAW

SELF STUDY MANUAL

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A HISTORICAL PERSPECTIVE AND A PROFILE OF THE FEMALE OFFENDER IN ONTARIO

WRITTEN BY:

Priscilla Reeve is Coordinator for Female Offender Reform with the Ontario Ministry of Solicitor General Correctional Services. Her interest in women in conflict with the law in the past was reflected by working as Volunteer Coordinator at the Vanier Centre for Women in Brampton and serving on the Board of Directors of the Peel / Halton Elizabeth Fry Society.

She has worked in corrections and mental health in both the private and public sector in Ontario and the U.K.. Previous positions include Area Manager for Probation and Parole in Guelph and Kitchener, Administrator of the Guelph Correctional Centre Assessment and Treatment Unit, Parole Board Member and Coordinator of the Community Service Order Program.

A HISTORICAL PERSPECTIVE AND A PROFILE OF THE FEMALE OFFENDER IN ONTARIO

PRISCILLA A. REEVE

SUMMARY

- Because of their small numbers the needs of female offenders in the Canadian correctional system have been largely ignored over the years.
- Female offenders have different needs, rather than equal needs, from male offenders.
- Most crimes committed by women are not violent and far fewer violent offences are committed by women than men.
- Female offenders tend to be low risk/high or medium need.
- A significant number of female offenders are victims of sexual or physical abuse.
- The majority of female offenders have children of dependent age and are sole support mothers.

HISTORICAL PERSPECTIVE

"A look at the treatment and punishment of the female offender in Canada since the earliest days reveals a fascinating mixture of neglect, outright barbarism and well-meaning paternalism. Because of their small numbers and the insignificance attached to their crimes, women offenders have been housed wherever and in whatever manner suited the needs of the larger male offender population." [1]

When the penitentiary for men opened in Kingston in 1835, women were first housed there although no particular location had been planned for them. From the early days there was concern about the manner in which they were treated. Over the next 150 years there were numerous reports and recommendations. In 1990 the Correctional Services of Canada released an enlightened and progressive report, "Creating Choices: Report of the Task Force on Federally Sentenced Women." This recommended the closing of the Federal Penitentiary for Women in Kingston, the development of regional facilities, and a strategy for community release with a greatly enhanced network of community facilities.

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1 Cooper, Shelagh, "The Evolution of the Federal Women's Prison", from "In Conflict with the Law, Women and the Canadian Justice System" edited by Adelberg, Ellen & Currie, Claudia, Press Gang Publishers, Vancouver, 1993.

In Ontario, the closure of the Mercer Reformatory and the opening of the Vanier Centre for Women in Brampton in 1967 was recognized as a significant step forward in providing treatment programs specifically designed for women in an open setting. But through-out the rest of the province small numbers of female offenders are scattered in jails and detention centres. The low numbers of women in conjunction with a predominantly male staff who have been primarily concerned with the problems presented by male inmates has often resulted in their needs either being ignored, or at best addressed as if they were the same as those of the male inmates.

Recently, there have been a number of significant attempts by the Ontario Ministry of Solicitor General and Correctional Services to address these concerns. In 1991, a discussion paper, entitled "Agenda for Change" was produced. In 1994, research by Margaret Shaw, funded by both the Ontario and Federal Correctional Ministries, provided a detailed and current profile of the female offender in Ontario. This was followed in 1995 by "Women's Voices, Women's Choices", a report with comprehensive recommendations to the ministry. This report emphasized that because the majority of female offenders are neither violent nor a threat to the community, alternatives to incarceration for women should be used whenever possible. It recommended that community dispositions must be promoted within all levels the criminal justice system. The report also made many suggestions about the ways in which those women who do require institutional settings should be provided for.

In 1996 there was a Commission of Inquiry by the Honourable Louise Arbour following a riot at the Kingston Penitentiary for Women in which male officers strip searched female inmates. A number of recommendations were made which are relevant to staff working with female offenders in the provincial system in Ontario. In particular, the procedures suggested for male staff to follow when working with female inmates should be considered because a large number of the women have been sexually or physically assaulted by males prior to incarceration.

A PROFILE ON WOMEN IN CONFLICT WITH THE LAW IN ONTARIO

The following information is based on the research report "Ontario Women in Conflict with the Law", initiated by the Research Services of the Ontario Ministry of Correctional Services and conducted by Margaret Shaw, published in 1994.

The sample was 650 women of whom 531 were in the adult sample, 243 in institutions and 288 under community supervision. The age range was 18 to 30 years.

Women are less than 10% of the provincial correctional population.

Women form a very small proportion of the population passing through the criminal justice system in Ontario. Only approximately 8% of those sentenced to custody and 18% of those admitted to probation in a year are women.

Offences are not violent.

The great majority of offences or charges involved property (46%). 15% were charged with drug offences, 14 % minor assaults and the remainder a variety of charges including breaches of court orders, "moral" and public order offences, drinking and traffic violations; 5% were charged with more serious offences of violence, primarily robbery.

Most female offenders are high to medium need and low risk.

Children

Sixty-nine percent of the women had children, a third of who were aged five years or below, and 43% were aged 6-16 years. Thus most of the children were at a dependent age. Eighty per cent of the mothers said that they had been single parents for all or part of their children's lives, and 55% said they had primary responsibility for bringing up their children.

Over half of the mothers had to make alternative care arrangements for those children living with them while they were incarcerated. When asked what was the most difficult problem which they had faced the most frequently mentioned response for the women was separation from their children and concern about the care arrangements.

Contact with their children while in prison was a major source of concern, and the need for more flexible policies is stressed, especially for contact visits.

Family and childhood and experience of abuse

The majority of the women had experienced abuse. Altogether 77% of the sample stated that they had been physically or sexually abused. 72% had experienced physical abuse and 48% had suffered sexual abuse.

Physical abuse was more commonly reported to have been experienced as adults than in childhood. In the great majority of adult cases (90%) the abuse was reported to have occurred at the hands of husbands, common-law partners or boyfriends. Most women rated their abuse as serious.

Sexual abuse was stated to have been common in childhood, and the majority of cases involved a wide range of relatives including fathers, step or foster fathers, uncles, grandfathers and brothers. In the case of sexual abuse as adults, 61% involved acquaintances or strangers rather than close partners.

Physical and Mental Health

Almost half of the women in the community and two thirds of those in institutions mentioned problems with their physical health, including some apparently serious conditions often associated with alcohol and drug use.

Just over a third of the sample had received some form of treatment in the past for mental health conditions, and just over half of those in institutions and over a third in the community felt that they needed mental health care now. Just over a third of both groups of women said they had attempted suicide at some time in their lives, around 30% had slashed themselves, and 20% had at times starved themselves or had episodes of bulimia.

A number of women on medication for mental health problems felt that they would prefer counselling to drugs.

Addictions

Alcohol and drugs have played a significant part in the lives of the most of the women: 79% of those in institutions and 60% of those in the community. Two-thirds of those in institutions and half of those in the community said that alcohol or drugs had been involved in their offending. In addition over a third said that they had been prescribed drugs by a doctor over a long period of time.

Education

Two-thirds did not have a high school diploma and thirty per cent had not reached Grade 10. Only 9% had received post-secondary qualifications, but as many as 82% said that they would like some form of education or work training .

Around two-thirds of the women were not working at the time they committed the offences. Most had been out of work for more than a year. The majority of jobs of those who were employed were in sales or services or unskilled manual work.

Thus the work skills and education levels of the women are low, and their work experience limited. They are poorly equipped to earn a reasonable income from a legitimate job.

Native Women

There are a disproportionately high number of native women in the Ontario

correctional system. Native people represent about 2% of the population but in 1990-91 12% of female admissions were native.[2] The native women were more likely to have been charged with minor assaults (31%) and drinking offences (15%) than the main adult sample, and less likely to be charged with property or drug offences.

The impact of alcohol on the lives of the native women was greater than the main sample. Over three-quarters said that alcohol was involved in their offending and almost half described themselves as heavy users. Few currently used drugs, but 15% had sniffed solvents. Over half had never received any treatment for alcohol abuse, and 44% said they would like help.

Young Offenders

There were 84 young offenders in the sample, 41 under community supervision and 43 in open or closed custody. The majority had been charged with property offences, (41%), 25% for assaults and 14% for breaches of court orders or probation orders. Half had been charged as Phase 1 Young Offenders.

Most (85%) felt they had problems in relation to their family, including violence, alcoholism and separations.

Young offenders, especially those in custody, were more likely to mention specific mental health problems than were the adult sample. Just under half of the sample said they had attempted suicide or had slashed themselves at some stage. There was less evidence of current involvement in alcohol and drugs than among the adult sample, but greater evidence of the mixing of drugs and alcohol, and 20% had injected drugs.

Most important needs

The women felt that the most important things which would help to keep them out of trouble in the future were employment, work training, help with emotional problems, housing, and treatment for substance abuse. Staff assessments were similar to those of the women themselves, although staff placed greater emphasis on the need for help with substance abuse than the women.

The findings of this study have helped to underline the particular needs of women in conflict with the law, and to show how they are different from the needs of the male population. These include their greater vulnerability to physical and mental health problems, their high levels of physical and sexual abuse as children and adults, their related abuse of alcohol, street and prescription drugs, their low levels of educational and work skills, and their status as mothers, often with sole responsibility for their children.

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[2] Ontario Ministry of Correctional Services, Annual Report 1992

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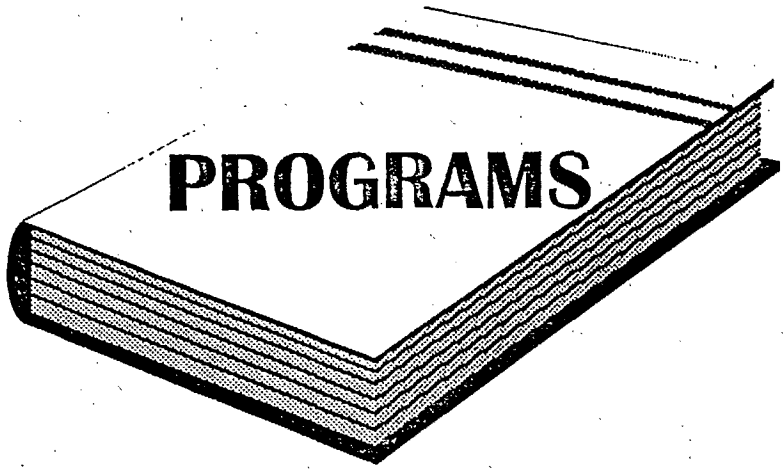
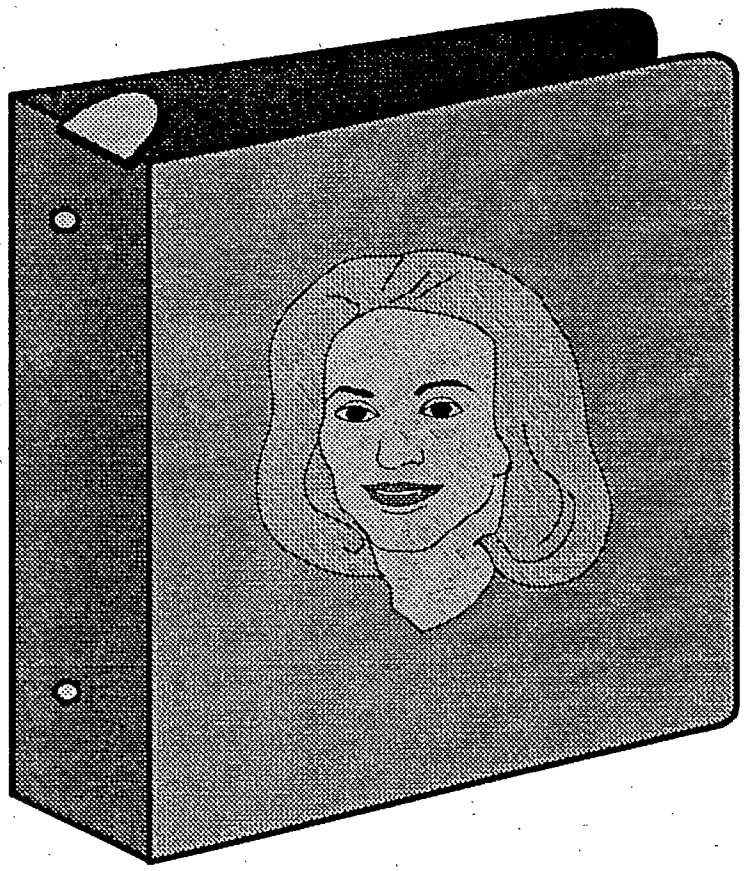


PROGRAM NEEDS FOR WOMEN OFFENDERS
CATHERINE MAUNSELL

ANGER MANAGEMENT PROGRAMS FOR WOMEN
SUSAN COX

ADDICTIONS
NANCI HARRIS & LUCY VAN WYK

INSTITUTIONAL PROGRAM NEEDS FOR WOMEN OFFENDERS



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INSTITUTIONAL PROGRAM NEEDS OF WOMEN OFFENDERS

CATHERINE MAUNSELL

SUMMARY

- Historically we have tried two different approaches when dealing with incarcerated women. Offering them "equal" treatment to that of men meant that their needs were ignored as male needs were uppermost in the minds of administrators. Differential treatment tended to reinforce gender stereotypes and the established division of labour [years ago for example, women incarcerates were trained to be domestic servants]. Programming for women today must acknowledge the differences between men and women, their experiences , as well as the realities of the world beyond the institution.

PHILOSOPHY

It is important to articulate and promote a philosophy which **values women** and recognizes their particular place in the world, gives them new skills for living in a different, non-criminal way, is aware of and sensitive to women's experiences, acknowledges their roles as mothers and, generally, primary care-givers to children . All activities and programming must contribute to women's sense of personal efficacy, help women see themselves as active agents in their own lives, as able to take responsibility and make significant choices for themselves. Given the past histories of many women, they will need help in grieving past losses, seeing themselves as survivors and in being able to move forward. All program initiatives should be tested against the established program philosophy.

PRINCIPLES OF PROGRAM DESIGN FOR INCARCERATED WOMEN

CONTENT

- Programs should be equal but different. Women have unique needs and programming should reflect this while recognizing that equal opportunities should be available for generic services.
- Programs should address issues relevant to the life experiences and the histories of offending of the women.
- Programs should be based on a holistic approach which acknowledges the interrelationship of many problems, such as being a victim of sexual or physical

abuse and using drugs or alcohol as a coping mechanism, leading to addiction problems.
- Programs should include gender specific issues and there should be opportunities for input and evaluation by the women.

DELIVERY

- In recognition of the research findings related to security needs, women should be classified functionally based on security, rather than on status as remand or sentenced offenders. Programming should be available to all women regardless of their disposition, i.e. remand/status.
- Short-term and long-term programming should be available in all facilities to accommodate the needs of women (remanded and sentenced) to stay as close to their own communities as possible.
- Participation in programming should begin upon admission to ensure a comprehensive and realistic plan and also recognizing that most women have comparatively short sentences (average number of day's stay is 64).
- Programming should reflect a belief that women are responsible adults and capable of assuming shared responsibility for their care.
- Programming should be client centred and include women in case management plans.
- Case management plans should reflect continuity of care with post custodial linkages to existing community programs.
- Ongoing interaction with correctional officers and case mangers acting as positive role models is the most effective response to sub-culture activity. Removing women from the general population should be discouraged wherever possible.
- Temporary Absence Passes are an effective community integration tool and should be utilized wherever possible.
- The majority of female offenders are mothers and the importance of offering assistance to keep the family together must be recognized. This includes the opportunity for contact visits with children and family bonding.
- Women with learning difficulties often have emotional barriers to learning. Learning is most effective in an environment where positive reinforcement is emphasized and where there is no fear of reprisal for taking risks and making mistakes. This applies equally to learning in educational programs, treatment programs or work programs.

RESOURCES

- Dedicated staffing is recommended so that the same correctional officers are assigned to work on the female unit, preferably by choice. Special training and orientation is suggested so that staff can demonstrate familiarity with policy and directives relating to female offenders and can articulate their special needs. While acknowledging that some women do not object to the presence of male staff, anecdotal evidence strongly indicates that a majority of them prefer not to

have men in the area while they sleep or attend to toiletry function. If possible at least one female officer should be on the living unity twenty-four hours a day.
- Community expertise should be utilized in the development and delivery of services through community contracts. Use of community contracts will also facilitate an easier transition to and continuation of the community services upon release.
- Peer support should be encouraged and developed.
- Human resources are needed to provide support for computer based learning programs.

PROGRAM MODULES

The following suggestions outline a number of program areas that would be helpful to women in the correctional system.

FAMILY AND PARENTING MODULES

This module recognizes that many incarcerated women are mothers and that this is often the most important aspect of their lives.

- Parent Effectiveness Training
- Childhood Illnesses and First Aid
- Normal Childhood Development
- Educational Play with Children
- Health Issues Related to Age and Stage
- Nutrition and Food Preparation
- Pre-Natal Classes
- Child and Family Visits
- Family Leisure Activities
- Family Reintegration through community placement and TAPs

ADDICTION AND RECOVERY MODULE

This module recognizes that a large proportion of incarcerated women struggle with addictions.

- Motivational Interviewing Approach to "start where the client is"
- Education re Impacts of Drug and Alcohol Abuse
- Relapse Prevention Programs for Substance Abuse
- Resources on Crack-addicted babies and Fetal Alcohol Syndrome
- Peer Support and Recovery Groups [harm reduction approach]
- Community Volunteer Programming [NA, AA, Women for Sobriety]
- Drive While Impaired Program

HEALTH AND FITNESS MODULE

This module acknowledges the need we all have to understand our bodies and how to care for them. Women living on the street have generally been living in a very unhealthy way.

- Education re normal female anatomy and functioning
- Eating Disorders and Healthy Body Image
- Birth Control and Family Planning
- HIV and other Sexually Transmitted Diseases
- Living with a Psychiatric Condition
- Learning and integrating appropriate fitness activities [walking, yoga, stretching, weight-bearing activities for osteoporosis]

(See also the Chapter on Health - Section on preventative health practices and Women's' Health Programs.)

SURVIVING ABUSE MODULE

This module acknowledges the widespread experience of abuse among female offenders and its contribution to other dysfunctional behaviours.

- Childhood Physical and Sexual Abuse
- Understanding Violence Against Women
- Individual Counselling
- Peer Support Groups
- Healthy Relationships
- Grieving and Expressing Feelings
- Life Without Prostitution
- Alternatives to Self-Injury

SKILL TRAINING MODULE

This module recognizes that there is a body of literature which has developed a set of skill training methods to assist offenders in maintaining a crime free life.

- Problem-Solving for a Crime-Free Life
- Fraud Prevention
- Relapse Prevention for Substance Abusers
- Emotional Control / Anger Management
- Assertiveness Training
- Stress Management

EDUCATION MODULE

This module recognizes that poor educational levels contribute to low self-esteem and under-employability.

- Literacy training
- High school completion
- Business skills for the workplace
- Life skills

WORK AND EMPLOYMENT MODULE

This module recognizes that many women have few jobs skills and often no work experience. There must also be an understanding of the changing nature of the work world.

- Vocational assessment and aptitude testing
- Basic job skill training in targeted growth areas
- Relevant job experience [with credits] while incarcerated

DISCHARGE PLANNING MODULE

This module recognizes that a core of women offenders have very complex discharge needs. Often women have several competing needs: for financial assistance, supportive housing, psychiatric care, addiction treatment, assistance in leaving the street life.

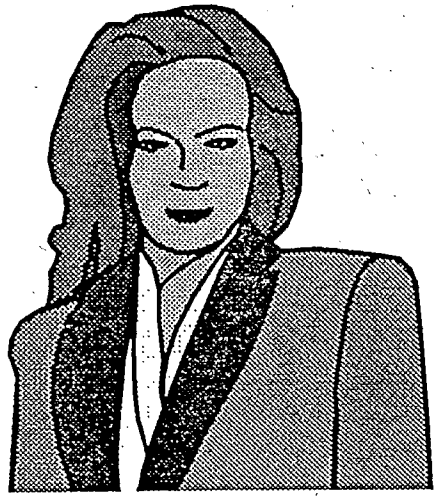
- Early targeting of discharge needs in individual case planning
- Information re community resources
- Support for major lifestyle changes i.e. getting off the street.
- Use of TAPs (Temporary Absence Passes) and CRA (Community Residential Agreement) beds to facilitate gradual reintegration
- Bringing community support groups into the institutions

ETHNIC SPECIFIC SERVICES MODULE

This module recognizes that mainstream core programming may not meet the needs of all incarcerated women.

- Native Daughters and use of Native Healers
- Black Awareness / Women of Colour groups
- Liaison with outside Ethno-Cultural Groups

ANGER MANAGEMENT PROGRAMS FOR WOMEN



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Susan A. Cox has a Masters of Applied Science (Psychology) from the University of Waterloo. Anger Management has been one of her major areas of interest and research for over ten years. She has developed an anger management program for female and male correctional clients, run anger management program for female and male correctional clients, run anger management groups for nine years and delivered workshops on anger management to a variety of audiences. Women's issues, addictions and mental health have also been an important focus for her. For the past 18 years she has worked as a Probation and Parole Officer in Kitchener.

ANGER MANAGEMENT PROGRAMS FOR WOMEN

SUSAN A. COX

SUMMARY

- This chapter gives an outline of ways in which you can look at women and their anger. Practical suggestions for helping women deal with their anger are given as well as suggestions for diffusing angry situations.
- Conflict is inevitable in all situations.
- It is O.K. to feel angry but it may not be O.K. to act the anger out.
- Behaviour when you are angry is learned and you can learn new ways to handle anger.
- Anger management requires people to engage in a process.
- In order for women to change their patterns of behaviour, they need encouragement and positive enforcement.
- The skills women need include self awareness of their anger, problem solving and the ability to communicate effectively.
- As a staff member you have to be aware of your own anger as well as that of others.

As a society at large, we are not comfortable with anger. One recent study looking at the number of studies done on anger compared with depression, found that there were 11 studies on anger and over 300 on depression. Yet anger and the inappropriate expression of anger are major problems for our society. Consequently, as you read this chapter, look not only at the anger expressed by the female offenders with whom you work but also at your own anger and how you view situations when you are angry. Often our response to a situation will effect the outcome, so we have to be aware how we respond.

WHAT IS ANGER?

Anger is an emotion and an important, necessary emotion. We often desire to "get rid" of anger and label it as destructive. Like other emotions, anger has its positives and its negatives. If we love someone too passionately, we can become obsessive and make poor decisions. If we become too angry, we can become aggressive and make poor decisions. The emotion, be it love or anger, is not the problem. Instead it is the ***intensity***, ***frequency*** and ***duration*** of the emotion as well as how we choose to express the emotion that is the problem. Hence, in managing anger, we want to experience our anger and use the

positive things about it but to keep control of our behaviour so we do not become self-destructive.

Anger -- a negative emotional state associated with specific cognitive and perceptual distortions, subjective labeling, physiological changes and action.

Aggression -- physical or verbal behaviour that does or could bring harm to another person or object.

Hostility -- appraisal and cognitive process whereby the person holds attitudes that other's actions are harmful and unjustified attacks.

MYTHS ABOUT WOMEN'S ANGER

1) *Women have difficulty acknowledging and expressing their anger.*

Fact: Tavris (1982) contends that women may feel anger differently than men but "neither sex has the advantage in being able to identify anger when they feel it or in releasing it once it is felt" (p. 185) Other researchers have noted that difference between men and women's response to anger has not been adequately studied. (Sharkin, 1993; Kopper and Epperson, 1991)

2) *Women use passive-aggressive forms of expressing anger.*

Fact: Aggression in women is generally narrowly defined in terms of physical aggression. Women's aggression needs to be considered in terms of cultural and societal expectations and not focus on sexual stereotypes.

3) *Premenstrual syndrome is the cause of women's angry outbursts*

Fact: There are no conclusive studies that show that criminal aggressive behaviour is linked to hormonal fluctuations. (Harry and Balcer, 1987).

FUNCTIONS OF ANGER

We can view anger as having both positive and negative functions in our lives. The following list is a few of the ways anger can be both positive and negative. Note that if anger is too *frequent , too intense or lasts too long* then our anger can turn from being a positive emotion for us to a negative one. The key is to prevent the negative aspects of anger and enjoy the positive ones.

FUNCTIONS OF ANGER

POSITIVES	NEGATIVES
-motivator to change	-can create health problems
-energizer	-hurt self and others
-helps you set limits	-thinking unclear
-cue to know something is wrong	-fuels violence
-defense of your territory	-stops communication
-influences others' behaviour	-harms relationships

WHY TREAT ANGER?

The cost of anger can be experienced by the woman herself, her family, her children and others in the community. For the woman, the style in which she expresses anger can have a major impact on various parts of her life. Health can be affected when anger is expressed too frequently or not frequently enough, for example, high blood pressure, heart conditions; more prone to cancer, ulcers, etc. Women who do not acknowledge their anger may also experience more frequent stomach ailments, asthma, arthritis, insomnia, back pain, obesity and psychosomatic complaints. Often, the more anger a woman experiences, the more likely she is to neglect her self care. Family violence also reflects the costs of dealing with anger in inappropriate ways. Various studies show that adults who were abused as children tend to continue the pattern with their own children. As well as physical and emotional costs there are also high financial costs involved. For example, consider the cost of police, court and custody as well as child protection needs should they result. Learning to handle anger more effectively is both necessary and cost efficient.

CHARACTERISTICS OF AGGRESSIVE PEOPLE

The following are some of the characteristics to look for when working with aggressive women. Remember that some women don't have the tools necessary to handle situations effectively. This can make a difference in how you approach them, and may help you to discuss their difficulties in a new way and help them plan how they can change.

- Deficits in social problem solving - the inability to adequately resolve problems when dealing with other people.
- Hostility bias or negative filter - usually as a result of past experiences, some women expect bad things to happen and approach situations in this way.
- Expectation of fewer negative consequences - if she grew up in a home where there was a lot of physical abuse, then she also may have learned that nothing bad happened to the one who was doing the abusing. Consequently, she learned to expect fewer negative consequences from her actions.

- Failure to learn from past experience - if the woman has only one or two ways to cope with a situation, then her repeated problems may be seen as failure to learn when the reality may be that she lacks the necessary skills.
- Tendency to justify her aggressive behaviour .
- Lacks empathy and does not have the ability to understand how the other person might be feeling or why they might be acting in this manner.
- Sees other's actions as deliberately provocative - due to lack of empathy and poor social problem solving skills, the woman may interpret other's actions as deliberately trying to hurt her and make her angry.

ADDRESSING THE PROBLEM

When anger is expressed too frequently, with too much intensity or for too long a time, then anger can become harmful. Many people tend to avoid dealing with conflict until they have no other choice. The process of getting angry is like filling up your "garbage bag". As we go through a day, a week, a month, we may not always recognize or try to deal with our anger. We may try to avoid dealing it by telling ourselves that the situation "isn't important" or that we can "just forget it". After awhile, the tension starts to build and we look for ways to relieve the tension, often by "dumping our garbage bag" and acting aggressively. After we have "dumped the bag", we often initially feel really good but then can feel guilt, remorse, anxiety etc. because of the consequences of our actions. At this point, we pick up the "dumped garbage" and stuff it back into the bag. If someone has a lot of past "garbage" in their bags, for example from unresolved abuse issues, then there is less room to deal with the day to day angers.

In order to break this cycle and deal more effectively with anger, the women you are working with need develop **self awareness** of their anger and how they fill their "garbage bags" (triggers). Maybe ask the woman to keep a journal and note when she gets angry and under what situations. This is a helpful way of identifying the patterns. When she has a good idea about what she is doing and what situations lead to anger, then she can begin to **problem solve** about how she might be able to handle those situations differently. Once an approach to the problem has been selected, then using **effective communication** skills and following through is necessary to achieve the best possible outcome.

DIFFUSING ANGER

When dealing with angry women, it is important to ask yourself the following questions:

1. **What stage of crisis am I dealing with?** If the situation is in an early, pre-crisis situation, then talking techniques will work well. If the situation is at the "rage stage", then you may need help.
2. **How threatened am I feeling?** The more threatened you feel, the more unlikely you are to be able to diffuse the situation. Determine if the anger is directed at you specifically ; at your role; or at the situation in general. The more personal the anger, the more in danger you may be in and the greater the need to get help to deal with the situation.
3. **How predictable is the person?** If the woman is in a psychotic, delusional or drug induced state, she is more likely to be very unpredictable and hence more dangerous than if she is angry.
4. **Has the angry behaviour been escalating?** If you know the person, you will have some idea of their limits of control. The longer the woman stays angry, the more likely that she will have a major blow up.

PRODUCTIVE THINGS YOU CAN DO TO DIFFUSE ANGER

- Be assertive, but not aggressive. Use "I" statements to let the woman know that she is at the limits of acceptable behaviour.
- Give behavioural feedback. Telling the woman her voice is getting louder and that she is moving in on you, is an example of behavioural feedback.
- Try to make the situation safe for you and the woman. Keep at a distance (out of their personal space); don't move in on her; use your voice in a calm controlled way; try not to interrupt. You want to model that you are in control and she can be in control too.
- Acknowledge that she is angry but don't try to offer solutions too quickly. Ask instead, what she would like to happen to help the situation. Be clear about your limits and don't make offers on which you can't follow through .
- Provide opportunities to deal with the physical arousal. Things like taking a walk, jogging on the spot, breathing exercises. Avoid activities like hitting pillows, which are aggressive.
- If appropriate, point out that what she is angry about may not have been a situation that was deliberate (i.e. address the hostility bias).

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ADDICTIONS

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ADDICTIONS

NANCI HARRIS AND LUCY VAN WYK

SUMMARY

The following chapter seeks to address the issues that face a woman with substance use/abuse problems. Wherever possible links have been made to the needs of incarcerated substance users and relevant information supplied to assist staff in making appropriate referrals and having the correct information to pass on.

Topics include:

- An overview of relevant terminology.
- Women's Socialization and Substance Use (because it is in this context we feel it is necessary to address the issue).
- Profile of the Woman Substance User incorporating what information is available on Federally Sentenced Women.
- Profile of the Pregnant Substance User.
- Discussion about Methadone and Pregnancy.
- Physical Effects of Drugs and Alcohol.
- Over the Counter and Prescription Drugs.
- Withdrawal Symptoms.
- What Programming Options are Available (including an overview of a very helpful way to view the way people change their behaviour).
- Counseling Issues.
- Gambling.
- Connection to Self Help and Peer Support.

Please keep in mind that issues looking at women in relationships, incidence of abuse, eating disorders and parenting issues have been incorporated into the Profile of the Woman Substance User in order to present the most comprehensive picture.

It is hoped that once reading this chapter a worker would have a good overview of what are the relevant issues impacting a woman substance user and what resources are available to provide her with the support she needs. As well, it is important to recognize the window of opportunity that incarceration may present and the resources to be able to facilitate change. Footnotes and a brief bibliography follow the chapter.

TERMINOLOGY

DRUG EFFECTS: People's bodies are affected in different ways by drugs and alcohol. Stimulants (e.g. amphetamines) speed up the body, depressants (e.g. alcohol/ benzodiazepines) slow down the body, and hallucinogens (e.g. marijuana) alter the way people experience things. The effects depend on the amount taken at one time, the user's past drug experience, the manner in which the drug is taken and the circumstances under which the drug is taken such as the place, the user's psychological and emotional stability, the presence of other people, or the simultaneous use of other drugs.

PHYSICAL DEPENDENCE: The body's adaptation over time to the presence of a drug. If the drug is suddenly not present withdrawal symptoms occur.

TOLERANCE: The phenomena in which larger amounts of a drug are required to obtain the same effects.

PSYCHOLOGICAL DEPENDENCE: The feeling of satisfaction which accompanies regular use of a drug which drives a person to seek the drug to maintain this effect in order to avoid discomfort. The drive to seek the drug may consume all of a person's energies, thoughts and emotions. It often appears compulsive or obsessive.

WOMEN'S SOCIALIZATION AND SUBSTANCE USE

The ways in which a female child is socialized shapes her understanding of herself, her roles and expectations of what she can accomplish. We recognize that in our culture women do not have access to power and control in the same ways men do in both the public and private spheres. Their earning power continues to be substantially less than men and their nurturing roles are not valued while simultaneously being expected. Women's use of alcohol and or drugs is also perceived very differently than that of men. Drinking and intoxication in young males is often seen as a rite of passage and symbolic of masculine behaviour; but for women it is seen as unattractive, delinquent or overtly promiscuous behaviour. Society's double standard often leads to low self esteem and confusion. Discrimination remains a constant in women's lives. The majority of women who work outside their home face a "second shift" when they arrive home. Lesbians and bisexuals contend with homophobia and judgmental societal attitudes. It is well recognized that these societal pressures may contribute to their use of alcohol and drugs as coping strategies.

PROFILE OF A WOMAN SUBSTANCE USER

Women's use of alcohol and drugs in general has been lower than that of men. The area in which women consume more than men is prescribed medications, where they are still prescribed at twice the rate of men. Women with fewer social and work roles are more likely to develop drinking related problems. There is a high correlation between the abuse of alcohol and depression, stress and other mental health problems. Many women who use alcohol and drugs come from families in which one or both parents have a substance use problem. Their homes are chaotic with little positive parental attention and inconsistent parenting. Often the young girl takes on a parental role to compensate and becomes the care taker for the alcoholic parent. Abusive childhoods are extremely common, approximately 80% of the women who present at treatment centres have a history of childhood abuse including sexual, physical and or emotional abuse. These patterns of abuse often continue into their adult lives. There is a high incidence of concurrent compulsive behaviours including negative body image and disturbed patterns of eating which at times become severe eating disorders such as anorexia or bulimia. Alcohol and drugs are often used to cope with the effects of abuse, neglect, stress and to deal with intense feelings of shame. In addition the majority of women with substance use problems have partners who abuse drugs and alcohol and have often been introduced to drugs by their partners. Although the relationships with parents and partners are often not supportive and at times destructive, most women maintain close connections which is a reflection of women's tendency to value relationships and define themselves through their relationships.

Women who have abused drugs and or alcohol are usually unable to adequately care for their children. As a result their children are at high risk for developmental, behavioural and psychological problems, as well as a great risk for emotional and physical abuse and or neglect. At present there are no residential treatment programs which have facilities to treat a woman and her children concurrently.

There is convincing anecdotal evidence that many women involved in the criminal justice system have abused drugs and alcohol. The document "Substance Abuse Treatment Needs of Federally Sentenced Women, Technical Report #2" (July 1992) reports that among incarcerated women the average age at which they began drinking was 17. They reported 72% had low levels of alcohol dependence, 15% moderate and 5% severe levels. Minor tranquilizers were the most common class of drugs used (38%), narcotic analgesics (35%), cocaine (31%), and cannabis (24%). Less than 15% reported a history free of any form of abuse. Given the prevalence of substance abuse it is imperative that these issues are addressed and that treatment services are made available. (Information for this paragraph contributed by Rebecca DeGuara, Case Management Officer, Corrections Service Canada)

PROFILE OF PREGNANT SUBSTANCE USER

Heavy drinking or drug use while pregnant can harm a woman's body as well as the developing fetus. There is a greater risk for miscarriage, stillbirth, spontaneous abortion, premature labour, and intellectual disability. Her child may also experience painful withdrawal symptoms. Pregnant users experience tremendous shame and guilt and are highly sensitive to being judged. Pregnancy is often the one time a woman may be more willing to examine her substance used because of her concern about the health risks for her child. It is critical that pregnant women be offered careful medical attention throughout her pregnancy. Women concerned about possible risks to the fetus can consult the **MOTHERISK CLINIC** at the Hospital for Sick Children. Phone consultation is available at 416-813-6780.

METHADONE AND PREGNANCY: The usual recommendation for pregnant opiate users is methadone which minimizes the health risks to the fetus. Methadone which is a synthetic opiate and does not make the user high, stabilizes the woman because it reduces cravings and risk behaviours associated with drug seeking behaviour. It may also create a window of opportunity to address her drug abuse. Pregnant opiate users are fast tracked to receive methadone which should apply regardless of incarceration. Information about methadone, its effects, and advantages over continued heroin use must be made available so that a woman may make an informed decision. Corrections Health Staff are able to facilitate referrals.

THE EFFECTS OF ALCOHOL AND DRUGS ON WOMEN'S BODIES

Initially our knowledge about the effects of alcohol and drugs was based on research on men and it was assumed to be the same for women. More recently, research has identified that although there are many similarities to the effects on men, there are also significant differences related to body composition especially the fat/water ratio, metabolism, hormones, monthly cycles and lifetime stages of the body's development. As women age, the effects of alcohol and drugs become more pronounced.

Women become more intoxicated than men on the same amount of alcohol even when they have comparable body weights. Women metabolize alcohol more slowly than men which means it takes longer to leave their bodies. Health related complications from alcoholism develop at an accelerated rate in women, a phenomenon termed "telescoped development". Serious health problems occur more quickly in women after a shorter history of heavy drinking even if their alcohol intake is lower. Women's bodies react differently to alcohol at different phases of their menstrual cycle with the greatest susceptibility to alcohol's influence just before

menstruation. Women who abuse substances are at increased risks for cirrhosis, ulcers, nerve damage, cancer of the lip, tongue, pharynx and esophagus.

OVER THE COUNTER AND PRESCRIPTION DRUGS: Women use prescribed and over the counter medications to treat anxiety, depression, sleep problems and pain twice as frequently as men. Physicians continue to prescribe tranquilizers far more frequently to women. Their problems are perceived to be related to their emotions and the seriousness of their problems minimized. The tendency is to prescribe tranquilizers such as benzodiazepines (e.g. valium, ativan, rivotril) and antidepressants (e.g. prozac, luvox, elavil) without an exploration or understanding of the underlying issues. Many of these tranquilizers are highly addictive and often physicians fail to inquire about a woman's use of alcohol or drugs when prescribing these. Often women use these medications concurrently with alcohol. Recent research suggests that prolonged use may not be effective for some of these medications. Monitoring and reassessment are essential. **OVER THE COUNTER MEDICATIONS:** Frequently these are perceived to be benign because they are so easily available. However, many are addictive for example: gravol, sleep medications, Tylenol #1 which contains 7.5 mg. of codeine per tablet.

WITHDRAWAL SYMPTOMS

Symptoms such as tremors, shakes, D.T.'s, nausea occur when a person who is dependent stops using alcohol or drugs. These may vary from mild to severe or possibly life threatening. Withdrawal from long term tranquilizer and codeine use is usually prolonged. Drugs such as tranquilizers, cannabis, and opiates which are metabolized in the body's fat cells may therefore take several months to be completely eliminated from the body. Women often describe feeling they are "going crazy", have extreme mood swings, difficulty sleeping, anxiety and distorted perceptions such as walls and floors moving. Always consult with a doctor before recommending stopping their use because abrupt discontinuation can be extremely dangerous.

PROGRAMMING OPTIONS/STAGES OF CHANGE

A range of options is available for women seeking treatment for substance abuse including day, residential, and out patient in both co-ed and women only settings. Many programs are funded by the Ministry of Health and are available as part of a woman's provincial health insurance coverage. The Drug Abuse Registry of Treatment **(DART 800-565-8603)** maintains current information about space availability in Ontario treatment programs and information about the types of services available. All treatment programs require an assessment. Metro Addiction Assessment and Referral Service **(MAARS 416-481-1446)** accepts collect calls and will conduct phone assessments. They will recommend a treatment program which best matches a women's needs.

Most treatment Centres incorporate the Stages of Change model into their program. Central to this model is the concept that change, not only recovery from addictions, occurs through a series of stages. These are: **Precontemplation:** there is no intention to change in the next 6 months; **Contemplation:** seriously considering changing the behaviour in the next 6 months; **Preparation:** intending to change in the next month and has taken unsuccessful action in the last year or has made small changes; **Action:** successfully altered behaviour ranging from one day to 6 months; **Maintenance:** remaining free of the behaviour for more than 6 months; and **Termination:** completed the cycle of change and experiencing no temptations and are 100% confident in high risk situations. Many people do not reach termination but remain lifelong in maintenance. Treatment strategies are designed to match a person's stage of change.

COUNSELING ISSUES

Effective treatment for women is sensitive to their specific needs and takes a holistic approach to recovery. Elements of such a program include: education about substance abuse and its effects on their bodies, dealing with their relationships, development of coping skills, offer skill development in areas such as assertiveness, coping with stress and dealing with anger, encourage the development of self esteem, assist women improve their relationships; learn to recognize high risk situations and acquire relapse prevention strategies to cope with triggers to use alcohol and drugs. These triggers may include emotionally charged situations, stress, or exposure to drug using situations. Each woman should learn to identify situations specific to herself and develop strategies to cope with them in future. It also critical that a treatment program place a strong emphasis on physical and emotional safety especially because so many women are dealing with unresolved issues related to abuse and a lack of safety in their lives.

CONNECTION TO SELF HELP AND PEER SUPPORT

Many people have found self help groups to be an invaluable resource to assist with their recovery from drugs and alcohol. The most familiar of these peer based groups is **Alcoholics Anonymous** which has groups world wide. Variations on these groups are **Narcotics Anonymous, and Cocaine Anonymous.** An alternative for women not comfortable with the AA philosophy is **Women For Sobriety**, however; groups are not available in all communities. Information about meeting locations and times can be obtained. For A.A. meetings call 416-487-5591, C.A. meetings call 416-927-7858 and for N.A. meetings call 416-691-1462.

GAMBLING

(This paragraph contributed by Nina Littman-Sharp, M.S.W., of the Donwood Problem Gambling Program, Toronto)

Gambling can be a devastating addiction, often going unrecognized because unlike drug or alcohol abuse it is easily hidden. Gambling problems are relatively common among female inmates. In one study of medium-security prisons, 28% of the females were problem gamblers, 12% of the women stated that they were in prison entirely or partially because of their gambling. There are also many opportunities to gamble in prison. Generally, gamblers use legal means to obtain money for gambling, but once these means are exhausted, some individuals many turn to activities such as cheque forgery, embezzlement, or prostitution. Women may engage in these activities out of desperation to continue gambling and/or to pay debts. Statistically, women tend to start gambling at a later age than men, and to have more rapid progression into problem gambling. Female problem gamblers may be more likely than males to be from troubled and/or addicted families, to have been abused, to have attempted suicide, to have partners with serious problems, or to be divorced or separated. Gambling often serves as an escape from stress, and a way of distancing from painful emotions. Spending hours sitting at a slot machine, for instance, is frequently referred to as "an anesthetic". Women are often poorly served by Gamblers Anonymous and other group programs, because of the very high proportion of male clients. Counseling either on an individual basis or in a women-only group format is preferable. It is important for service providers, particularly in corrections, to screen for gambling concerns; if assessments do not include specific questions about gambling behaviour, the problem is easily missed.

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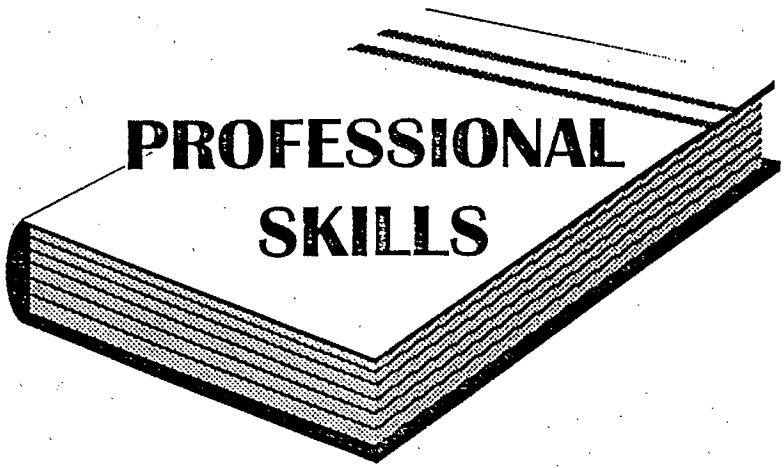

EFFECTIVE SUPERVION SKILLS FOR STAFF IN RESIDENTIAL SETTINGS
JOAN WINCHELL

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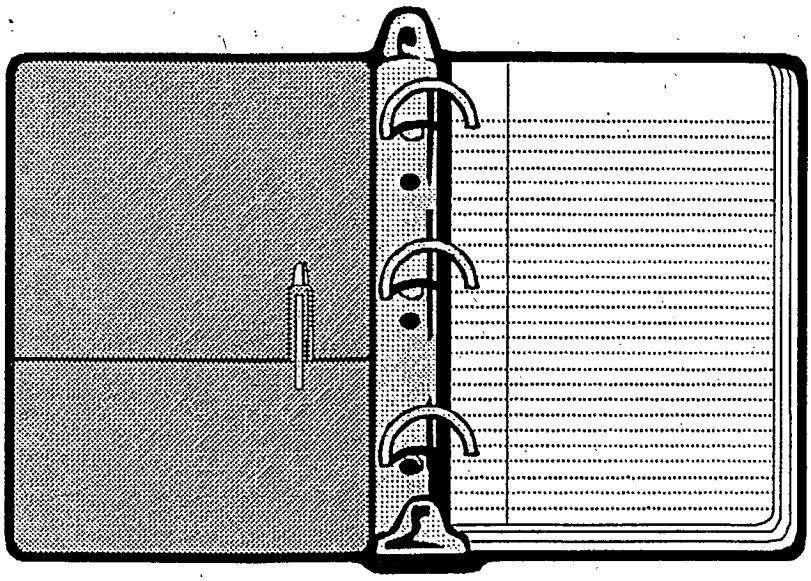
TERRY MENAGH & SASHA PEDERSEN

EFFECTIVE SUPERVISION SKILLS FOR STAFF IN RESIDENTIAL SETTINGS



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EFFECTIVE SUPERVISION SKILLS FOR STAFF IN RESIDENTIAL SETTINGS

JOAN WINCHELL

SUMMARY

This chapter discusses how to create a supportive environment where the principle of respect, dignity, individualizelfation, consistency and fairness are observed, and a non-judgmental and non-threatening environment is established.

KNOW YOURSELF

1. It is important to remember that your responsibilities will not always gain you favour with the offenders. Sometimes it is your job to say "no", which is never a popular answer. However, it is more important for you to be respected by the inmates than liked by the inmates. In order to achieve that, you must be consistent. If being liked is a priority for you, it is important to question the appropriateness of this, given your work situation. You are the person with power and authority, you can come and go. Naturally the inmates may automatically dislike you for that alone. So work towards being respected not liked, by being fair and consistent. If the inmates can depend on you to display those two qualities they will respect, trust and accept you, which is the best possible fulfilment of your job.

PERSONAL BOUNDARIES

2. As previously stated, consistency is extremely important and clear adherence to one's personal boundaries is a vital component. Many boundaries are of course dictated by the institution. Most will have rules such as not sharing your phone number and home address, however, there are areas that are grey and require an analysis of consequences and exploration of personal motives. Often we feel that the only way to show empathy is to share personal information "Yes I do know how you feel, I'm a recovering addict myself". Is this the only way to show empathy? Although we may believe that sharing this type of personal information has a normalizing effect, does it truly benefit the offender to know this? Normalization will occur in groups and programmes between the offenders. Your personal information will create a false sense of intimacy and may lead the offender to expect special treatment. Additionally, you would probably share this type of information

with only a few, creating a perception of favouritism. This will eventually become divisive creating conflict, tension and stress between the offenders, your co-workers and staff and offenders.

3. You are interacting with an offender, not an offence. Crimes are committed by people and it is the people who are in your charge. Many will already feel de-individualized because of their life experiences and the regimented structure of prison. Many of the women you work with will already feel tremendous guilt for their crimes. They see themselves as "bad", as worthless and they come to expect poor treatment. In order for them to move on they must internalize the belief that they do have value. By treating them as a person, a person who has value and deserves respect, you are assisting them in their healing process. It is crucial that the women see themselves as individuals and not hookers, shoplifters, addicts etc. If you see them as individuals, they will begin to see themselves as individuals.

4. If you are following the principles stated in #1 - 3, then you have already begun to demonstrate respect for the offender. Consistency, fairness, equal treatment and recognition of individuality all demonstrate respect. You may have to show respect for the women even in moments when they do not show respect for themselves. In a system that is dedicated to "correction" not just punishment we recognize the need to alter behaviours. Often if the internal values change then the behaviours will follow. If you treat a woman with dignity and respect she will begin to believe that she is worthy of these things. She will begin to see herself differently and therefore behave differently. As she is better able to receive respect, she will be better able to show respect. This will create a much more satisfying work environment for you.

5. To create a supportive environment, you must first determine what are the necessary factors. Perhaps the most profound factor is the relationships between the staff and the offenders. If the environment is not good for one it will not be good for the other. If frustrated and dissatisfied each group will likely direct their anger at the other. Each of the points discussed in this section will contribute towards creating a supportive environment when the principles of respect, dignity, individualization, consistency and fairness are observed, and a non-judgmental and non-threatening environment is established. This, in addition to making one's professional life more pleasant, allows an atmosphere of growth to accelerate rehabilitation.

6. "Asking permission" is an excellent example of demonstrating respect. For example, although staff have the authority to enter a woman's cell without her permission, that simple act of asking will do much in creating an attitude of trust. Whenever possible recognize and exercise the individuals' right to choice. This technique assists the offender in experiencing some (though minimal) sense of control. This is significant, as a sense of control will offset

some of the offenders' frustration and create a calmer environment.

RESPONSIBILITY FOR DECISIONS

7. This applies to both the correctional officer and the offender. One of the major difficulties in power imbalance in relationships is the tendency for either party to abdicate the responsibility for the making of or the consequences of having made the decisions. When prisoners are not allowed any meaningful input to decision making they have a tendency to become infantalized or child like. This regressive behaviour will impede the formation of honest, open relationships. Positive relationships will result in greater job satisfaction for the correctional officer as well as a more positive atmosphere for conflict resolution.

CREDIBILITY

8. It is never easy to honestly confront or oppose actions or attitudes which are contrary to the expectations of the groups or individuals we interact with in the course of our careers. Honest, frank and direct answers, explanations and interactions build open relationships. Trustworthiness facilitates interaction within our peer groups, as well as within our career roles. Honestly really is the best policy, although not always the easiest.

ACCEPTING EMOTION

9. Emotions, especially those which appear to threaten your safety or control are always difficult to deal with. It is important that you are aware of your personal responses to fear, and loss of control in certain situations and are aware of your response mechanisms when feeling threatened. Emotions are healthy and are a safety valve for destructive anger and fears. The possibility of violence is greatly reduced when emotions can be expressed openly, in a safe environment. It is also important to remember that a large percentage of the women you are dealing with have no other skill for dealing with the repercussions of abuse, addictions, abandonment, loneliness and fear. The creation of an environment which is accepting and safe with mutually agreeable boundaries will greatly enhance your successful interaction with women inmates.

RESPECTING SPACE

10. Each of us has a comfort zone known as "our space". One of the quickest ways to escalate any situation within the prison environment is to crowd or invade an inmates space. Whether it be a correctional officer or another inmate the simple act of asking permission or informing the inmate can alleviate or at least smooth interactions within any environment. "Space" may include personal belongings, phone calls, written materials or the area an individual occupies. Again, simple dialogue and common courtesy go a long way towards smoothing out difficult situations as well as facilitating interaction between your peer group, the inmates and between the inmates and correctional officers.

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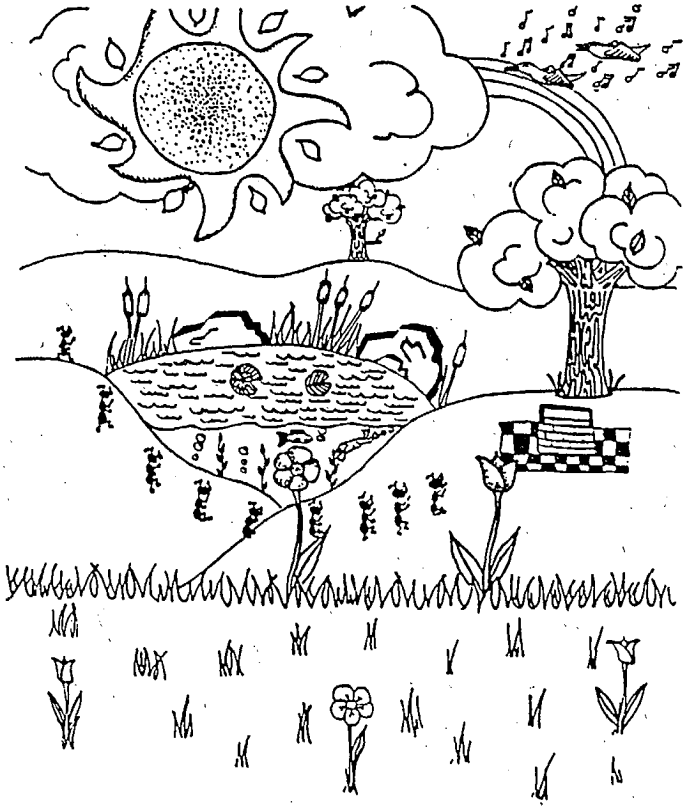
COPING WITH WORK RELATED STRESS



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THE CHALLENGE OF SURVIVING THE CORRECTIONAL SYSTEM COPING WITH WORK RELATED STRESS

TERRY MENAGH AND SASHA PEDERSEN

SUMMARY

- Working with clients who are survivors of abuse, self-injurious and exhibit threatening behavior can be stressful.
- Information is given on how to identify if stress is effecting you and on ways to cope.

Corrections - be it within an institution or community setting - presents one of the most challenging yet stressful work environments. Correctional clients bring workers into contact with a variety of life situations encompassing every aspect of life. Workers are privy to a host of human tragedies, sufferings, and behavioral problems. Our clients are not only identifiable by their personal problems but by the crimes they commit. As workers' understanding of the relationship between criminal behavior and experiences of physical/sexual abuse increase there is the additional recognition that clients may also be victims as well as perpetrators of criminal activity.

The variety of daily client problems and issues and the fact workers are not able to chose who their clients will be, can be a source of stress. Workers are required to balance the necessity of their authoritative position with feelings of compassion and caring for their clients. Inherent in this work is a degree of uncertainty and worry about clients especially if they engage in self-injurious behaviors, are suicidal, or exhibit threatening behaviors. The challenges presented, demands the worker be flexible and adaptable. For example, a worker may respond differently to abuse survivors with whom they can empathize than to perpetrators for whom they may feel contempt. Both clients however, have a right to be afforded respect and dignity and to expect the worker to respond objectively. Workers who are survivors themselves may experience other difficulties if contact with victims or perpetrators triggers childhood memories or uncovers unresolved feelings. This situation may also be true for other parallels of life experiences. Increasing caseloads and the harried pace of some work environments can add to existing stresses and concerns of workers. There are times when paper work and adherence to policy mandates and procedures can frustrate the worker/client relationship. Recidivism and the perceived failures with clients is another issue which can heighten workers' frustration and erode professional confidence. In addition to these stress factors there are external pressures which can elevate

stress levels. For example, fiscal restraints, limited and depleting resources for clients, restructuring, job security, political and public criticism can distract workers and influence their work performance.

Regardless of how professional or knowledgeable workers are, the multiple levels of stress can evoke strong, emotional reactions. The problem is not so much a matter of there being an emotional response but rather what action or non-action is taken as a result of the emotional response, and awareness of how specific reactions can effect work performance and professionalism. Inappropriate responses to client demands, or to colleagues can have irreversible consequences. In order to perform professionally workers must find ways to cope with the stress caused by their work.

Although there are many variations and styles of dealing with stress, workers who find it difficult to cope typically react in one of two ways. They become emotionally distant and indifferent or they become emotionally involved and try to 'fix' their clients problems or become engrossed in ongoing issues in the workplace. Both responses are unhealthy as they produce even greater degrees of frustration, stress, job dissatisfaction and even a sense of incompetence or failure.

Workers who become emotionally distant and indifferent may deny that they are experiencing any problems or personal stress. They learn to shut down their feelings at work and ignore any suggestion of impending problems. They may protect themselves by becoming apathetic and unconcerned about their clients' needs and tend to rely on authoritative strategies and approaches in their interactions with clients. This emotional 'shut down' can result in physical symptoms that may not seem to be related to workplace stress. Relationships with clients may be strained as the worker may begin to minimize the clients experiences and seem to be uncaring.

Workers who become emotionally involved with their clients may begin to spend more time working with or worrying about their clients. They may relate their personal experiences with those of their clients and begin to feel intense emotions such as frustration, helplessness or grief. They may cope by trying harder to help their client, which creates more stress for the worker and leaves the client feeling more helpless and needy. Client and worker boundaries may become blurred and the professional distance and objectivity lost. The result is that the worker begins to worry and feel unable to help, overwhelmed, and unable of doing her/his job. Left unchecked, the scenario described can lead to 'burn out'.

Since uncovering personal factors and coping mechanisms can be a difficult task and lengthy process, some strategies and techniques have been provided to assist in your personal discovery. As stated earlier, the suggestions which follow are only a sampling of how to address this issue, and you are encouraged to openly discuss this topic with colleagues and to share your unique way of coping.

STEP 1: PAY ATTENTION TO YOUR BEHAVIOR AND HOW YOU ARE FEELING AT WORK

You can ask yourself some of the following questions. They may help to identify if stress is effecting you.

- Is it hard to get up out of bed to attend work?
- Do you eat or smoke more?
- Do you feel tired or frustrated more often?
- Do you question your ability to do your job effectively?
- Do you spend more or less time at work or with certain people?

Any change in your behavior or how you feel may be an indication you are reacting to work related stress. You may want to monitor yourself and see if you feel differently on work days than you do when you have time off, or if you have some days or situations at work that are more difficult than others.

STEP 2: ONCE YOU ARE AWARE OF STRESS SYMPTOMS - WHAT'S NEXT?

It is difficult to combat stress if you do not understand what is causing your reaction. If you are noticing any changes in your behavior or how you are feeling at work try the suggested strategies to help you uncover some of the major issues and concerns.

- Look back at the kinds of clients and issues you have been dealing with.
- Which are the ones that are the most difficult for you to deal with.
- Which clients or situations do you react to most strongly.
- How do you react to difficult situations or clients.
    a) Become more worried and involved.

    or

    b) Indifferent or apathetic.
- Do any of the clients issues or behaviors remind you of what you have experienced in your life or trigger unresolved thoughts or feelings.

STEP 3: FINDING WAYS TO COPE

If you recognize that your work is affecting you, it is important to find ways to cope. There is no one way to cope with workplace stress. You may have to experiment until you find what works for you. The following are suggestions that some people have found helpful.

- Be clear about what your role is in relation to your clients.
- Establish clear goals with your clients and remember you are there to support and that you cannot 'fix' your clients problems.
- Set clear boundaries with your clients.
- If you are dealing with a particularly difficult client seek help from a supervisor or your peers and ask them how they cope with issues.
- Educate yourself.

STEP 4: LEARN TO TAKE CARE OF YOURSELF

Acknowledging the effects of ones personal issues is about caring for oneself. By identifying personal issues one not only opens her/himself to the possibility of change but helps to clarify our needs and limitations. Learning to care for oneself is an art rarely encouraged.

- Leave work issues at work. If this is difficult for you try using imagery. *"Imagine that as you lock your files or sign out for the day, that you are locking away or signing away all of the days problems."*
- Pamper yourself. Have a hot shower or soak in the bath tub, go for a walk, play peaceful music, read, play sports or board games.
- If you are thinking about work change your thinking or distract yourself.
- Make time for yourself.
- RELAX, PLAY, and do THINGS YOU ENJOY.

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HEALTH ISSUES

- *HEALTH CARE RELATED ISSUES FOR THE FEMALE OFFENDER*
  WENDY MALESH

- *MENTAL ILLNESS IN THE FEMALE OFFENDER*
  LAUREL PUTNAM

- *SELF-INJURY*
  PAM SKINNER

- *EATING DISORDERS AND THE FEMALE OFFENDER*
  MERYL BEAR

HEALTH CARE RELATED ISSUES FOR THE FEMALE OFFENDER

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In addition to performing these roles, Wendy writes most of the health care/clinical services policies for the Ministry. She has participated on many Ministry committees related to health care services and has become well-known as a nursing resource for the Ministry.

In her personal time, Wendy is an oil painter, and has had several shows in her home community.

HEALTH CARE RELATED ISSUES FOR THE FEMALE OFFENDER

WENDY MALESH

SUMMARY

This section will cover:

- A brief historical perspective of women's health issues and medication use.
- Preventative health programming recommendations specific to female inmates.
- Information relating to confidentiality issues.
- Guidelines regarding female specific health care items and medications.
- An overview of cultural health issues and how they may affect health related interactions.
- Discussion of the Aboriginal female inmate and her options related to Aboriginal traditional medicines and caregivers.
- Information on female genital mutilation and its impact on the health of women affected.
- Pregnancy and special considerations for the pregnant inmate.
- Pre-natal and post-natal care and the need for counseling and special care.
- Post-partum care and recommendations for facilitating mother/child bonding.
- Termination of pregnancy and related considerations.
- Health care issues for the older female offender.
- Women with HIV/AIDS and special needs.
- Women with Hepatitis C and special needs.

INTRODUCTION

It is essential women be involved in their own health care and be given every opportunity for health education and decision making related to health care practices. Women are entitled to modesty and privacy as much as possible and are entitled access to health care providers in a confidential setting.

HISTORY OF WOMEN'S HEALTH ISSUES

The history of women's health has been most often related to women's reproductive health and to the perception that women are "complainers" of symptoms, while men "describe" their symptoms. The term "hysteria" is closely tied

to how women were perceived and was a label that described a grouping of the worst "feminine" traits (Sandelowski, 1981).

In the 1800's, society accepted and encouraged what is termed the "sick role". Women of society were thought of and treated as "invalids" who were weak and sickly much of the time, who suffered "vapors", consumption, and who could faint at any moment. On the other hand, the poor working woman was seen by both sexes as dirty and the carrier of disease (Sandelowski). Women were looked down upon and were divided.

Women of this century have been subjected to many health practices which were not necessarily in their best interests. Sandelowski notes women have had abortions, hormone therapy, sterilization's, and "preventative" radical mastectomies (breast(s) removal), hysterectomies (uterus removal), and removal of ovaries. Medical practitioners have been criticized for performing unnecessary Cesarean sections on women.

Sandelowski writes that negative behaviour regarding women continues today. The perception that women are "complainers" is alive and well. How many times have staff of correctional institutions heard that female inmates are more difficult, cause more trouble than male inmates, and "complain" more.

While women do access health care services more than men, this may also be due to their pivotal role in family health, and to accessing preventive health services and services related to reproductive health.

Women are increasingly learning of the need to be informed and to take control of their health. Incarcerated women, typically socially disadvantaged, need assistance with self-advocacy, health education and practice of preventative health behaviours.

WOMEN AND MEDICATION

Closely related to the history of women's health issues is the medicating of women. In the 1800's it was not lady-like to drink alcohol, but it was acceptable as part of the sick role to take home remedies, tonics, and medicines. Many of these products were laced with alcohol and/or opiates, and many women became addicted.

In the 1900's, vast numbers of women were prescribed tranquilizers and sedatives for any number of "complaints" and addictions resulted.

Medications commonly prescribed to women in this century include:

- hormone therapy - use of estrogen in healthy women (with risk of endometrial cancer)
- birth control pills - with risks of high blood pressure, embolism, increased numbers of vaginal infections, clotting, and other side effects
- psycho-active medications - increasingly prescribed for women as they age (includes tranquilizers, sedatives)

Today it is acceptable to take prescribed medication and acceptable to take any number of the over-the-counter medications available, targeted to the female consumer to ease whatever ailment exists. The woman as caregiver is encouraged to give medication to others; "Dr. Mom". Women use legal, mood-altering drugs (prescription and over-the-counter) double that of men. Drug companies market products to physicians and suggest the drugs will assist women under their care to "cope" better (ARF, 1996). Women are more likely to be given prescriptions for mood altering drugs and less likely to question or discuss what they are being given.

Since it is "accepted" that women will complain more than men, it is accepted that drugs are frequently offered as a "psychological strategy" (Sandelowski).

ARF cites a 1995 national survey done by Health Canada where in each category of medications such as sleeping pills, tranquilizers, and cannabis, five percent of women reported use in the previous 12 months. The rate was up to fourteen percent for use of prescription pain medication.

Reasons contributing to women's use of medication include physician's prescribing practices, lack of self esteem, lack of control or assertiveness in the health care relationship to question prescriptions or to fully describe health issues, stresses related to past experiences with violence and sexual abuse, poverty, lack of education, and poor health (ARF 1996).

When dealing with individuals in correctional facilities who are frequently requesting prescription and over-the-counter medication, patterns should be identified and a plan established to assist the female offender to recognize and deal with possible over use of medications, and with a possible drug dependency.

PREVENTATIVE HEALTH PRACTICES AND WOMEN'S HEALTH PROGRAMMING

Preventative health care and related education are now considered the cornerstones of good health. Female offenders have unique health care needs and the health care needs of these women are strongly impacted by social factors (education, poverty, family, support systems).

Critical to meeting the particular health needs of the female offender is a focus on health promotion, involvement in her own health care, access to health related information, and a comprehensive, holistic, and multi-disciplinary approach. Ministry policy requires that health care services comparable in quality to those

available to the general public be available to offenders in the custody of the Ministry.

While there may be limitations to the provision of a wide ranges of service to female offenders, where possible, it is essential that comprehensive health care services be provided with an emphasis on health promotion.

A number of preventative and health education programs may be offered to female offenders. It is possible these programs may be offered by Ministry staff, by contract staff, or by referral resources such as Public Health, Women's Groups, Cancer Society, AIDS Network, and so on.

Those working with female offenders should consider a number of health promotion programs with core information.

Areas for inclusion to wellness and health promotion programs for female offenders include:

- **Wellness for Women**: Such a program should have a curriculum which covers general health topics including exercise, diet and nutrition. Many women need basic knowledge about their own anatomy and the program should include the normal female anatomy. Other content titles should include women's health issues including: menstrual cycle, pre-menstrual syndrome, conception, healthy pregnancy, normal fetal development, the birth process, osteoporosis, menopause, endometriosis, vaginitis, toxic shock syndrome, pelvic inflammatory diseases, spontaneous abortion (miscarriage). Each component should include health promotion strategies and prevention of disease or illness concepts. It is essential to include education about health maintenance practices such as breast self examination, mammography, and the Pap test (Papanicolaou smear).

- **Communicable Disease Prevention and Education**: Topics should include hepatitis B, hepatitis C, tuberculosis, Human Immunodeficiency Virus and AIDS, transmission, prevention of transmission, diagnostic tests and treatments available. Important would be to include education about sexually transmitted diseases, safe sex practices and other prevention strategies, and treatment of sexually transmitted diseases.

- **Family Planning/Birth Control**: With an overall goal of promoting healthy sexuality, education about family planning/birth control will outline pregnancy prevention methods and use, and planning for or avoiding pregnancy. Other topics should include birth control methods such as condoms/dental dams, spermacidals, birth control pills, birth control devices such as the intrauterine device (IUD), rhythm method, and the rates of prevention of pregnancy associated with each one. A focus on responsible sexual behaviour is important.

- **Parenting Program**: A program to teach female offenders parenting strategies may be considered depending on resources available. Such programs normally

include: stages of child growth and development and expected milestones, importance of play, safety in the home and first aid, child health care and immunization schedules, nutrition, coping with stresses of parenthood in a positive manner, infant and child stimulation and education, child care arrangements, forms of discipline, family planning, step parenting, parenting the special child, and emotional and mental health.

- **Pre-natal and Post-natal education**: Such education should be made available to individual female offenders who are pregnant, or who have recently given birth. Topics include: nutrition for the mother and the newborn (including bottle/breast feeding), exercise, labour and delivery, self-care, care of infant, the normal infant growth and development, infant hygiene, health care and immunization needs and hazard prevention in the home.

FEMALE OFFENDERS CONFIDENTIAL ACCESS TO HEALTH CARE PROVIDERS

Where a female offender is seeking health care assessment and/or interventions from a physician or from a registered nurse, the female offender is entitled to the confidential relationship which normally exists between the patient and the health care provider. Respecting this entitlement is addressed in Ministry Clinical Services policies ADI 07 21 01, "Female Inmates Confidential Access to Health Care Providers".

To ensure the confidential relationship between the female offender and her health care provider, no other person should be present during any consultation or discussion between a female offender and her health care provider.

There are some limited exceptions where another person may be present. These exceptions would be limited to times where the female offender requests another person be present, where the health care provider is male (e.g. male doctor) and a female nurse is present, or where there are exceptional circumstances where correctional staff must be present due to clearly identified security concerns. Should another person be required to be present when a female offender is receiving health care, there is an expectation (which is to be outlined in institutional standing orders) for the confidential nature of the health discussions or examinations to be respected.

PROVISION OF FEMALE SPECIFIC HEALTH CARE ITEMS AND MEDICATIONS

There are a number of female hygiene, personal health care items, and medications which female inmates should have access to.

Increasingly, health care staff are permitting self-medication regimes and female inmates may have in their possession a limited supply of medications. Such medications may include birth control pills, vaginal creams and/or suppositories and

breast pumps. Female inmates should have ready access to tampons and sanitary napkins.

Those working with female inmates should ensure a system is in place so the approved use of specific personal care items and medication(s) is not incorrectly identified as "contraband". Memos to the unit file should suffice noting that items are approved for personal use (written so as not to violate health care confidentiality - administrative summary format)

Information inadvertently learned by staff regarding a female offender's personal health, medications, and feminine hygiene must be respected as confidential information.

ABORIGINAL WOMEN'S HEALTH

The diversity of Aboriginal traditional healing practices and lifestyles of Aboriginal people regardless of residency and status must be recognized and respected.

The Ministry supports the recognition, facilitation and inclusion of traditional caregivers and traditional teaching in a variety of services, including health care.

Ministry staff may be required to assist the Aboriginal female offender to gain access to tradition caregivers which may include traditional healers, medicine people, midwives, Elders, and other practitioners. The Aboriginal female offender may alternate between western and traditional medicines, or may seek combined care from both. Care may be for preventative, supportive or palliative reasons, or may be for crisis intervention.

The pregnant Aboriginal female offender may request an Aboriginal midwife to provide traditional midwifery services. When such a request is made, all efforts should be made to provide such service to the female offender.

Ministry facilities may have provision for traditional ceremonies such as sweat lodge and use of traditional resources such a sweetgrass, tobacco, sage, and other natural resources. Staff should refer to various Ministry policies addressing such traditional practices. At the time of this writing, a draft Ministry policy for Clinical Services is pending approval and once approved can provide further information ("Aboriginal Health Policy", Clinical Services policy for the Adult Institutions Manual).

FEMALE GENITAL MUTILATION

Female genital mutilation is a practice common to cultures of Africa, parts of the Middle East, and parts of Asia. Genital mutilation consists of a number of procedures that alter the female sexual organs in varying degrees. Within the

cultures where female genital mutilation rituals are performed, the procedures are usually done on children. Hawke (1995) states more than two million girls are believed to suffer genital mutilation each year and state the ages most common are between four and eight, but may also be done on babies, during adolescence, or after the birth of a first child.

Forms of female genital mutilation include:

Clitoral circumcision: this is circumcision of the clitoris where the tissue covering the clitoris is cut away.

Clitoridectomy: this is where the entire clitoris and the tissue covering it is cut away. There may also be excision of the labia as well.

Infibulation: the most severe of the procedures where the clitoris, the labia minora, and the labia majora is cut away. The vulva is then sutured together. Only a tiny opening is left through which urine and menstrual blood may flow.

In some cases the wounds are joined together using thorns, needles, or stitches (Hawke, 1995) in less than sanitary conditions. Where the clitoris is intact, it may be pierced.

There are a number of ongoing health problems for women who have suffered genital mutilation. Staff working with female offenders who originate from areas where such practices are common should be aware of the health problems these women may have which are related to genital mutilation.

Repeated infections are common, particularly when infibulation has been done. Urine and menstrual blood may back up behind the sewn up genital tissues remaining and serious and repeated infections are common as a result. Bedwetting may be a problem.

The woman may have scar tissue over the genital area which can cause additional problems. Sexual activity may be quite painful. Pregnancy is a particular concern and more surgery is often indicated at the time of birth (to open the vagina or delivery by caesarian section).

The female offender from countries who practice this ritual may seek "refugee" status in Canada and will seek resources to assist in this area.

Ongoing emotional and psychological support may be indicated to deal with the post-traumatic stresses which may be associated with the genital mutilation.

PREGNANCY

A number of female offenders are pregnant. The pregnant female offender may have a number of related health issues, including high risk pregnancy. A number of female offenders may also be addicted to alcohol and drugs, compounding health issues for the mother and the fetus and presenting many challenges for correctional and health care staff.

Huft, Fawkes, and Lawson (1993) write about maternity care in the prison setting and set out related values and assumptions including: 1) pregnancy is a healthy state, 2) every pregnant woman has the right of self-determination regarding her body and its functions, and 3) every woman has the right to physical safety and access to certain health care services.

Issues surrounding the pregnant offender which staff should be aware of and anticipate may include:

- stress and other emotional issues related to the pregnancy; unwanted pregnancy, family issues, pregnancy during incarceration, decisions to continue versus terminate the pregnancy
- possible mental health issues including depression
- the need for pre-natal and post-natal education and possible parenting skills training
- nutritional issues (pregnant women should have a diet high in protein, with iron, milk, and vitamins as guided by standard nutritional requirements for pregnancy)
- the need for proper exercise during pregnancy
- potential for inappropriate work assignments to pregnant offenders
- special consideration during strip search procedures
- the need for provision of special clothing as the pregnancy progresses
- special consideration in managing the violent pregnant female and restraining procedures
- medical temporary absences for obstetrical appointments and the birthing procedure
- the pregnant offender who has a substance addiction
- pregnant women taking Methadone
- the pregnant woman with HIV/AIDS
- premature or emergency delivery of the infant
- mother/baby separation after the birth with resultant emotional and mental health issues

Those working with pregnant offenders should develop a team approach to plan to address mental health issues, to promote assisting the woman to experience a positive and healthy pregnancy experience, and to develop a plan of care for a safe delivery, and a healthy mother and child.

Referral resources should be used to assist the mother with pre-natal planning for the placement of the child after delivery (unless the courts mandate the placement). Counseling to prepare for the separation of the mother and her baby will be essential.

PRE-NATAL AND OBSTETRICAL CARE

When a female inmate is suspected of being, or known to be pregnant, it is her right to receive medical attention concerning her pregnancy from a qualified medical practitioner.

Staff must ensure pregnant inmates are provided with special health care counseling, regular examination and treatment, and such dietary supplements, as may be necessary to the woman's condition. Pregnant inmates shall be referred to an obstetrician if the pregnancy is high risk, suspected high risk, or if potential problems are identified.

For purposes of pre-natal counseling, external resources may be contacted for information and support (e.g. Public Health educators, Crisis Pregnancy Groups).

POST-PARTUM CARE

Female inmates who return to the institution following delivery and the post-partum hospital stay will have any prescribed post-partum treatment continued with the approval of the respective facility physician.

Where it is feasible, attempts should be made to have the mother and her new baby together as much as possible during this important time of maternal-infant bonding.

Alternative arrangements to correctional institution housing may be considered including the possibility of transfer to a community location such as a half-way house. The female inmate may be able to apply for early parole for compassionate reasons, or for unescorted temporary absence. Security needs of the inmate are obvious considerations in alternative placement for such an inmate.

For inmates who do not meet criteria for alternative placement and who must remain within the confines of a correctional facility, arrangement for care of the baby shall be made with family, guardians, or with the Children's Aid Society (CAS) depending on the individual situation. These arrangements in such situations should be made well in advance of the anticipated delivery date.

The institution should make every attempt to provide for the mother and baby to be together. Where the mother wishes to breast feed her baby, the health care unit may be used to facilitate this request. The health care unit staff should also facilitate the mother being able to express her milk for later use, and store it (freezer) for the family/caregiver/CAS to obtain to continue the nourishment for the baby at home.

TERMINATION OF PREGNANCY

There are a number of issues for the female offender related to termination of pregnancy.

Miscarriage: Pregnancy may be unexpectedly terminated through a miscarriage, in medical terms, a spontaneous abortion. A supportive environment for the female offender who has miscarried is essential in the event she experiences grief after the procedure. Staff should consider referring the female offender for supportive counseling to assist her in dealing with the loss of the pregnancy.

Therapeutic Abortion: A therapeutic abortion is the surgical interruption of the pregnancy. It may be done for medical reasons and may possibly be done on an urgent basis should the continuation of the pregnancy endanger the woman's health. Therapeutic abortions may also be done at the woman's request for personal choice reasons.

Ministry policy outlines that termination of pregnancy during incarceration is regulated by Provincial and Federal law.

Where a female offender voices the decision to have her pregnancy surgically terminated (abortion), the woman must be referred to a physician for counseling, discussion of options, decision making, and necessary referrals as indicated. A number of counseling services may be accessed for the female offender by health care or other clinical staff.

Should a surgical procedure to terminate pregnancy be arranged, correctional staff may be required to escort the offender on the medical temporary absence necessary to have the procedure completed as no abortions will be done within Ministry facilities. Normally, where an employee's stated religious beliefs are in conflict with facilitating an abortion, such beliefs will be taken into consideration. Where the health of the female offender necessitates abortion, the employee may be compelled to facilitate the treatment in the course of his/her duties (Refer to Ministry Policy, Adult Institutions Manual, ADI 07 21 01).

There may be occasions when a female offender requests the option of accessing abortion services from a private abortion clinic. In such case, special arrangement may need to be arranged by the Health Care staff. In such cases, the Ministry Senior Medical Consultant is contacted.

Ministry employees must be vigilant in respecting the female offenders right to access personal health care services and in respecting the confidentiality of the woman's health care issues

HEALTH ISSUES OF THE OLDER FEMALE OFFENDER

As a large portion of the population ages it is anticipated there will be increased numbers of older female offenders involved with the correctional system.

Morton (1993) states the National Institute of Corrections (USA) considers "older" over fifty years of age. She further notes older women are more likely to live alone and have limited family support, live below the poverty line, miss out on medical and financial and private insurance support programs, are more likely to be ill and need care, and have higher incidents of certain debilitating diseases, including strokes, visual impairments, hypertension, and diabetes. Osteoporosis (a loss of bone density) predisposes women to back deformities and fractures of bones such as the hip. Morton further outlines the negative social image of older women (unattractive, unhealthy, asexual, sedentary) and notes the difficulties older women have of finding a job.

Staff working with older female offenders should maintain an awareness of the health care needs of older women and should allow for added time to address the various needs of the older woman.

As with any female offender, privacy and modesty issues must be considered.

The health needs of older women must take into account preventative health practices. For example, annual mammograms are recommended for women over the age of fifty.

There is an increased awareness of the mental health needs of the older population and it is essential to report signs of mental health problems such as depression.

Some woman approaching menopause (change of life) may experience a number of symptoms due to hormonal changes, which may lead the woman to seek health care. Menopause is a natural part of the woman's life cycle. Through self-care and health education, menopause can be a positive experience.

As menopause approaches, the menstrual flow gradually gets lighter, with some periods being skipped. Some women have symptoms such as hot flashes and night sweats which are temporary and uncomfortable. For some, symptoms are eased when hormone replacement therapy (estrogen) is taken. Other symptoms

may include weight gain, skin changes, increased facial hair growth, urinary changes with possible incontinence (involuntary loss of urine), and vaginal changes such as dryness or loss of elasticity.

It should be noted menopause can be surgically induced where the ovaries are removed. This may bring a range of abrupt changes for the women and preventative health care is essential.

It is important for older women and women going through menopause to be provided with good nutrition, an opportunity for regular exercise, calcium supplements, and a supportive environment. Mood altering foods such as caffeine, sugar, and chocolate, should be encouraged to be avoided and nutritional and health counseling would be helpful to the older woman to learn to manage her health.

Staff should be aware older women are very likely to be prescribe mood-altering drugs by the physician and to request over-the-counter medications. As with any offender demonstrating a pattern of drug use, these patterns need to be identified and reported so a treatment plan can be initiated to assist the female offender to appropriate medication use. Health care screening should include careful history taking and possible mental health counseling referral considered as treatment options instead of mood altering medication where clinically possible.

WOMEN WITH HIV/AIDS

In Ontario in 1996, about 4.8% of diagnosed AIDS cases were female (PHERO, 1996). Persons with AIDS are people who progressed from being HIV positive to having the disease of AIDS which is characterized by a number of specific diseases and health problems. Incidence rates are higher in the United States, however the significance of this rate in terms of numbers of Ontarians cannot be overlooked. In the past 10 years over 260 women in Ontario have progressed from having HIV to being diagnosed with full-blown AIDS. Statistics for numbers of women who are HIV positive are not available. Public Health reportable diseases requires AIDS be reported to public health authorities, not specifically the identification of HIV, although positive HIV results do go to public health authorities from Ministry of Health laboratories. Many women may be HIV positive without knowing it or demonstrating symptoms.

Lawson and Fawkes (1993) noted that HIV may be more common among prison and jail inmates, especially women, quoting a study by Johns Hopkins School of Public Health where from 2.5 to 14.7 percent of female inmates were HIV positive, and in most correctional facilities assessed, women had higher rates of HIV infection than did men.

Those working with any offender must be vigilant to practice "universal precautions", and to assist the offender to obtain essential health care and follow-up. Counseling for women with HIV or AIDS must be arranged. Service providers may

vary from Ministry health care providers, to community experts who are most often very willing to assist.

At times, the female offender may choose to share her diagnosis of HIV/AIDS with those working with her. Ministry confidentiality of medical records policies state that such medical diagnosis only appear in the medical files so staff must ensure related information is sent to the health care file and not placed on any other records.

The HIV positive woman is likely to be counseled to avoid pregnancy which may result in a significant emotional responses. The woman who learns she is HIV positive while pregnant will have a number of issues to address and cope with, including the decision whether or not to continue with the pregnancy.

Health counseling to HIV positive women considering pregnancy must outline the risks of vertical (mother to the child) transmission of the virus, and information about the use of the anti-HIV medications to attempt to stop the transmission of the virus in utero.

Ongoing mental health support to the HIV/AIDS positive female offender is vital. The woman experiencing full-blown AIDS may need to plan for a significantly shortened lifespan and will have numerous health care needs. Where children and family are involved, the situation becomes more complex. Those working with a woman who is terminally ill with her disease should seek a location providing hospice or palliative care where possible. Early parole for compassionate reasons may be considered or temporary absence programs could be considered.

Women who are HIV positive will require ongoing health monitoring and diagnostic tests to determine the status of the disease process. The HIV positive female offender may be required to take a number of medications around the clock and at very specific times. This can necessitate the requirement for the female offender to be wakened in the night for medication.

Drug therapies for the treatment of HIV/AIDS may change based on research and drug trials.

The female offender with HIV/AIDS may be on medications which include: Pneumococcal Vaccine (one dose in lifetime), vitamin C therapy, multivitamin therapy, nutritional supplement therapy (e.g. Ensure), Vitamin B12 injections monthly, anti-fungal medication, anti-viral medication, and medications specifically to treat HIV/AIDS including Didanosine (DDI), AZT (Zidovudine) (Retrovir), Zalcitabine (DDC)(HIVID), Saquinavir, Ritonavir, Indinavir. Combination drug therapy is currently the method of choice in the treatment of HIV/AIDS. Antibiotics and other drugs may be necessary at times to treat opportunistic diseases which may also occur.

It may be possible to assist female offenders to access up-to-date treatment and medications by contacting the HIV Trials Network based from Sunnybrook Hospital in Toronto (1-416-480-4451). Medication used in drug trials (research) may be available at no charge and the Network can assist the offender to link with a physician experienced in treating HIV/AIDS.

Voluntary organizations such as AIDS Networks or other HIV/AIDS groups can be accessed for additional support for the offender.

WOMEN WITH HEPATITIS C

Hepatitis C is a liver disease caused by the hepatitis C virus, which is found in the blood of persons having this disease. The infection is spread by risk behaviours (or accidents) involving contact with the blood of an infected person or by blood transfusions. The infection can lead to chronic liver disease which may end up as cirrhosis of the liver, and/or liver cancer. In terms of treatment for Hepatitis C, the only drug approved for the treatment of Hepatitis C is Interferon alpha-2b and is not indicated for all individuals with Hepatitis C. About 10-15% of those treated may have a long lasting response from the treatment, however, long-term impact of the treatment is not yet known. Even after treatment, the hepatitis C may reactivate.

Due to confidentiality regulations for health care providers, in most cases, staff working with female offenders will not know when the female offender has a diagnosis of Hepatitis C. Due to the high-risk behaviours of many offenders, staff can expect rates of Hepatitis C infection to be high. Careful and consistent application of universal precautions is essential for staff to protect themselves from all blood born diseases.

At times, the female offender may choose to share her diagnosis of Hepatitis C with those working with her. Ministry confidentiality of medical records policies state that such medical diagnosis only appear in the medical files so staff must ensure related information is sent to the health care file and not placed on any other records.

Health Care staff or, at times, other staff may be called upon to assist the female offender to obtain specialized diagnostics and treatment for hepatitis C. Within institutions, the female offender can be referred to the Health Care Unit and physician.

For those assisting a female offender with a discharge plan or assisting her to access resources in the community, a referral service is available for offenders with Hepatitis C.

The referral service is called the CARE LINE. CARE stands for Canadian Advisement Reimbursement Exchange and the responders of this telephone referral service will assist offenders to obtain medical follow-up for Hepatitis C on release.

To set up an offender with the CARE line, staff should contact the CARE line to obtain a "liver program number", a number specifically assigned to individual case. Medical information (with a signed consent for disclosure form) is normally requested by the CARE line.

Once set up on the CARE line system, offenders are given their "liver program number" and the CARE line toll-free number (1-800-363-3422). The offender should always have her program number available when calling the CARE line. The CARE line can then assist the offender to access the medical care required for managing hepatitis C.

SUMMARY:

In this section, a large number of health related issues pertaining to the female offender have been introduced. Those interested in acquiring further knowledge on a particular subject are encouraged to review references, to contact public health educators and ministry health care staff, and to contact numerous voluntary organizations who deal with women's issues.

QUESTIONS/ANSWERS

Q. Resources are tight. How can we offer any preventative health programming for women?

A. At a minimum, a small library of brochures and pamphlets (frequently obtained at no charge) could be set up. Volunteer organizations may be able to provide health education at no charge (e.g. AIDS network, Lung Associations, Cancer Society)

Q. A female inmate has requested an Aboriginal midwife to assist her with her delivery. What do we do about this?

A. It is possible for an Aboriginal midwife to be involved in the care of the pregnant inmate. A ministry policy is pending on this subject. In the interim, consult an Aboriginal Program Co-ordinator or the Ministry Senior Medical Consultant.

Q. The female offender is always asking for prescription and over-the-counter medication.

A. You have identified a possible problem with drug over-use or dependency. This problem should be documented and reported to the health care staff and multi - disciplinary team where available.

Q. What should I do if the female offender is HIV positive or has Hepatitis C?

A. Practice careful universal precautions for all offenders. Maintain confidentiality. Refer the female offender to a health care providers or other referral resource (e.g. Public Health, CARE Line (for Hepatitis C referral).

Q. I am planning to set up a Women's Wellness program. Where do I start?

A. There are numerous content suggestions listed in this chapter under "Preventative Health Practices and Women's Health Programming". Topics can be researched by researching women's health books and prevention magazines, by contacting other program leaders of women's health programs (clinics, hospitals, Public Health). Health Science department of colleges and universities may be able to assist.

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MENTAL ILLNESS

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MENTAL ILLNESS

LAUREL PUTNAM

SUMMARY

This chapter is intended not only to assist in identifying female offenders requiring intervention by mental health personnel, but also to provide techniques to safely handle situations until such help can be accessed.

GENERAL INFORMATION

- Women are 2-3 times more likely to experience depression than are men.
- Depression and anxiety disorders are the most common mental illnesses in women.
- Many provincial inmates may have a psychiatric illness.
- Some are considered seriously mentally ill.
- Many of the 60,000 female offenders under community sentences have symptoms of mental illness with less than 2% suicidal, grossly impaired, or delusional.

GENDER DIFFERENCES

- Women report a higher incidence of anxiety and depression.
- Presenting signs and symptoms are comparable in both males and females.
- Less is known about differences in treatment because of the failure to include women in clinical trials.
- Women who are mentally ill are not a homogenous group with uniform needs. Types of treatment depend upon the individual.
- Differences in the therapeutic relationship and even the topics discussed, are dependent upon the sex of the client and the therapist.

THEORIES

Explaining CAUSES OF MENTAL ILLNESS in women are many and include:

- a response to societal influences, i.e., learned helplessness, inferior status, stresses associated with multiple roles and expectations, lack of economic equity, education / occupation opportunities, sexual abuse, etc.
- chemical imbalances in the brain
- structural abnormalities in the brain
- heredity
- hormonal imbalances, i.e., post partum depression

or

a combination of any of these

TREATMENTS

Treatment is determined by the needs of the individual. The following are examples of intervention , and is by no means intended as a complete list:

- medication
- psychotherapy
- social skill training
- behaviour modification
- relaxation training
- family education and counselling
- relapse prevention
- counselling
- cognitive restructuring
- group therapy
- addiction counselling
- assertiveness training
- self - help groups

DIAGNOSTIC LABELS

The following define some Medical DIAGNOSTIC LABELS you may encounter in you work with the female offender:

PSYCHOSIS is a term that usually refers to loss of touch with reality as with a schizophrenic experiencing hallucinations and delusions.

NEUROSIS is a term that refers to a mental illness that interferes with a person's ability to lead a normal life as with an offender with a panic disorder.

BIPOLAR AFFECTIVE DISORDER is a term that refers to a depressive illness that can be unipolar or bipolar.

DEPRESSION

- Depression is the only mood in a unipolar disorder.
- Depression alternates with manic behaviour in bipolar or manic-depressive disorder.
- Runs in families.
- Depression more common in women.
- Bipolar disorder occurs equally in men and women.
- Persons with bipolar disorders are more likely to commit suicide when depressed.

SCHIZOPHRENIA a biological brain disease that affects thinking, perception, mood and behaviour.

- Believed to be related to faulty brain chemistry.
- Affects 1 % of the population.
- Runs in families.
- LIFE IN A WORLD THAT IS DISTORTED
    - may sense things that do not exist, i.e., hear voices (hallucination)
    - may hold false personal beliefs, i.e., people are after her (delusions)
    - may not show signs of "normal" emotion i.e., show emotion inconsistent with speech / thoughts
    - may have jumbled thinking
    - may have difficulty sorting out or connecting thoughts, often does not make sense to others
    - may show a lack of energy, initiative and interest

10 % OF ALL PERSON WITH SCHIZOPHRENIA WILL KILL THEMSELVES

- Refer to hallucinations and delusions for further details.

PERSONALITY DISORDERS

- Disorder in a persons character.
- May be able to function in daily life, but emotionally and psychologically crippled by an unstable personality, i.e., someone who is extremely dependent.
- Difficulty with relationships and fulfilling potential.

ORGANIC DISORDERS

- Result of trauma, disease, or physical impairment to the brain.
- Wide variety and severity of symptoms including:
    - short attention span
    - disorientation (time, place, person)
    - poor judgment
    - memory problems
    - disturbances in mood (i.e., alternating laughing , crying, temper)

- impulsive
- poor judgment
- intellectual deficits

OFFENDER BEHAVIOUR

DEPRESSION

a pathological mood disorder characterized by feelings of sadness, despair, hopelessness, pessimism and dread.

DEPRESSION IS THE MOST COMMON PSYCHIATRIC DISORDER IN WOMEN.

MANY WOMEN ARE SOCIALIZED TO SMILE AT ALL COSTS. THEY MAY HIDE THEIR DEPRESSION BEHIND A CHEERFUL FACE.

RECOGNITION
feeling of helplessness, guilt, hopelessness, and worthlessness

- negative outlook
- poor concentration and memory
- may isolate self
- sad facial expression, tearfulness
- lack of interest in activities or relationships
- lack of energy, slowed or speeded movement
- decreased or increased appetite
- sleep disturbances (early morning wakening)
- decreased sex drive
- poor hygiene

UNTIL AGE 65, TWICE AS MANY WOMEN AS MEN RECEIVE TREATMENT FOR DEPRESSION.

20% OF WOMEN OVER AGE 60 HAVE HAD AN EPISODE OF DEPRESSION.

APPROACHES

- be warm and accepting,be patient and understanding
- avoid light-heartened approach
- share time
- reassure, do not cheer
- acknowledge offenders pain and despair, but convey your sense of hope
- do not add to their guilt by blaming them
- check for signs of suicidal behaviour
- refer to health service or appropriate community resource

SUICIDE 30 TIMES HIGHER AMONG THE DEPRESSED THAN THE REST OF THE POPULATION. 15% OF DEPRESSED PEOPLE EVENTUALLY DIE BY SUICIDE.

SUICIDAL BEHAVIOUR

those attempts or verbal threats that result in death, injury or pain consciously inflicted upon oneself.

RISK - higher incidence

- with age in divorced or single persons
- with history of suicidal behaviour or psychiatric illness
- with drug addiction
- in spring and summer
- family history of suicide, depressive or psychiatric illnesses
- with no family ties

WARNING SIGNS

- depression - **especially when depression lifting**
- isolation
- impulsiveness
- preoccupation with death
- thought, words, actions that are end oriented
- giving things away
- termination of significant relationships or commitments
- sudden uplifts in mood or serenity when previously depressed

MYTH
PEOPLE WHO TALK ABOUT SUICIDE DO NOT REALLY WANT TO DO IT.

APPROACHES

- ask questions - Is she thinking of harming herself? Has she made plans about how? What preparation has she made ? (i.e., saving pills, rope etc.) Has she made any attempts? Are voices telling her to hurt herself?
- if she answers Yes to any of the above, do not leave her alone
- notify health service or escort to an appropriate community resource

WOMEN ATTEMPT SUICIDE MORE FREQUENTLY THAN MEN.

ANXIETY

a feeling of uneasiness and apprehension to a nonspecific threat. The source generally unknown and not recognized. Anxiety ranges from mild to severe.

RECOGNITION

- experienced through physical changes to the body, i.e., increased heart rate, blood pressure, rapid breathing, tightened muscles, loss of appetite, sweating, shaking
- feelings of impending doom
- PANIC: state of terror, communication not understood
- OBSESSIONS: preoccupation with an idea or thought that dominates the mind interferes with daily activities
- COMPULSION : overwhelming urge to perform an irrational act or ritual, i.e., hand washing, touching, that interferes with daily actives
- PHOBIAS: persistent irrational fears of an identified object or situation , I. e., heights, snakes, open spaces

APPROACHES

- speak slowly and calmly
- use short, simple sentences
- assure her she is safe and you will help
- stay with her
- remove from noise and confusion and source of anxiety
- limit contact with others, allow her to set the pace
- do not interrupt rituals, allow privacy
- encourage talking and walking to relieve anxiety
- relate to her as an adult
- alert health service or refer to community agency

FEMALES EXPERIENCE PANIC DISORDERS AND PHOBIAS MORE FREQUENTLY THAN MALES.

MANIC BEHAVIOUR

a disordered state of extreme excitement.

RECOGNITION

- elated, cheerful, playful, high
- inflated self image
- irritability, anger, rage
- boundless energy
- accelerated speech
- poor judgment
- weight loss, increased activity and too busy to eat
- hyperactivity
- inability to sleep
- disorganized
- bizarre dress
- delusions
- uninhibited sexual interest
- easily distracted, short attention span

DO NOT BE TAKEN IN BY OFFENDER'S PLAYFUL AND AMUSING WAYS.

APPROACHES

- decrease noise and confusion in immediate environment
- limit participation in group activities
- discourage others from encouraging inappropriate behaviour
- do not engage in long conversations. Short, frequent contact
- provide outlets other than conversation i.e., drawing
- monitor activities to protect from impulsive, poor judgment
- monitor sleep and meals - give finger foods
- be aware of potential for increased sexual acting out
- set limits on behaviour
- refer to health services or appropriate community resource

HALLUCINATIONS

a sense perception that doesn't exist in the real world. Can involve all five senses.

CAUSES

- schizophrenia
- bipolar disorder
- brain lesions
- drugs
- fatigue
- organic disorders
- medical condition

RECOGNITION

OFFENDER:

- senses things that don't exist, i.e., hears voices (most common), sees things, smells things, feels things
- appears preoccupied and unaware of surroundings
- has difficulty following conversation, i.e., instruction
- misinterprets words and actions of others
- may isolate self
- wears Walkman constantly (to tune out voices)

APPROACHES

- give personal space
- don't touch without permission
- speak slowly and quietly using short sentences. Remember it may take her longer to process information
- call by first name
- instruct to listen to my voice, do not listen to the other voices
- explain your actions
- ask questions: Are you hearing voices other than mine? What are they telling you? (Important to identify risk to self or others) What do you see, feel, taste?
- reduce confusion, i.e., bright lights, television, radio
- be aware, stress may increase hallucinations
- be aware, hallucinations may increase in the dark --ask
- inform health personnel of your observation

DO NOT pretend you are experiencing the hallucination - **YOU ARE THE GROUNDING IN REALITY.** *I don't hear the voices, but understand that you do.*

DELUSIONS

CAUSES

- schizophrenia, bipolar disorders, organic disorders, medical conditions, i.e., acute infections, delirium, drug intoxication

RECOGNITION

OFFENDER MAY:

- believe self to be someone of importance
- be excessively religious
- sexually act out
- be extremely suspicious
- avoid food/ medication for fear of poisoning
- have sleep difficulties because of fear of being harmed
- misinterpret others' words and actions
- appear afraid
- isolate self

APPROACHES

- keep your distance, no touching
- position yourself at her level
- avoid whispering and laughing, as this may be misunderstood
- remember that what is on an individual's mind is not always obvious
- ask questions about what the delusion is all about (potential for self harm or violence), i.e., Are you having any thoughts that are disturbing / upsetting to you or to others?
- explain your intentions before you act
- short frequent contact
- do not argue or try to convince her the thoughts are not real. Do not attack delusions
- do not show or say you believe in the delusion. Instead explain, I believe you are telling me this as you see it
- do not smile or nod your head when she is discussing delusion to prevent misunderstanding
- do not dwell on delusion
- interpret reality by stating facts clearly. Assure her she is safe and you are not going to harm her. Reduce situations that make her anxious, she may by very terrified
- be aware that your position of authority may make her more suspicious. Her experience with authority in her culture or country of origin may have been a terrible one
- alert health authorities of your observations
- DO NOT DECEIVE - BE HONEST AND OPEN IN ALL SITUATIONS

GENERAL DO'S AND DON'TS

- DO treat the offender with dignity and respect as you would want your mother or sister treated.
- DON'T tease , belittle or humiliate.
- DO talk slowly and quietly. Remember, your impulse if you do not feel you are being understood, is to speak quickly and loudly.
- DO keep your distance and respect personal space.
- DON'T touch without permission.
- DO identify yourself and others, and explain you intention / actions.
- DON'T be in a hurry. Take your time. DON'T push it.
- DO eliminate noise and distractions, i.e., television, radio, bright lights.
- DON'T deceive. You are reality.
- DO give choices whenever possible so the offender can maintain some level of control.
- DON'T challenge.
- DO give assurances you intend no harm and want to help.
- DON'T forget the pain and fear she is experiencing. Remember emotion can be painful, even to the most bizarre.
- DO point out your reality, but don't rob her of hers.
- DO remember how sensitive she may be to the way you communicate nonverbaly

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SELF INJURY IN FEMALE OFFENDERS

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SELF INJURY IN FEMALE OFFENDERS

PAM SKINNER

DEFINITIONS & SPECTRUM

Self abuse, self injury and self mutilation are terms that are often used interchangeably to describe self destructive behaviours. For the purpose of this article, **self abuse** is used as an "umbrella" term that includes many forms of behaviour that are *destructive to the self*. Some of these forms are socially acceptable (smoking, overwork, excessive exercise, poor eating habits) and some are not (substance abuse, eating disorders, self sabotage).

Self-injury is used to describe a subset of self abuse that would include behaviours that are typically described as self mutilation. Self injury refers to behaviour that does *physical damage to the body*.

Self injury includes behaviours such as:

- slashing
- hair pulling
- biting
- head banging
- breaking bones
- burning
- opening, infecting wounds
- inserting objects under the skin
- punching walls
- strangulation
- swallowing objects (e.g. paper clips, razors) or dangerous substances (e.g. drain cleaner)

Self injury is a behaviour that is more likely to be observed amongst individuals who are institutionalized, such as inmates in a correctional facility or psychiatric patients in a mental health facility. The forms and dynamics related to this behaviour differ for each of the above mentioned populations. For the purpose of this handbook, the focus will be on female offenders.

It is very natural to have strong emotional reactions when you come across a woman who has self injured or who is in the process of self injuring. These emotional reactions often include horror, disgust, fear and anger. Learning what self injury is all about can help you to respond with understanding and compassion, enable you to anticipate and prevent self injury, and to help self injures develop healthier ways of dealing with emotional tension.

INCIDENCE

There are no clear figures to tell us about the incidence of self injury in society. It is a behaviour that most are able to keep "hidden". They do this by selecting the location of the self injury in such a manner as to keep it covered. It is also a behaviour that is typically practiced in private because of the shame associated with it. Having stated this, there are also those who have no compunction about self injuring in front of others, and who freely display their injuries.

A 1989-90 study of 44 women at the Prison for Women in Kingston discovered that 59% self injured at some time or another.

MYTHS ABOUT SELF INJURY

- women who self injure enjoy pain
- women who self injure don't feel pain
- women who self injure are addicted to pain
- when women self-injure, they are attempting suicide
- women self injure to get attention
- self injury is an unsuccessful suicide attempt

WHY PEOPLE SELF INJURE

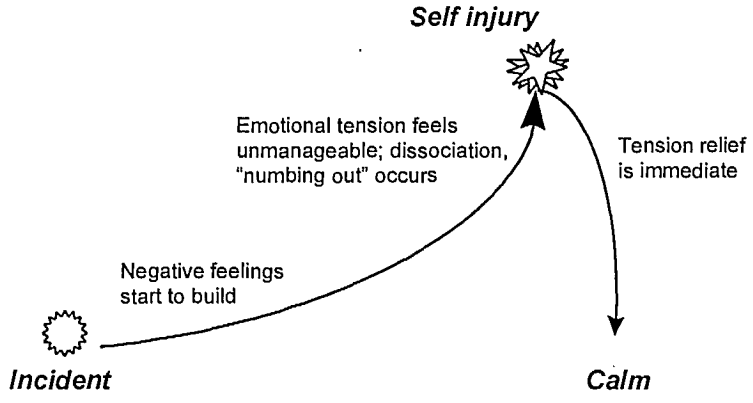
When trying to understand why people self-injure, it is helpful to think about **primary** and **secondary** reasons. The primary reason for self injury recognizes the underlying process that is taking place when a person self injures. The secondary reasons reflect the added "benefits" that are realized by the self injurer.

Child Abuse and Self Injury

Studies have shown that there is an extremely high correlation between self injury and child abuse. Child abuse usually follows a pattern. The abused child lives in dread of the next attack, and her tension increases. As the time of the abuse draws nearer, and the abuser approaches, the emotional tension becomes unbearable in anticipation of the abuse. Children are amazingly able to dissociate as a way of coping and surviving abuse. It is at this point of unbearable tension that the child dissociates so that she does not experience the intensity of the abuse. Once the abuse is over, she can relax, knowing that for a period of time -- hours, days, weeks, or months, depending on the pattern -- she will be left alone. Before too long, the cycle of tension, anticipation and dread begins again.

Cycle of Self Injury

The cycle of self injury mirrors the abused child's experience of abuse. Something provokes anxiety in the survivor, and her tension increases. This may be something that reminds her of her abuser, or an incident that provokes the same feelings as the abuse situation. The familiar feeling of dread overcomes her and with time becomes unbearable. The woman may not express "dread", but a related emotion such as anger, stress, anxiety. It is at this point, where the woman feels that she cannot bear the tension, the anticipation of something awful that is going to happen to her, that she dissociates and self injures. Having experienced "something awful" (the self injury), she experiences a sense of relief. The majority of women who self injure report that they don't feel the pain of the self injury until after – this is because she is in a dissociative state while self injuring – she is "numbed out". Before long, she will also feel ashamed or guilty because of the self-injuring behaviour, but she feels much more calm and able to cope.



Most women who self injure aren't consciously aware of this cycle. They only know that when they are very tense and upset that self injury is the way that they can very quickly feel release. The tension release is so powerful and so immediate that it maintains the cycle. If a woman is interrupted and unable to complete her self-injury, she may find that the need returns quickly and with even greater intensity.

Survivors say that they self injure to:

- Express pain (see the pain flow in the blood, others will know the pain I'm in)
- End or bring on periods of dissociation (calm racing thoughts, or to overcome feeling "dead" inside)
- To express anger (confusion of where anger belongs - with self or others)
- To gain a sense of safety (keeps people away)

Some of the purposes that people most often associate with self injury include:

- to protest ill treatment
- escape from unmanageable situations
- force therapeutic attention or care
- emotional blackmail
- to prove she is alive
- to provide physical evidence of her emotional distress
- self-punishment
- as a response to abandonment, isolation, segregation
- to gain sense of control
- to cope with anger/hostility
- reduce anxiety/tension
- *These are the reasons most often stated by self injurers*

Situations that can provoke these feelings are plentiful in the correctional system:

- court proceedings
- segregation
- admission & strip search
- witnessing violence
- anxiety re discharge
- staff inconsistencies
- deportation
- withdrawal from drugs/alcohol
- lockdowns
- visits not showing up
- ignored/confronted by staff
- issues re custody of children

SUICIDE AND SELF INJURY

There are many similarities, on the surface, between suicide and self injury. Similar methods may be used (cutting, ingesting dangerous items, strangulation), and the feeling surrounding the behaviour may be similar (anger, depression, fear, sense of powerlessness). The key differences are important to note:

Suicide	Self Injury
• the person intends to die	• the person does not intend to die
• the person is giving up & ending their life	• the person is attempting to cope with life

While suicide and self injury are distinct behaviours in terms of their purpose, it is possible for them to be connected:

- If a person who uses self-injury as a coping mechanism is rendered unable to use it, she may become so overwhelmed by her feelings that she begins suicide ideation.
- Self injury ideation and suicide ideation may co-exist in the same person, although usually not at the same time. Self injury can in such cases actually help suicidal feelings dissipate.

APPROPRIATE INTERVENTION STRATEGIES FOR CORRECTIONAL PROFESSIONALS

Different correctional facilities have different procedures for responding to women who self injure. Familiarize yourself with the procedures in your setting. Whatever those procedures are, they should include the components listed below. Depending on your particular role, you may be involved in all or only some of these processes:

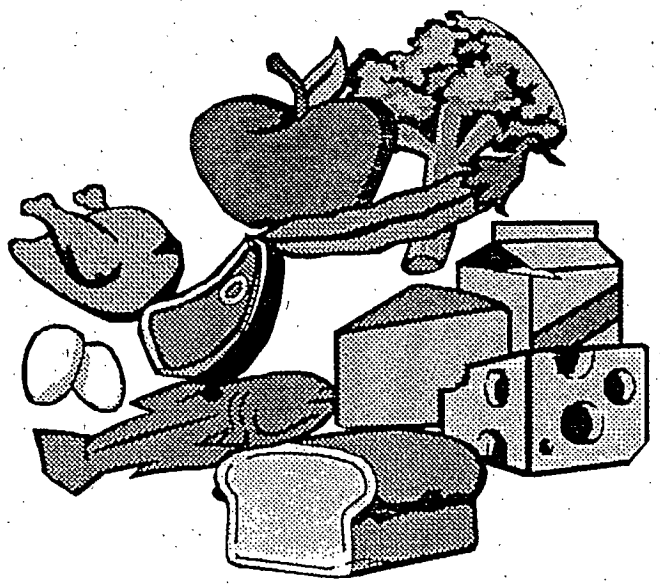
- Procure medical aid for her, and ensure that you utilize universal precautions for your own protection.
- Assess *the behaviour*. Distinguish between self injury and a suicide attempt. Involve her in this assessment -- she will most often be quite clear about the purpose of her behaviour. Assess for *the risk* to further self injure. If she has completed her self injury, the need may be gone. If you interrupted her self injuring, her need to engage in self injurious behaviour may become intensified.
- Provide a safe environment for her that is the least restrictive possible. For example, if she is not suicidal, she does not require a security gown. Segregation may not be necessary (this is not a suicide case), but it may be important for her to be with someone that she is comfortable with, or in a location where she may be closely observed if there is concern that she will self injure again.
- Educate her about self injurious behaviour – its dangers and its causes. Often, self injurers don't fully understand their behaviour, although they have discovered that it helps them to "feel better" so that they can cope with emotional tension. She may feel ashamed, and may think herself "crazy". Helping her to understand that this is a coping mechanism that has helped her survive, and that it can be replaced with healthier coping mechanisms, can give her a new perspective which enables her to make healthier choices.
- Work with her to help her identify the "triggers" that prompt her to self injure, and to problem solve about other options – people she can talk to, other methods of tension reduction.

Responding appropriately to the woman who has self-injured is important. Perhaps it is even more important to develop ways to anticipate incidents of self injury and to prevent the situations that lead to self injurious behaviour. Experience and research have shown that there are certain dynamics that are almost guaranteed to contribute to self injurious behaviour. Feelings of powerlessness and loss of control; threats of violence; feelings of being abandoned or betrayed; fear of being "evaluated" and found wanting -- all contribute to the increased anxiety that leads to self injury. It is not surprising that self injury is so prevalent in correctional institutions, particularly in the more controlling and restrictive (e.g. maximum) settings.

Self injury is often considered to be a "way of getting attention" or of being "manipulative". There are clues here as to how we can prevent self injury. Sometimes a woman needs emotional attention, but generally that is much harder to

get than physical attention. When self injury occurs, she gets both kinds of attention. Manipulation is a way of trying to get what one wants or needs without asking for it directly. Attending to the emotional needs of the women in our care can reduce the incidence of self injury as they are able to deal with emotional tension in a constructive manner with support from staff.

EATING DISORDERS AND THE FEMALE OFFENDER



WRITTEN BY:

Meryl Bear, M.Ed (Psych), is the Program Director of the National Eating Disorder Information centre (NEDIC). She has taught at university, college and school levels, as well as having worked as a school psychologist. She currently teaches part-time at George Brown College in the Community Services Division. Meryl has a long history of volunteer work as a rape crisis counselor, educator and consultant.

She as authored and co-authored a number of books and journal articles on issues related to food and weight preoccupation and overseen numerous public awareness campaigns. She has been included in the Who's Who of Canadian Women since 1996, and was named Woman on the Move in 1995 by the Toronto Sun.

EATING DISORDERS AND THE FEMALE OFFENDER

MERRYL BEAR

SUMMARY

Q: WHAT are eating disorders?

A Eating disorders are a cluster of physical and psychological symptoms characterized by pathological food and weight concerns. Eating disorders are about self-esteem and control, not vanity. They have the highest mortality rate of all psychiatric classifications.

Q: WHO is at risk of becoming eating disordered?

A: Ninety to 95% of individuals who develop eating disorders are women. Eating disorders are experienced by individuals from all groups of race, class, sexual orientation, and ability.

Q: WHY do women develop disordered eating?

A: Control over food and weight may be the only avenue our client has to express some control in her life. Displacing emotional conflicts onto a fear/hatred of her body may be a coping strategy which distracts her from a situation in which she feels no control.

Q: WHEN should we be concerned about food and weight concerns?

A: When our client's concerns interfere with her ability to enjoy and respect her self and her body, and impact on her quality of life.

Q: WHERE can people go for answers to their concerns?

A: The National Eating Disorder Information Centre provides information and resources on food and weight preoccupation including eating disorders. We will refer callers to available services in their area.Tel.(416) 340-4156

THE CONTEXT OF FOOD AND WEIGHT PREOCCUPATION

Most of us have gone through periods of not liking our bodies, and of trying to take "control" over them. This may have been in the form of moderating our intake of sugar and caffeine, or more rigorous exercise programs, or dieting (restrictive eating for the purpose of losing weight). What makes it harder for us is that our bodies are not seen just as the vehicles with which we move in the world: In mainstream North American culture, we have begun to judge people's abilities, characters and morals on the basis of their physical appearance. As a result, it is not surprising that many people struggle with disordered eating.

THE NORTH AMERICAN CULTURAL MEANING OF APPEARANCE

Think about it. Close your eyes, or look away from the page and list in quick succession, without censoring yourself, what descriptions come to mind when you think of a slender woman. Now do the same thing, thinking of a fat woman. When I do this exercise with groups, regardless of whether they are male, female or mixed, elementary school children, or adults, the same things always come up: Thinness is equated with self-disciple, sexiness, popularity, money, health and beauty. Fatness is equated with unhappiness, ill-health, lack of self-control, ugliness, dirtiness and laziness.

There is a continuum on which we can place food and weight concerns. They range from people who are mildly dissatisfied with their bodies and occasionally "watch what they eat" to individuals who are obsessed with the notion that their bodies are disgusting and that they are out-of-control. There are many stages between the two, but for our purposes we will explore the more extreme concerns that individuals may exhibit. It is important to note, however, that two out of three of North American women experience body-dissatisfaction: Research indicates that about 30% of normal weight and 20% of *underweight* adolescent girls want to lose weight, with as many as 60% of *underweight* girls being *satisfied* with their weight.

WHAT CHARACTERIZES EATING DISORDERS?

Anorexia Nervosa (AN) is characterized by self-imposed starvation and activities aimed at weight-loss. Most individuals with AN do not recognize how underweight they are, and even when emaciated may "feel fat".

Bulimia Nervosa (BN) is characterized by periods of uncontrollable binge-eating followed by some form of purging in an attempt to rid the body of unwanted calories. Forms of purging may include self-induced vomiting, abuse of laxatives, excessive exercise, or periods of fasting, all of which are ineffective and ultimately harmful. Individuals with BN generally experience fluctuating weight.

Binge Eating is the experience of eating large quantities of food, often those high in fat content, in a way which is driven by emotion rather than physical hunger. It may be used as a way of soothing or punishing oneself. It can be a continuation of a regular meal or initiated separately from meals. The binge is not followed by purging.

Both AN and BN are characterized by a fear of fat, which is the symbol of being out of control, and feeling ineffective and worthless for most sufferers. How

does this link with our cultural perceptions of physical appearance, and can elements of this be seen in "every-day dieters"?

WARNING SIGNS OF ANOREXIA AND BULIMIA

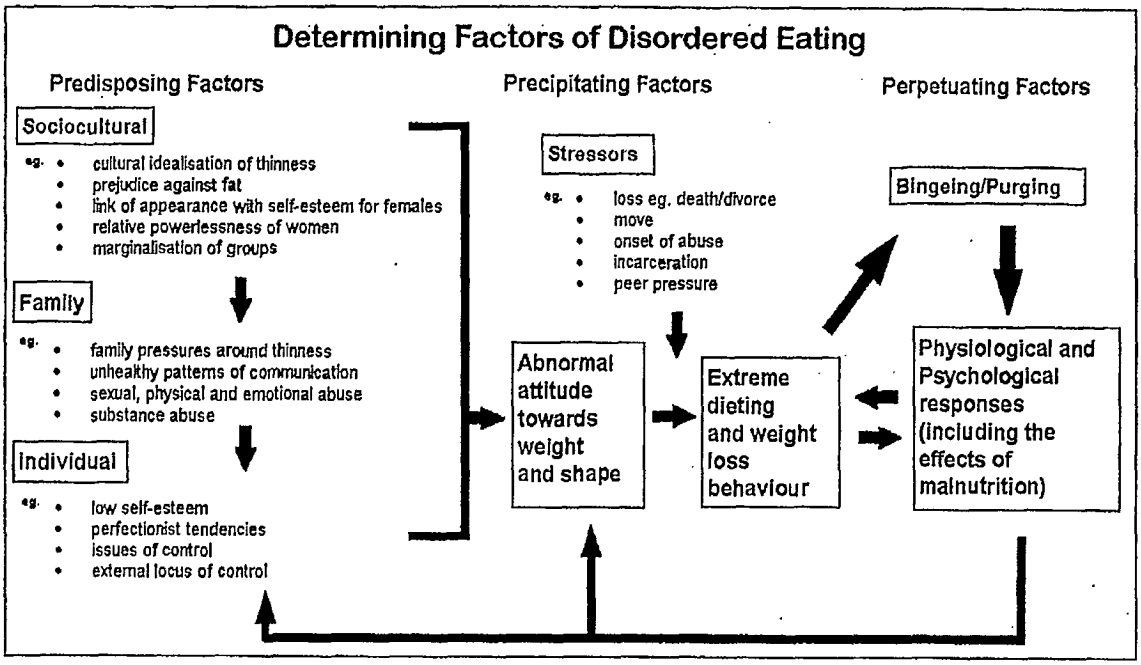
- excessive concern about weight, shape and calories
- feeling fat when not "over-weight"
- guilt or shame about eating
- strict avoidance of certain foods, particularly those considered "fattening"
- unusual eating habits
- disparagement or body shame
- irregular menstruation or loss of periods
- depression or irritability
- increased social isolation
- significant mood swings
- noticeable and prolonged weight loss in anorexia
- frequent weight fluctuations in bulimia

FACTORS CONTRIBUTING TO THE DEVELOPMENT OF EATING PROBLEMS

Consider what you know about your own experiences with "feeling fat". When are you most likely to have this feeling? What feelings is it linked to? What kinds of circumstances precipitate the feeling?

None of us develops in a vacuum. We are all influenced to some extent by the cultures that surround us, our race, class and religious affiliations.

The clients with whom you are working have had particular experiences which influence the way they think and behave. If taking control of food and weight is the only way in which your client can feel that she has some effect in her life, what does it say about her experience of her position in society?



Adapted from Garner and Garfinkle: Psychological Medicine (1980)

THE CULTURAL CONTEXT

Women have traditionally had specific roles in society. They were contrasted with men's roles, which were typically outside the home, more adventurous and risk-related. Thus our culture has come to see women as typically more emotional, more erratic, more in need of guidance and less able than men in general. This has frequently translated into a paternal attitude towards women in which decisions are made on their behalf. This may happen within the education and health-care systems, religious institutions, places of employment as well as correctional institutions. The decisions may be made by men or by women in more powerful positions than the women with whom they are dealing.

The cultural context within which we live is one in which physical, sexual and emotional abuse is unfortunately common: both within the family and without. Consider the factors which make women, and your clients in particular, vulnerable to abuse.

The consequences can be that your female clients may feel powerless and marginalised. Where they do not have the resources to deal with this, they may turn to taking control over the only aspect in their lives that the can: their bodies, and food intake.

Most people do not realize that like height, weight and shape are genetic features that we inherit. While our environment and lifestyles influence weight, despite what the fashion and advertising industries continually tell us, we cannot alter our set-point, which is the genetic weight range around which, with healthy

eating and healthy exercise, we naturally fluctuate. Dieting is thus the first behavioural step towards developing an eating disorder.

FAMILY INFLUENCES

Families may also increase the client's vulnerability to developing eating problems, in a number of ways such as: increasing the person's sense of not being in control of her life, poor conflict resolution, abuse issues, the modeling of inappropriate food and weight attitudes, and substance abuse issues.

INDIVIDUAL FACTORS

Certain unique experiences and characteristics may increase the risk of your client developing eating problems. They generally include a low sense of self-worth, and hence a sense of ineffectiveness. The client may feel that she is always needing to please others, and feel that she must achieve certain standards or else she is worthless. Often this person feels that she is never "good enough" and tends to think in dichotomous ways: she is either first or she is last, if she is not thin then she is fat, etc.

When an individual who is vulnerable to psychological disturbances develops within a climate which glorifies abnormal food and weight behaviours, suggesting that being thin will bring self-control, popularity and success in all its forms, it is easy to understand how a stressor could tip the person over into disordered eating behaviour.

STRESSORS FOR THE FEMALE OFFENDER

A female offender may feel even less in control of her life and this may intensify the need for her to take control in whatever way she can. Consider the clients whom you see: What factors may be present in their lives that may act as a catalyst for food and weight preoccupation? Imminent release? Incarceration? Strip searches? Lack of privacy? Mandated behaviours? Loss of parenting roles? Being surrounded by authority figures? A history of physical, sexual and emotional abuse? Sometimes we make assumptions about what is most salient for the individuals with whom we work, instead of sensitively providing them with the opportunity to explore their own experiences and coping strategies.

In the correctional system the means of dealing with eating disorders is sometimes to label the individual as being on a hunger strike, and putting them on a "food-watch". This can heighten the offender's need for secrecy.

SEX TRADE WORKERS

Our clients who use their bodies in commercial trade, much like pregnant women, may find themselves ambivalent and hyper-conscious of their bodies. These women may feel an uncomfortable mixture of pride, fear and down-right hatred for their bodies and how their bodies are considered "public" property. Their work and personal histories may heighten feelings of vulnerability, exposure and lack of autonomy and choice.

PERPETUATING FACTORS

The very behaviours in which your client is engaged may make it harder for her to stop: The effects of starvation can cause physical and psychological responses which perpetuate the behaviour.

CONSEQUENCES OF RESTRICTIVE EATING BEHAVIOUR WHICH MAY PERPETUATE EATING PROBLEMS:

- preoccupation with food
- a desire to binge-eat
- mood swings, with increased irritability and depression. Depression may be both a physiological response to malnourishment and an emotional expression of the dissatisfaction caused by all the rules and regulations of a diet which result in a sense of being deprived and punished.
- social withdrawal - combined with the fact that many social outings revolve around food, moodiness/depression make social interactions less satisfying and can lead to social avoidance or conflict.
- lowered sexual interest (ironic, since being thin is equated with being "sexy")
- impaired concentration and judgment, which increases the difficulty of seeing her problems and seeking help
- physiological consequences such as lowered heart rate, body temperature, respiration and basal metabolic rate.
- discomfort with normal quantities of food, leading to bloating and a resistance to normalizing eating patterns.

As is clear, it is not realistic to expect a client with food and weight preoccupation to just "snap out of it". Professional assistance and education is required. Without addressing the underlying problems, your client is unlikely to be able to recover from her eating disorder.

SOME SPECIAL CONCERNS AND DISORDERED EATING

As you can imagine, being in any way "different" challenges even women with good body-image, or those who've planned the changes in their body. It is more difficult for our clients who are vulnerable to food and weight concerns to tolerate and nurture changes in their physical condition.

Insulin dependent diabetes (IDDM): women with IDDM may fail to report dieting, binge-eating and insulin omission to lose weight or to prevent weight gain, because of feelings of shame or fear of criticism. Such behaviour can however have serious and long-term medical consequences.

Fertility and pregnancy: women with eating problems generally have poor fertility levels, more problematic pregnancies and less healthy babies. However, stable remission of the disordered eating will enable a normal pregnancy and infant.

Disabilities: Our clients with disabilities may be at increased risk of eating disorders in that they may have additional experiences of loss of control and an increased pressure to look or be "acceptable".

Addictions: Some individuals will use alcohol or narcotics to replace a binge, or to lower resistance to bingeing. Many women use tobacco in the place of food.

WORKING WITH DISORDERED EATERS AND FINDING RESOURCES

Since disordered eating is an issue of self-esteem and control, how does your client's behaviour help her to structure her life and take control in the only way that seems possible to her?

We need to take a "two-track" approach to clients with eating problems: both her eating behaviour and the root causes need to be addressed. Our clients can only make changes to their habits at a pace tolerable to them. In the same way that we all tend to revert to known or self- comforting patterns of behaviour, it is to be expected that letting go of well-established eating patterns which give a sense of control will be difficult, especially if the individual's dealing with difficult issues in her life. "Slips" are to be expected along the road to recovery.

Sometimes we find it very frustrating and difficult to work with eating disordered individuals: it is hard to constantly encourage a person to deal with her issues in a healthier way when malnutrition and fear make her resistant to healthy lifestyle changes.

The most important thing that we can do for anyone in this situation is to be educated, understanding and patient. When the issues are beyond our abilities to handle, the individual should be referred to an expert in the area of eating disorders.

The National Eating Disorder Information Centre has a national resource directory of clinicians working in this field. A wide range of written information on disordered eating is also available:

The National Eating Disorder Information Centre
200 Elizabeth St., CW1-211
Toronto, Ontario
M5G 2C4

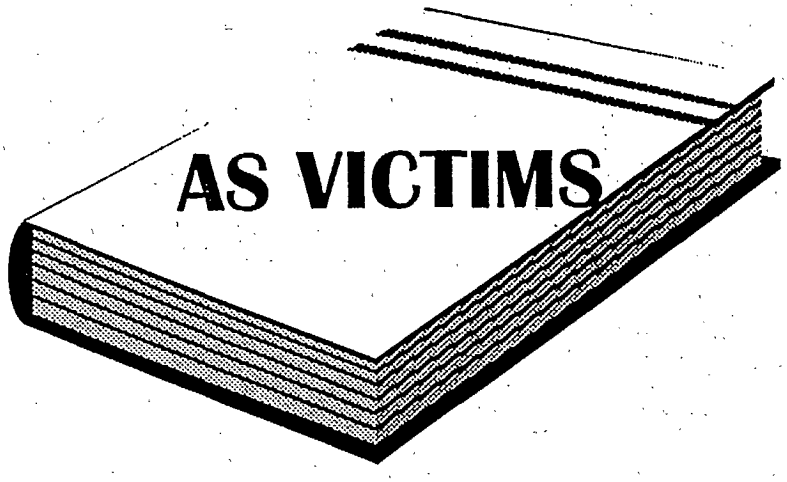
BIBLIOGRAPHY

Eating Disorders: An Overview. The National Eating Disorder Information Centre. Toronto
Extensive information on the causes, treatment and biology of eating disorders.

Intuitive Eating. Tribole, Evelyn & Resch, Elyse, (1995) St. Martin's Press. New York.
A good resource for understanding the dynamics of dieting, and strategies for healthy relationships with food and body.

Consuming Passions: Feminist approaches to weight preoccupation and eating disorders. Catrina Brown and Karin Jasper (eds). (1993) Second Story Press. Toronto
A wide range of issues relating to food and weight preoccupation is discussed.

For a detailed list of recommended readings contact:
The National Eating Disorder Information Centre
200 Elizabeth St, CW1-211
Toronto, Ontario M5G 2C4
tel: (416) 340-4156 fax: (416) 340-4736



AS VICTIMS

WORKING WITH FEMALE VICTIM/SURVIVORS OF PARTNER ABUSE
ROGER NEWELL

WORKING WITH FEMALE SURVIVORS OF SEXUAL ASSAULT
PAM SKINNER

WORKING WITH FEMALE VICTIMS/SURVIVORS OF PARTNER ABUSE

WRITTEN BY:

Roger Newell has worked for 10 years as a Senior Staff Development Officer and has been responsible for training in the area of Domestic Violence for much of that time.

Previously, he was Chief Social Worker at Bluewater Centre for Young Offenders and a Probation and Parole Officer in London, Ontario. As a Probation and Parole Officer he conducted groups for men who had assaulted their partners. Also, he was seconded to help in the creation of "Changing Ways", a community agency which continues to conduct psycho-educational programs for men.

Roger has been actively involved in addressing the issue of domestic violence since 1982 and has conducted workshops across Canada with special emphasis on working with male perpetrators of domestic violence. His current interest in this area centres around risk assessment.

WORKING WITH FEMALE VICTIMS/SURVIVORS OF PARTNER ABUSE

ROGER NEWELL

SUMMARY

- 77% of all female corrections clients have experienced physical or sexual abuse according to a 1992-92 survey.
- Intimate partner abuse is about using intimidation and threat tactics at a specific target, not about using intimidation and threat tactics at a specific target, not about anger management deficits per se.
- Victim/survivors are responsible for their own safety in the members of the social support network.
- Understanding the 5 stages out of battering allows helpers to provide stage specific support.

In the general population, one-quarter of all women have experienced violence at the hands of a current or past marital partner (includes common-law unions). More than 1 in 10 with reported violence in a current marriage have at some point felt their lives were in danger. These are key findings of a Statistics Canada Survey of 12,300 women, 18 and over that describe what is happening in the general population.

In our institutions and under community supervision, a 1991/1992 survey found that 77% of the adult women indicated they had experienced physical or sexual abuse. Clearly, the majority of the women in our institutions and community supervision caseloads are victim/survivors of domestic violence or date violence.

It is crucial to understand what is meant by wife/partner assault. I will use the words "wife assault" in this definition, however, the definition applies to common - law partners, same sex partners and date violence. Also, this definition includes physical, sexual, emotional/psychological abuse.

Wife assault involves the intent by the husband/partner to intimidate either by threat or by use of physical force on the wife's person or property. The purpose of the assault is to control her behaviour by the inducement of fear. Underlying all abuse is a power imbalance between the victim and the offender.

Deborah Sinclair, Understanding Wife Assault

Question: Is wife/partner assault an anger management problem?

According to the definition, it is not. Rather, it involves the intentional intimidation of a targeted person for the purpose of gaining power and control over her.

"Fear is a woman's worst enemy. Fear serves to paralyze women, holds us in place, saps our energy and imagination. Fear keeps us close to home. It silences us. And if we wait until we are unafraid, or fixed, or analyzed, we may have waited too long."

Harriet Godhor-Lerner

Two working assumptions for spousal assault cases are as follows:

1. The victim/survivor is responsible for her own safety in the context of social support for her effort.
2. Domestic violence is a public, not a private matter.

Given these working assumptions, it is reasonable to address the question: "What support do we have to offer victims/ survivors in their efforts to take responsibility for their own safety?"

The usual focus is on providing information about community resources such as "safe houses" or battered women's advocacy clinics (where they exist), the use of the police and other public safety services, etc. While helpful, this is not enough. It is also important to attend to the stage in the "battered women's" experience. Where she is in the stages out of a violent relationship will provide direction in how to work with her.

5 STAGES IN THE BATTERED WOMEN'S EXPERIENCE

Stage 1: *Denial*

An abused woman's most common response to early battering incident is to say that there is a problem. Denial is a common human response to any traumatic experience.

Stage 2: *Blaming Herself*

Guilt and turmoil characterize the woman's feelings as she begins to recognize that she is battered. Three factors contribute to her self-blame:

- the abuse make her doubt her worth and she begins to believe she deserves the abuse
- others blame her

- she needs to feel some power and gets this by trying harder to do things that he says provoke his violence

Stage 3: *Seeking Help*

Reaching for help can be a difficult experience. People may have difficulty believing her, she finds that involving the legal system does not necessarily lead to her protection and sometimes helpers lack an in-depth understanding of her situation.

Stage 4: *Ambivalence*

Those who wok with abused women say that 80-90% of women leave and through this ambivalent stage, potential helpers can become very frustrated and they may want to give up on her. This stage can be short or last for years.

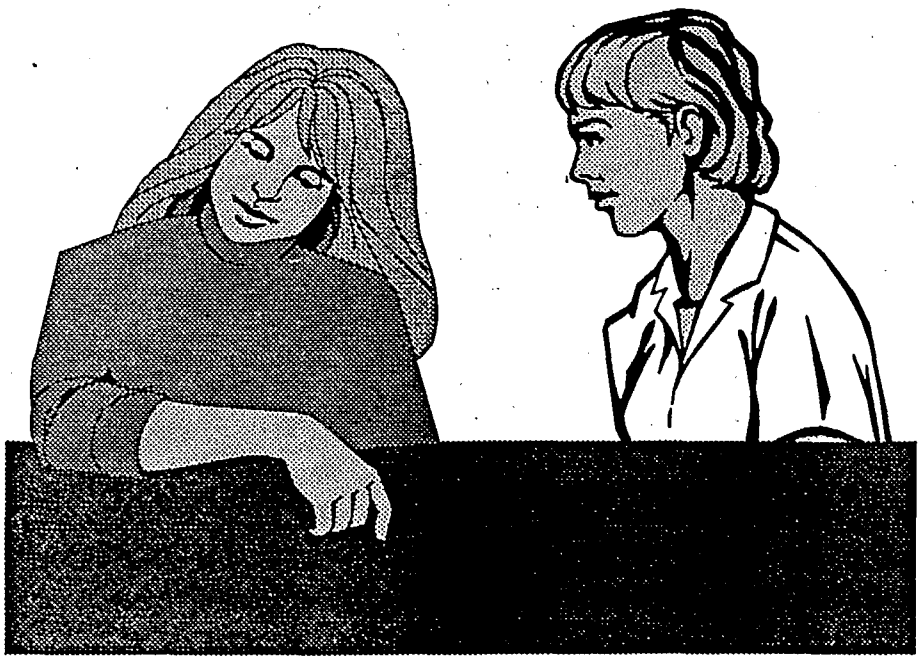
Stage 5: *Living Without Fear*

After leaving an abusive relationship, it can take a long time to begin to live without fear.

Battered women often harbor untold stories of violence for many good reasons. The deeper our understanding of the dynamics of violence and the reasons why women remain in violent relationships, the more we can act in ways that build trust. This can lead to better assessment and appropriate "stage sensitive" interventions. Awareness of the stages is a good first step. Expressing concern about safety of the women and children (if she has children living at home), and providing the woman with stage specific information that meets her immediate needs is the central to effective work with this client group.

We in the criminal justice system are often the first people the victim/ survivor talks with who are interested in hearing about the violence and supporting her with regard to her safety. This is the opportunity.

WORKING WITH FEMALE SURVIVORS OF SEXUAL ASSAULT



WRITTEN BY:

Pam Skinner has 19 years of experience working in various parts of the Ministry of Solicitor General and Correctional Services. For the last seven years she has been working out of Bell Cairn Staff Development Centre, delivering training and providing consulting services in organizational development; change management; and team enhancement through-out the ministry. Most recently, Pam has moved to the Ministry of the Attorney General for one year as the Executive Assistant to the Assistant Deputy Minister of the Integrated Justice Corporate Services Division.

WORKING WITH FEMALE SURVIVORS OF SEXUAL ASSAULT

PAM SKINNER

STATISTICAL INFORMATION RE INCIDENCE OF SEXUAL ASSAULT

- 1 in 4 women will be sexually assaulted at some time in her life.[1]
- Incest is devastatingly common among both children and teenagers. An estimated 1 girl in 3 and 1 boy in 7 are victims of this form of sexual assault.[2]
- Where estimates are that 1 in 4 (25%) of women will be sexually assaulted in their lifetime, a 1991/92 survey of female offenders in our ministry indicated that 48% had been sexually abused at some point in their lives, with 34% reporting child sexual abuse. Two-thirds of those who had been sexually abused reported it as a regular/occasional experience rather than an isolated event.
- 58% of young offender females reported being sexually abused, much of it occurring during childhood.[3]
- Every 6 minutes a woman in Canada is sexually assaulted.[4]
- One half of all Canadian women have experienced at least one incident of sexual or physical violence.[5]

IMPACT OF SEXUAL ASSAULT

A victim of sexual assault is at significant risk of severe and long term psychological and physiological health problems. These include depression, nightmares, flashbacks, eating disorders, self injurious behaviour and more.

The effects of and reactions to sexual assault are highly individualized. Any reaction or perceived lack of reaction can be consistent with having been sexually assaulted. The way a woman copes with sexual assault depends on:

- her internal strengths
- her coping mechanisms
- her family and social support structures
- the nature of the crime itself and how long ago it occurred
- how many times the woman has been re victimized

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[1] Brickman, J & J. Briere, "Incidence of Rape and Sexual Assault in an Urban Canadian Population", The International Journal of Women's Studies, 7(3), 1984.

[2] The (Badgley) 1984 Report of the Committee on Sexual Offences Against Children and Youth, Ottawa, Canadian Government Publications.

[3] Ontario Women in Conflict with the Law - Draft Report - Research Services, Ministry of the Solicitor General and Correctional Services, 1992.

[4] National Survey Ottawa; Health Canada, 1996.

[5] Statistics Canada, "The Violence Against Women Survey", 1993.

- the reactions, attitudes, timeliness, and quality of support provided by those with whom she has had contact after the assault

Some observed symptoms and responses may be characterized as common. These include:

- extreme mood swings from feelings of helplessness to anger, sometimes resulting in a strong need for control
- feelings of degradation, shame, embarrassment, guilt
- lowered self-esteem, an increase in internalized sexist attitudes
- minimizing, rationalizing, or forgetting all or parts of the assault
- substance abuse, in an attempt to "self-medicate". It is estimated that 74% of alcohol and drug *addicted* women have a history of sexual abuse/assault.[6]
- depression
- eating disorders
- sleep disturbances, including nightmares
- flashbacks of the assault or of parts of it
- "spacing out", splitting, and dissociation, including multiple personalities
- suicide attempts – sexual assault victims are 8 times more likely to attempt suicide than non-victims.[7]

Eighty-two percent of sexually assaulted women report that the attack permanently changed their life.[8]

THE CONNECTIONS BETWEEN SEXUAL VICTIMIZATION AND ILLEGAL ACTIVITY

Having been previously sexually victimized increases the probability that a woman will participate in illegal activities. Some people who are anxious, angry about problems they feel helpless to address, or who are experiencing stress based on unresolved issues such as child sexual abuse respond in ways that are socially acceptable and socially adaptive, such as being "very, very good girls". Others, under those same life conditions, will respond in aggressive, self-destructive, conflict producing ways that can set the stage for criminal behaviour. Both extreme responses, that of being compulsively "very, very good", and that of falling into being "very, very bad", are understandable, and are two ends of a very wide continuum of behaviour.

Sexual victimization can result in the victim/survivor experiencing extreme emotional pain, re victimization, an inability to succeed in school or work situations, and seeing her body as the way to negotiate male power in the world. Victims/survivors often live in poverty. These results of sexual victimization are directly related to crimes of fraud, substance abuse, and prostitution, as well as being indirectly related to many other offences.

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[6] Solicitor General of Canada, "Female Victims of Crime", bulletin 4 Canadian Urban Victimization Survey , 1985.

[7] Gordon, M.T. and S. Riger, The Female Fear, New York, The Free Press, 1989.

[8] (Draft) Interdisciplinary Training Package on Sexual Assault, Ontario Women's Directorate.

If you are working with incarcerated women, it is important for you to recognize that the process of incarceration structurally recreates the dynamics of abuse in three primary ways:

1. Regarding **power**, there is a tremendous power imbalance between the system and the inmate in day-to-day life, just like the power imbalance between the abuser and the victim.

2. Regarding **trust**, the degree of control exerted by the system sends the message that inmates cannot be trusted, and that they cannot trust the system, just the mistrust that victims experience toward their abusers and, in the case of child abuse, toward those people in authority who did not protect her.

3. Regarding **stigmatization**, inmates are explicitly told that they are bad and are being punished because of that, just as many abusers justify the abuse by telling the victim that she is bad, dirty, irresistible, etc., and she is punished for that.

For women of colour, aboriginal women, women with disabilities, and lesbians, the tremendous power imbalances are heightened, and experienced as abuse.

TWELVE GUIDELINES FOR TALKING ABOUT PREVIOUS SEXUAL ASSAULT

✳1. *Discuss the Ontario Ministry of Solicitor General and Correctional Services guidelines in order to provide a framework for informed disclosure.*

You have certain reporting obligations with regard to knowledge of criminal activity which you are expected to follow. When offenders disclose to you that they have been sexually assaulted, whether it was yesterday or 20 years ago or more, you have an obligation to report this knowledge to the police. Refer to the *Protocol for Contacting Police*, December 1992. Additional policies that speak to this requirement include requirements to report when a child is at risk of abuse. This may apply when, for example, you discover that the father who sexually assaulted a client when she was a child has children living in his home.

Historically, crimes of sexual assault and wife assault have often been viewed as private matters and not taken as seriously as other crimes of assault or property crimes. Prosecution of these crimes has been spotty, and in most cases, difficult, and there have not been adequate services for victims to work through the feelings of stigma and rebuild their lives. All of these factors have influenced the hesitance of those who know about these types of assault to report the crimes to the police.

Many of these factors have been altered by growing awareness of the seriousness and long-term effects of the sexual assault. Research is showing that when abusers are brought before the criminal justice system, later abuse by those offenders is prevented or significantly lessened. Prosecution of these crimes sends a

message to society that this type of assault will not be condoned by silence, aiding in the prevention of sexual assault in general. As well, as more services become available, victims of these crimes are able to get some of the support that they need, often helping them break their silence caused by the false belief that they somehow "deserved" the abuse.

A problem remains, however, as once an assault is reported to the police, the investigation of that crime is not under the control of the victim/survivor. This may feel to the woman that her choices are once again being violated, and if she is not the person who reported the crime to the police, her relationship with the person who did may be severely affected.

The purpose in reporting is the attempt to create safety by ensuring that we do not collude with abusers by maintaining secrecy, and to attempt to hold suspected abusers accountable.

For these women who disclose past assault, and then have the someone that they trusted report that assault to the police, "for her own good" and for society's good, it can feel like a further betrayal. It is imperative to do all we can to maximize the positive outcomes of reporting for society and for the individual, while minimizing any potential difficulties and possible re traumatization.

In all cases, therefore, when working with women offenders:

- Let her know of the limits of confidentiality and your reporting obligations, in order to allow for more informed discussion, choice, and disclosure.
- Let her know why the policy is in place; articulate the commitment to end abuse both within institutions and within society in general; inform her that most abusers re-offend if not held accountable for their actions.
- Let her know that once the report is made, she will not have direct control of how that information is used; let her know, however, that many times prosecution cannot go forward because of the difficulty of obtaining evidence, unless there have been previous complaints against the accused.
- Attempt to be clear and straightforward about what will happen if she discloses identifying information, and why it will happen.

If you do need to make a report:

- Inform the woman of what you must do; do not report behind her back.
- Ask her how she feels about your duty; in some cases she may be grateful that you are doing what she may feel she cannot do.
- Ask how this impacts on her safety and her life situation (for instance, if she is on probation or parole and the accused is a family member with whom she is in contact), and on her relationship with you as a support person. Problem solve

around these issues; offer her the opportunity to receive support from someone else, if she chooses and it is possible.
- Continue to offer information and support about whatever action is being taken as a result of the reporting, even if she has chosen to go to someone else for support surrounding the sexual assault.

2. **Know yourself and your own skills.** It is your responsibility to decide to what extent you are able to work with the woman on these issues. Most women will need some long term support and counselling to help their healing process. You can explain your role and its limits to the woman and discuss with her that you can refer her to someone who has more experience working with sexually assaulted women, if she chooses. Even in small interactions, however, you can reinforce her strength as a survivor, and that she is not responsible for the assault/abuse she suffered.

3. **Do not ignore the topic of sexual assault.** Women have often spent many years in counselling and have never been asked if they were sexually abused, although their lives are still affected by that traumatic experience. Even without asking, you can talk about it. "Sometimes women who have been sexually assaulted experience what you are experiencing because they blame themselves instead of their attacker, who deserves the blame.

4. **In assessment, recognize symptoms and behaviours which might be linked to an experience of sexual assault.** The immediate problem might be an addiction to drugs or alcohol, eating disorders, suicidal feelings, self abuse, or sexual problems.

5. **Be alert to hints from a woman that she has been assaulted and wants to talk about it.** If you are too cautious, you can give the message that sexual assault is too dangerous to talk about. However, neither should you push a woman if she is not ready to discuss the issue.

6. **Be ready and respect the woman's pain.** Remind yourself that crying is a healthy response and releases stress which the woman might have felt for years. Use your intuition about how to respond and comfort the woman. You can use reflective, empathic listening and try to describe the woman's feelings. You can say: "It is so painful for you to talk about this." "It is upsetting for you to remember this in all its detail." "You feel so helpless when you think about how he took advantage of you." "You feel sad that you had to go through all this." "It is good to cry, it will help you to heal the pain."

7. **Validate anger as a sane, healthy response to abuse, and encourage the woman to express it.** Remember that the anger is not directed against you and that it is helpful for you to assist the woman in dealing with her anger. You can use reflective listening: "I can see how angry you feel, and you have every

right to feel that way." "It is good that you can free that anger that has been bottled up in you for so long."

8. **Remember to emphasize the courage it took for the woman to disclose her sexual assault.** Tell her how many women never reveal their sexual abuse and how it can affect their entire lives. Providing positive feedback for revealing painful experiences can help the woman rebuild a positive self image.

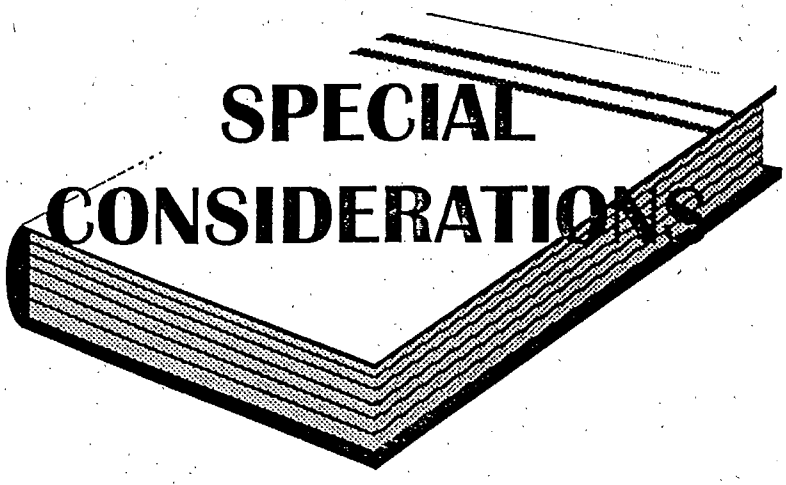
9. **If you don't understand what the woman is trying to tell you,** ask for clarification in a helpful way. Do not interrogate her, or doubt the truthfulness of what she stated earlier. "I'm confused. I might have misunderstood what you said earlier. Could you explain again to me, what happened. . .?"

10. **Paraphrase at appropriate times,** and try to summarize the conversation from time to time. This gives the survivor a chance to ground herself in the present, and know that you have understood what she has said.

11. **Collect information about other services in your facility and your community for sexually assaulted women,** refer the woman to appropriate services, and check with her about what kind of support system she currently has.

12. **Encourage her to express and manage her emotions.** If she cannot put feelings to her experience yet, feeling numb, she probably has not yet had a chance to integrate the memories and the feelings. At the other extreme, help her find ways to feel in control of overwhelming feelings or flooding memories.

(Adapted from Bass & Davis, *The Courage to Heal*, 1988, and the Guelph Crisis Centre Manual)



SPECIAL CONSIDERATIONS

- *MOTHERHOOD AND PARENTING ISSUES FOR WOMEN OFFENDERS*
  CATHERINE MAUNSELL

- *LESBIAN AND BISEXUAL WOMEN*
  CATHERINE MAUNSELL

- *ETHNOCULTURAL CONSIDERATIONS*
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  CAROL MONTAGNES

- *ADOLESCENT FEMALE OFFENDERS*
  ROGER NEWELL

MOTHERHOOD AND PARENTING ISSUES FOR WOMEN OFFENDERS

WRITTEN BY:

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MOTHERHOOD AND PARENTING ISSUES FOR WOMEN OFFENDERS

CATHERINE MAUNSELL

SUMMARY

- For most incarcerated women who are mothers, this is the central and most significant facet of their identity.
- 70% of women offenders have children and 76% of these children are of dependent age.
- Society places a higher expectation on mothers than fathers for the care of children.
- Dwindling resources in the community mean that single mothers are among the most disadvantaged in our society.
- Being in conflict with the law does not mean women are "unfit" as mothers.
- Women offenders represent a range of parenting responses and skills.
- Where healthy mother-child relationships exist these should be encouraged to minimize damage to children.
- Each parent-child situation should be individually assessed to determine whose needs contact will serve.
- Children often experience the separation from their mothers as traumatic and upsetting.
- While women caught in the power of an addiction may not be able to parent effectively at this time, we should not be judging the legitimacy of their concern for their children.
- Visiting areas in institutions and probation offices should be child-friendly.
- Sentenced women are to be placed using the "least restrictive option" thus appropriate women could be returned to the community (Community Resource Agreement bed, Extended Temporary Absence Pass - ETAP, Electronic Monitoring - EM) to continue providing child care.

MOTHERHOOD AND IDENTITY

For almost all incarcerated women with children, being a mother is central to their identity, to their view of themselves and may represent the only facet of their lives about which they feel good. Their role as mother provides a "reason for being"; in some cases motherhood is the most important identifier in lives otherwise devoid of happiness or a sense of achievement.

Women's conflict with the criminal justice system, although traumatic and disruptive for their children, should not be used to justify assertions that they may be inadequate to parent. Within the correctional system, we may see women with active addictions, psychiatric difficulties or trauma and abuse histories that have left them ill-equipped to respond to the needs of dependent children. While they may desperately want to see themselves as effective and loving mothers, they are too preoccupied with their own overwhelming issues to provide appropriately for their children. On the other hand, there are women who have managed to create a stable and nurturing environment for their children. Their difficulties with the criminal justice system create a traumatic interlude and disruption to their children but do not represent an inability to parent appropriately. As correctional professionals, we need to recognize and value the fact that many incarcerated women are parents. We need to ensure that we make a careful assessment of each woman's current relationship to her children, the overall parent-child situation and establish an individual plan sensitive to the needs of the child and the parenting abilities of the mother.

WOMEN WITH CHILDREN: THE NUMBERS

Shaw's data (1994) show that almost 70% of women offenders have children and among those 76% of the children were of dependent age (i.e. 16 or under). 80% of those women were single parents for all or part of the children's lives. Over 50% of the women had to make alternative care arrangements when they were incarcerated.

WOMEN'S RESPONSIBILITIES FOR CHILDREN

It is generally recognized that our society places a higher expectation on mothers for the care of their children than it does on fathers; the burden of care for children remains with women. Single mothers often get blamed for their status; yet this is a safer option for themselves and their children when they decide to leave abusive relationships. Economically in our current society, the choice is a difficult one. Welfare payments are being cut and community child care options are dwindling. Mothers trying to raise children alone remain among the most disadvantaged in our society.

"FITNESS" AS MOTHERS

We sometimes find women offenders labeled as "unfit mothers" based on the fact of their criminal offence involvement alone. Years of experience with foster and group home placements have shown the difficulties inherent in placing children in surrogate homes. Women offenders represent a range of parenting responses and skills. Custody issues may be a focus for some mothers. Where parents are

involved in a custody battle, the woman's incarceration can be used against her, in an attempt to prove her an unreliable parent. Some women are obviously emotionally dependent on their children and look to them to meet their own unmet needs, clearly not a satisfactory situation for children. Other mothers have been providing stable and appropriate child care but have become involved in conflict with the law due to their inability to deal with some of their personal issues. In each case, we need to look to see whether assisting women to resume their parental roles to the fullest extent possible (via visits, weekly Temporary Absence Passes, Community Residential Agreement placement, Electronic Monitoring, Extended Temporary Absence Passes or parole) is within their current capabilities and whether it serves the best interests of the child(ren). Of course, this also occurs within the context of overall community safety.

CONTINUING RELATIONSHIPS WITH CHILDREN

Most mothers, but not all, will want to maintain contact with their children during a period of incarceration. It then becomes the role of institutional staff to make some assessment of the appropriateness of facilitating contact with children. In terms of what we already know about the impact of placing children in foster/group home setting, we should operate from the principle that where healthy/stable mother-child relationships exist, these should be encouraged to minimize damage to the children and motivate mothers to embrace their own efforts at healing, recovery and reintegration. There is no doubt that children who are well connected to their mother experience the separation as traumatic and upsetting. They may display new and unusual symptoms - withdrawal, refusal to attend school - as a way of communicating their pain. The separation is also a major hardship for incarcerated women.

We also know that fostering healthy family ties plays a significant role in reducing the risk of re-offending. As we develop an individualized plan appropriate to each mother-child situation, we must take into account the following issues:

- What is the mother's overall emotional stability?
- Are there past or current psychiatric issues
- Are any child care agencies (CAS) involved with this mother and child?
- Are there previous children who have been given up for care/adoption?
- Is the woman addicted to either drugs or alcohol?
- What has been the past history of involvement with the child? Living together, intensity of contact? How connected is the child currently to the mother?
- Will contact destabilize (create suicidal feelings) the mother?
- What significance will contact have for the child? Is it in the child's best interests?
- What are the long-term possibilities for continuing mother-child involvement? Will they be living together on release?
- Whose needs will the contact meet?
- Are spouse, extended family members or other sponsor's supportive of this contact?

ADDICTED MOTHERS

It is not uncommon to hear both offenders and staff dismiss women with addictions who talk about their child care concerns. Some see these women as using the children as an excuse to get out and get drugs. We should never underestimate the power of an active addiction, but its presence does not negate the possibility of genuine care and concern for children. It generally means however that this mother, with an untreated addiction, should not be considered ready to resume parental responsibilities. Again as we look at society's disapproval of the addict, this censure seems to fall more heavily on the backs of addicted mothers because as a society we expect them to carry the major responsibility for the raising of children.

VISITS AND PASSES

Traditionally, our correctional institutions have not been designed with the special visiting needs of women and children in mind. Contact visits in a friendly, non-threatening environment, perhaps with a rocking chair and some appropriate toys and activities for children, would be the ideal.

A lot of women decline visits with their children because of the unsatisfactory environment. In addition, many feel that the visits bring painful feelings to the surface for both parent and child. Some feel it is more stabilizing for the child not to be on the emotional roller coaster of visits and separation. Some women report feeling judged about being single mothers.

One way to minimize the negative impact of inhospitable institutional visiting situations is to consider passes in the community for women offenders with children. Our ministry promotes the concept of the least restrictive option for all sentenced men and women. Providing ongoing child care or maintaining regular comfortable contact with children ought to be seen as a legitimate rationale for weekend passes or for placing suitable, low risk women in a structured community agency or in their own homes on Extended Temporary Absence Pass or Electronic Monitoring.

WOMEN ON PROBATION

In light of our earlier discussion we can expect that many women on probation will be mothers with dependent children and limited financial resources. Single mothers lacking family support will want to arrange reporting in a way that does not conflict with parenting responsibilities or they may be obliged to bring young children with them to the office. Any attempts to make the waiting area more child friendly - toys, children's books and chairs - would send a positive signal to the mothers and make the process of reporting a less stressful, and more positive experience.

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LESBIAN AND BISEXUAL WOMEN

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LESBIAN AND BISEXUAL WOMEN

CATHERINE MAUNSELL

SUMMARY

- A number of women within the correctional system will be lesbian or bisexual
- Homophobia, fear of and hostility towards homosexuals, exists inside and outside corrections and leads to stigmatization and self-hatred.
- Self-awareness is important as staff and residents unfamiliar with lesbian or bisexual women may feel some initial discomfort in working together.
- Homosexuality is no longer viewed as a dysfunctional mental disorder.
- The world functions on the basis of the heterosexual assumption and we were all - homosexual and heterosexual alike - raised this way.
- Appropriate lesbian positive resources in the health centre, the library and on units and in offices, help create a positive environment.
- Lesbian and bisexual women fear that their orientation may be used against them in custody battles.
- The prevalence of addictions among these women may be due to self-medication to deal with internalized homophobic attitudes.
- It is the responsibility of all staff to create an environment that is accepting of lesbian and bisexual women as discrimination is prohibited under our Human Rights Codes.

DEFINITIONS

It may be useful to begin with some definitions borrowed from Bonnie Simpson (Opening Doors).

"Sexual orientation refers to an individual's predisposition to experience physical and affectional attraction to members of the same, the other or both sexes. Established early in life, it is the result of a little understood but complex set of genetic, biological and environmental factors. Sexual identity describes the conscious integration of sexual orientation into an individual's self-definition."

Lesbians, then are women who are attracted to other women. Like heterosexual women, lesbians identify themselves as female and are satisfied with being women; they do not wish they were men. Bisexual women may be attracted to either men or women. Lesbians and bisexuals have been around as long as heterosexuals, though precise numbers are unknown.

Many studies have tried to estimate the percentages of lesbians and bisexual women in the population but this has been difficult due to the invisibility and stigmatization associated with same-sex orientation. Sometimes it is unclear what is being measured - public identification or behaviour. We can probably say that same-sex orientation is more common than being left-handed or over 6.5 feet tall but does not occur as frequently as opposite-sex orientation.

We can expect therefore that a significant number of women within the offender population will be lesbian or bisexual. In fact, if we look at the data on young people that come to the attention of residential agencies and social service agencies, we see a higher than expected proportion of lesbians, bisexuals and gay youth, perhaps because of the anti-gay discrimination these young people face at home and on the street.

Recent data indicates that about 30% of young people who commit suicide are lesbian, bisexual or gay as are 20%-40% of youth living on the street (O'Brien, Travers & Bell, No Safe Bed). This group is also at risk for substance abuse and survival prostitution. It is not then a great leap to expect that we may see a somewhat larger percentage of lesbians or bisexuals within a correctional setting than would occur in the general population.

HOMOPHOBIA

The myths, fears and sometimes, outright hostility, associated with homosexuality are generally referred to by the term homophobia. Lesbians, bisexuals and gay men are labeled unnatural, a threat to the values and ideals of the nuclear family or even mentally ill. Those who work in correctional and social services have sufficient experience to know that the nuclear family itself is not necessarily a haven of safety and emotional health. Homosexuals, like heterosexuals, can be stable and productive or they can have psychological problems, be struggling with substance abuse or any other human issues.

The widespread occurrence of these negative beliefs has led to a stigmatization of lesbians, bisexuals and gay men. Many have chosen to "stay in the closet" rather than disclose their sexual orientation. Discrimination and gay-bashing are still realities. Families often have difficulty accepting a lesbian, bisexual or gay child. "What did we do wrong?" is a frequent question. It is, however, a well known fact that most homosexuals have heterosexual parents! While parents may be struggling with their feelings about homosexuality, perhaps their own homophobic attitudes, their children are looking for continued love, support and understanding. The child or adult "coming out" to parents does not see that the parents did something wrong to make them that way. They simply wish to be accepted as themselves, for what they naturally are. The correctional client who identifies herself as lesbian or bisexual is also looking to be accepted as she is and treated with the same respect accorded other heterosexual residents.

These views, so pervasive in society, are also likely to be found amongst both staff and inmates at correctional facilities. What can we as correctional staff do to create a more positive, non-discriminatory environment for lesbians and bisexual women in correctional settings?

EVALUATING OUR OWN BELIEFS: SELF-AWARENESS

As staff, it is our responsibility to examine our own attitudes and biases as honestly as we can. Sometimes when people have not had exposure to a different cultural group for instance, they may feel uncomfortable or uncertain. Sexuality is generally a fairly loaded subject so that heterosexuals who have not had exposure to lesbians or bisexuals may feel uncomfortable. Some counsellors and therapists have often found an unexpected level of discomfort when counselling lesbians, bisexual or gay couples. This work will inevitably force individuals to face their personal feelings about homosexuality and their own sexuality.

It is worth remembering that society is structured in a heterosexual way (e.g. legal marriage, survivor benefits) and we are all, whether heterosexual or homosexual, raised to believe that heterosexuality is the norm.

ACCEPTING LESBIAN AND BISEXUAL RESIDENTS

In 1973, The American Psychiatric Association finally dropped homosexuality as a diagnosis, i.e., it was no longer a "disease" from which one had to be "cured". Although this is now over 20 years ago, negative stereotypes persist. For this reason, some lesbians, bisexuals and gay men prefer to remain "in the closet" rather than to risk rejection or discrimination. There is good evidence that disclosing or "coming out" is positively correlated with psychological well-being. This is the foundation for the Lesbian and Gay Pride movement. Staying "in the closet" is, on the other hand, a health hazard leading to alienation and self-doubt, intensifying feelings of guilt, anxiety and paranoia that can contribute to problematic alcohol and drug abuse.

Despite the fact that a woman publicly identifies herself as either lesbian or bisexual does not mean that she may not still have some negative feelings about herself and her orientation. It may be difficult not to internalize some homophobic feelings, given the prevalence of these attitudes in the wider world. One goal in working with her would be to help her deal with these feelings which could, if left unaddressed, fuel substance abuse or other dysfunctional behaviour.

THE HETEROSEXUAL ASSUMPTION

The whole world operates on the basis of heterosexual assumption. Young people taking dates to the prom are expected to invite members of the opposite sex (though a few brave souls have challenged this expectation recently). Legal marriage is reserved for heterosexuals. Generally people are shocked when individuals challenge this assumption.

We can help to provide a lesbian-positive environment by using neutral language, i.e., by not making the assumption that all residents are heterosexual in orientation. By employing terms like friend rather than boyfriend, or partner rather than husband, we provide an opportunity for residents to tell us about their reality and their situation. All of us have probably had experience with a related issue if we think of gender neutral language. Often when I say, "I have been to see my doctor....." the automatic response is, "Oh, what did he say," but my doctor is a woman. It will take most of us some time to get used to using language that does not "assume" gender or sexual orientation, but is will help indicate to our clients that they can talk to us openly.

LESBIAN, BISEXUAL AND GAY POSITIVE RESOURCES

The availability of books and pamphlets, videos, films as well as other resources that are lesbian and bisexual-positive help create an environment in which lesbian and bisexual residents feel comfortable and accepted and therefore better able to do work they need to do for their own recovery and rehabilitation. These resources should go beyond the educational and social service spheres. Lesbian and bisexual fiction, as well as "coming out" stories would help contribute to a positive environment.

HEALTH ISSUES

As condoms are available to men in provincial correctional institutions in Ontario, dental dams are also available to women. While sexual activity is not permitted, the availability of dental dams acknowledges the reality that sexual behaviour does occur and that lesbian and bisexual women are present in the population.

CUSTODY ISSUES FOR LESBIANS AND BISEXUAL WOMEN

Custody issues may be an area of concern to lesbian and bisexual mothers. Women who are incarcerated tend to face questions about their "fitness" to parent based on their involvement in the criminal justice system. Lesbian women often fear that the courts will make decisions based on their sexual orientation. This fact may be used by the father in his attempts to get sole custody of his children.

LESBIANS AND ADDICTIONS

Lesbian and gay culture has developed its own bar scene, creating an environment where lesbians and gay men feel safe and accepted. While there are now many other non-drinking activities sponsored by the gay community, historically homosexual men and women were drawn to this bar culture to meet other like-minded people.

While it may be tempting to blame the "bar scene" for substance abuse problems among lesbians and bisexuals, in fact these generally result from self-medication to deal with self-esteem issues resulting from marginalization and stigmatization, the consequences of living in a homophobic society.

ADDRESSING HOMOPHOBIC BEHAVIOUR

As staff, we have a responsibility to address homophobic attitudes and behaviour among residents and other staff in the same way that we would address racist or sexist behaviour. This can be quite difficult when the offending person is a staff member. Sexual orientation is now among the prohibited grounds in both the provincial and federal Human Rights Codes. These changes do not guarantee that lesbians or bisexuals will not face sexual harassment/abuse or verbal slandering as homophobic attitudes are quite prevalent in the general population, but it does place the onus on us as staff members to address these behaviours. If we fail to, we condone these behaviours and contribute to mistreatment and silencing of lesbians and bisexual women.

CORRECTIONAL ISSUES IN RESIDENTIAL SETTINGS

Female offenders will tend to be more physically close and affectionate with each other than will male offenders. Walking arm and arm, and giving hugs occurs frequently among women as they offer each other support and friendship. Physical closeness is not necessarily an indicator of same-sex orientation.

As in all residential or treatment settings outside of corrections, our institutions do not permit sexual activity between residents. In corrections, where subcultural attitudes are found, residents could be coerced into unwanted sexual activity. As well, residents whose attention is on the development of a romantic or sexual relationship will not be able to focus on their personal rehabilitation issues.

Historically in treatment and other institutional settings we have tended to "pathologize" lesbians and bisexuals seeing them as predatory, promiscuous or otherwise brim full of psychological problems. There is nothing inherent in homosexuality that produces predatory or promiscuous behaviour. As among

heterosexuals, there are some individuals who are abusive in their interpersonal and/or sexual relations. This should not be assumed but if observed should be addressed in the same way that "muscling" for drugs would be approached. A woman taking advantage of other, more vulnerable women, should be confronted and the behaviour addressed.

Staff indicate that they often see a lot of sexual activity among women who do not identify as lesbian or bisexual. Women may be seeking closeness in an unpleasant environment. It may be that they don't view the behaviour as "sexual" in the same way if penetration is not involved.

Residents found to be engaging in sexual activity will be placed on misconduct for a breach of institutional rules. It is important for managers and administrators to ensure that they are enforcing this rule in a way that does not discriminate against lesbian or bisexual women, i.e. that the women's sexual orientation should not be stigmatized as part of the discipline process.

LESBIAN, BISEXUAL AND GAY MALE STAFF

Lesbians, bisexual women and gay men work in our institutions and probation offices. In the past it has probably not been considered good professional practice for these staff to "come out"; it has been seen as a private issue, a boundary issue.

If we hope to create a safe environment for lesbian and bisexual residents we must also create a safe environment for lesbian and gay staff. If we fail to do this, we give a double message. While encouraging residents to "come out", we show that it is not really safe for staff to do so. Many people argue that lesbians and gay men should not "come out" or discuss their sexual orientation in the workplace. What we often forget is that heterosexuals are "out" de facto. Engagement and wedding rings are proudly worn. In a world based on the heterosexual assumption, heterosexual couples feel no need to be closeted about their sexual orientation.

Our Human Rights Codes bar discrimination based on sexual orientation yet we need to go further than simply ending active discrimination. When homosexual staff are as accepted, comfortable and visible as heterosexual staff in our workplace, only then can we truly say we have created a positive environment for our lesbian, bisexual and gay male clients.

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ETHNOCULTURAL CONSIDERATIONS

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Lauren brought to the ORC a background in training consulting gained from her experiences with the former Race Relations and Policing Unit in which she worked with municipal police services and the OPP. She has also worked as a training consultant with Ontario's Ministry of Citizenship and for the Canadian military. She has a B.A. (Hons) as well as a certificate in Adult Education and in Race, Culture and Empowerment and she is currently working on her M.A. in Education at the Ontario Institute for Studies in Education.

Ernie Harris is the Manger of the Office of the Anti-Racism Coordinator for adult corrections. The office conducts reviews of corrections policies, programs and services and supports management and staff in their attempts to prevent systemic discrimination and promoted inclusive service in correctional workplaces. He is responsible for identifying relevant issues and recommending appropriate programs and training initiatives as required.

Ernie brings to the Office over twenty years of teaching experience in inter-cultural issues, anti-racism program development, curriculum design and anti-racism organizational change strategies. He has a B.A. in International Politics and an M.Ed. in Curriculum Studies/Teacher Behaviour.

ETHNOCULTURAL CONSIDERATIONS

ERNIE HARRIS AND LAUREN WENSTROM

SUMMARY

- In order to provide services which are culturally appropriate, inclusive and non-discriminatory, we must be aware of important ethnocultural considerations.
- A personal anti-discrimination orientation recognizes that discrimination exists, provides people with the knowledge they need to identify personal and systemic discrimination, and gives them the skills they need to challenge discrimination wherever it is manifested.
- Ethnicity, race and culture are distinct aspects of a person or group.
- Women Offenders who are ethnoracially different from the dominant group in society have particular issues and concerns in addition to those of all women offenders in a correctional system designed predominantly by and for men.
- Correctional staff need to develop skills to ensure sensitivity to the needs of women from diverse ethnocultural backgrounds.

INTRODUCTION

When you think of the term "ethnocultural", what comes to mind? Do you think of yourself as having a distinct ethnic and cultural heritage? Ethnocultural considerations in the context of this manual take into account the attitudes, knowledge and behaviour needed to identify and to address the needs of female offenders of diverse ethnic and cultural heritage. Ethnic background may include a person's race and other outward identifiable features like skin colour, facial characteristics or hair texture, whereas cultural background may refer, but is not limited to values, norms and beliefs. In attempting to meet the program needs of females in custody, staff must ensure that programs and services are culturally appropriate, inclusive and non-discriminatory.

It is hoped that by studying this unit you will have a clearer understanding of the difference between race, ethnicity and culture and how these factors may affect attitudes and behaviours towards the women you supervise. We hope that this unit will also enhance your awareness of resources available to assist you in working with ethnoracial women who are in conflict with the law and their vulnerabilities. You may also gain a deeper appreciation of how these visible differences may clash with the power your position affords you, not to mention the privilege that comes from being perceived as part of the socially dominant group. The content of this unit should provide you with the ability to identify inequitable treatment based on ethnic or racial

stereotypes and the skills to prevent that type of treatment from occurring in the workplace.

ARE WE SPEAKING THE SAME LANGUAGE?

There is some confusion about terms used in discussing ethnocultural diversity. Some people are comfortable with the term *multiculturalism*, others use *race relations* and still others are comfortable with the term *anti-discrimination*. An anti-discrimination orientation recognizes that discrimination (based on race, sex, class, ethnicity, religion, etc.) exists and provides people with the knowledge to identify systemic and personal discrimination and the skills to challenge discrimination wherever it is manifested. A glossary of terms is provided at the end of this unit which you may find useful. Since it is almost impossible to always isolate the gender variable when dealing with discrimination, all staff require some common knowledge and skills in order to provide effective and equitable correctional services for clients from a variety of racial, ethnic and cultural backgrounds.

FEMALE OFFENDERS AND SERVICE EQUITY

There are many social, economic and political contexts in which women in Ontario reside. As a result, various communities and individuals experience the world in different ways. Because women are not a homogenous group, equal or same treatment is not always fair or effective. For example, hair care products provided for a dominant Caucasian female population may cause hair damage, hair loss, or scalp disorders for Black women. Similarly, Aboriginal inmates may not all observe the same religious ceremonies. The provision of a sweat lodge at a correctional facility may not meet the spirituality needs of all Aboriginal inmates.

Sometimes staff, without intending to, may treat women from diverse racial, ethnic or cultural backgrounds differently in a way that has negative impact. Research has shown that where staff have discretion in implementing policies and following procedures, some staff have used their discretion to create unfair outcomes. For example, among women inmates who are pregnant, ethnoracial women report that they are forced to carry out harder physical work at later stages of their pregnancies. When some staff make racial or ethnic jokes in their workplaces about certain ethnoracial groups, this behaviour affects the way inmates perceive the treatment they are receiving, or are likely to receive *(Racism Behind Bars, 1994).*

Differential treatment may be based on conscious or subconscious biases and prejudice. To determine whether you have developed a personal anti-discrimination orientation, complete the following exercise.

In my dealings with women who are racially or ethnically different from me:	Always	Regularly	Never
I reflect on my personal bias and prejudice.			
I accept the reality of diversity in my workplace.			
I actively challenge prejudice and stereotyping whenever I encounter it.			
I eliminate my own discriminatory behaviours			
I offer support to offenders who are victims of discrimination			

CONFLICT BETWEEN SYSTEMIC AND PERSONAL ORIENTATIONS

Our systems and institutions have tended to generalize the experiences of members of the dominant group to everyone. In a correctional setting, where men, particularly white men, have been in the majority and could influence policies and procedures because of their social and economic power base, members of the non-dominant groups, especially women, tend to be marginalized. Where more than one factor (e.g. race, ethnicity, culture, language, etc.) are at work, the disadvantage multiplies. The fact is women are trying to cope in a correctional system that was designed predominantly by and for men. Women from ethnoracial groups have to deal with the added disadvantages of being visibly different, and in conflict with the law which is socially unacceptable. An anti-discrimination orientation allows staff to identify the unwritten privilege the system provides to some groups to the disadvantage of others. This can sometimes create a conflict between what you believe to be fair and what the system and other members of the privileged group will allow you to do. It is sometimes seen as a type of betrayal of the prevailing dominant values and norms. How can you resolve the inner conflict you may experience and at the same time increase your awareness of discrimination? How can you begin the process of developing and demonstrating your anti-discrimination orientation? Your answers to the following questions may provide some assistance:

1. *How do I feel when people make assumptions(mostly negative) about me?*
2. *What assumptions have been made about the women I supervise?*
3. *What biases, if any, do I have (a) in favour of some groups of people, and (b) against some other groups of people? What are the origins of these biases?*
4. *In what situations have I participated in racial or ethnic jokes or name calling?*
5. *How have I challenged discriminatory actions or behaviours in the past?*
6. *What is my view of discrimination-free and inclusive correctional service?*

WHAT'S IN A NAME? - CULTURE, RACE AND ETHNICITY

Cultural difference is **not** synonymous with racial or ethnic difference. Culture is a learned way of life. It is based on the beliefs, values, norms, symbols, relationships, class systems, communication systems, rituals, ceremonies and identities of groups of people. We learn culture all our lives through family conditioning, the education system, language conventions, religious beliefs and rituals, and public institutions. All people and cultures learn the socialization processes through these personal and social institutions and conventions. Cultural differences lie in the interpretation and expression of these social features. Everyone has a cultural identity. We are most comfortable in an environment of shared cultural norms. When different cultures coexist in the same environment, there is potential for conflict because people tend to rank their own cultural values and norms as being superior, hence the term "ethnocentrism", or seeing one's ethnic group as the centre of existence.

Race and ethnicity are to some degree social labels. You may have heard it said that race is skin deep. Race usually refers to common descent or external features such as skin colour, hair texture or facial characteristics. Research has shown that there are more differences among people of *similar* racial backgrounds than there are among people of *different* racial backgrounds. What accounts for the obvious differences we experience among people?

In the historical development of human beings, terms have been used by individuals and groups to define themselves and others. Ethnicity tends to be based on common culture, language or nationhood. People who are seen to belong to the same race may belong to many different ethnic groups. A Jamaican of Chinese descent belongs to a racial group we label as Chinese or Asian. That person also belongs to the ethnic group labeled Caribbean or West Indian and is of Jamaican nationality. That person would most likely share features of Jamaican or Caribbean culture. If that same person has spent some time in Canada, it is reasonable to expect that person to exhibit elements of Canadian culture. That same person could be mistaken for someone born in Hong Kong or another Asian country. The mistake could be based on the person's Chinese ancestry. Should such a person come in conflict with the law in Ontario, how would you determine her cultural background? To assume cultural behaviour based on ethnicity or race would be misleading. There are many variations within racial and ethnic groups, and among individuals belonging to those groups. When working with people from various backgrounds, it is important to be able to distinguish between (a) individual or personal attributes and (b) group identity and the stereotypes which are attached to members of that group. It is therefore unwise to listen to one "woman's voice" and interpret it as the voice for all the women within a particular ethnoracial group.

WHAT DOES THIS MEAN FOR CORRECTIONAL STAFF?

The Ontario correctional system provides opportunities for staff to work in an environment that is multicultural and multiracial. There is also a corrections sub-culture which many staff identify with on a conscious or subconscious level. Cultural awareness is the key to understanding ourselves and how we relate to people from other cultures. It provides us with the tools to function in two or more cultural modes. Intercultural understanding by its very nature puts people in a position to observe other people following literally at least two *"cultural scripts"*; neither of which is inferior to the other, but each different from the other in many subtle ways. Cultural difference does not equate with cultural deficit. Difference is, as such, value free.

Answering the following questions about yourself and then about someone you know from a different racial or ethnic group may help to sharpen your cultural awareness and may help to illustrate how various cultural aspects are sometimes interpreted and ranked.

1. *What accent do I speak with? Are people's reaction to your accent positive or negative? Why do you think people react to your accent in the way they do?*
2. *To how many cultures and subcultures do I belong? How do I rank the cultures to which I belong?*
3. *What important beliefs do I hold? Are they religious or secular?*
4. *What daily rituals do I follow? How would I feel if I were unable to perform these very important rituals?*

ISSUES FOR ONGOING DISCUSSION

Women are affected by some aspects of culture particularly because they are women, regardless of their racial or ethnic background. For ethnoracial women issues like patriarchy, class, power, body image, female beauty, maternity, parenting, kinship relationships, marriage, sexuality, privacy, social roles and women's rights may take on added significance in a correctional context. Therefore, these women may need more, not less understanding and protection from correctional staff. Discriminatory behaviour can take many forms. What could be the impact of staff (female and male) who are mostly white working with women of colour? Without intending to do so, staff may cause the following impact from their interaction: demonstrating disfavor through verbal and non-verbal interaction with ethnoracial women; seeing racial segregation as a security concern; participating in extra scrutiny of offenders from particular ethnic or racial backgrounds; and making incorrect assumptions about individual needs based on group stereotypes.

PUTTING ETHNOCULTURAL KNOWLEDGE INTO PRACTICE:

The following scenario provides an opportunity for you to apply your understanding of the concepts you have been studying in this unit.

A Scenario

A female offender who is a member of an ethnoracial group in an institution gets permission to phone home to speak with her teenage children at 21:30 hours. No one answers the phone. There is a line-up to use the phone and the phones are turned off at 22:00 hours. She tries repeatedly to get through, until the next person in line complains, and she goes to the back of the line. She repeats this process twice. The correctional officer on duty announces that the phones are being turned off for the night. The woman is clearly agitated, and asks to try to call the children one more time.
The officer says, "You know the rules. It's 10:00. Why should you be the exception?"

1. *Did the officer demonstrate appropriate use of discretion in this situation? Explain.*
2. *What issues arise from this scenario that relate specifically to female offenders?*
3. *How would you have handled the situation?*

Consider these points as you process the above scenario.
Ethnoracial female offenders often have additional concern for the safety and protection of their children given one or more of the following factors:

- *social/economic circumstances;*
- *over-policing of their neighbourhoods/communities and the history of relations with police;*
- *increased scrutiny of racialized youth by some members of the community; and the impacts of stereotypes, prejudice and racism on their children;*
- *if recent immigrants, how long the children have been in Canada.*

You may be thinking at this point about how difficult it is to be aware of and sensitive to every ethnocultural issue that may arise in the course of your work with women from such diverse backgrounds. Just as there is no recipe for working effectively with all individuals, there is no formula for working successfully with members from every different ethnocultural group.

The following are some suggestions which might help to make your work with ethnoracial offenders more inclusive and non-discriminatory.

- adopt an anti-discrimination orientation;
- learn about your own human rights and how to protect the rights of others;

- ask for clarification, if you are not sure about ethnocultural norms and behaviours;
- develop an action plan for challenging discrimination when you see or experience it;
- follow your collective agreement, the *Ontario Human Rights Code*, and the *Canadian Charter of Rights and Freedoms* in your dealings with discrimination;
- demonstrate that culturally sensitive programs and services are the basic rights of individual women and not special privilege.

GLOSSARY OF TERMS
RELATING TO ETHNOCULTURAL CONSIDERATIONS

anti-discrimination/racism -is the practice of identifying, challenging, and changing the values, structures and behaviours that perpetuate personal and systemic discrimination and racism.

bias -an inaccurate, limited or slanted way of perceiving a group or individual. Negative bias towards members of a group can be expressed through language, published materials and other communications and practices.

discrimination -unfair treatment or action based on stereotype and/or prejudice. It is the overt, covert, or systemic denial of equal treatment, civil liberties and opportunity to individuals or groups. Discrimination becomes more complex when two or more factors (e.g. economic status, class, racial visibility, etc.) coincide. Discrimination may arise as a result of direct, differential treatment, or it may result from the unequal effect of treating individuals and groups in the same way.

equitable treatment -treatment that brings about an equality of results, or impact, and that may, in some instances, require different treatment. It requires the removal of systemic barriers which impede full participation and fair outcomes for all communities.

multiculturalism -in Canada, is a government-promoted program and doctrine which has standing in law. Its purpose is to ensure equal treatment for everyone, regardless of their ancestry or place of origin, while focusing on differential features (e.g. heritage, cultural features).

prejudice -an opinion or premature judgment based on inadequate knowledge, stereotyping, or irrelevant considerations - especially an unfavourable opinion or judgment.

racism -a system of implicit or explicit beliefs and actions that may be based on an ideology of the inherent superiority of one racial or ethnic group over another. It is the means by which individuals or groups exercise power that disadvantages or abuses others on the basis of skin colour and racial or ethnic heritage.

stereotype -an oversimplified, false or generalized portrayal of a group of people. A stereotype is based on observation of one, or only a small sampling of, members of the group. It is based on a generalized notion of the group as a whole, and not on individual attributes.

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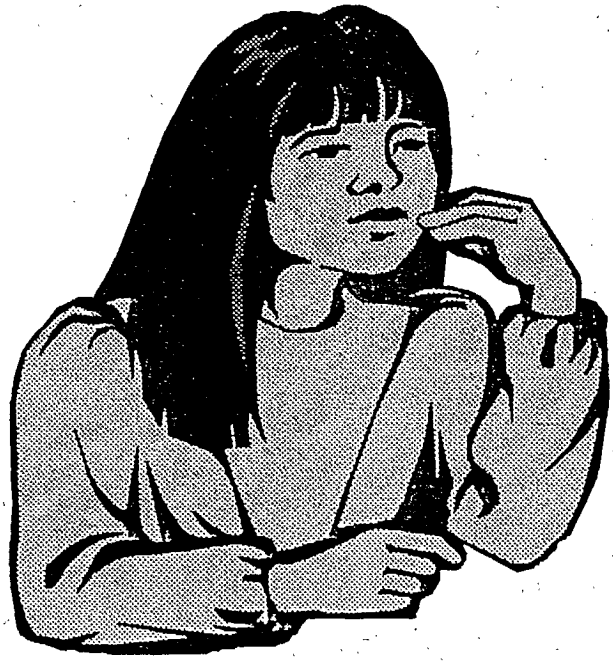
ABORIGINAL WOMEN IN CONFLICT WITH THE LAW



WRITTEN BY:

Carol Montagnes, Executive Director for the Ontario Native Council on Justice, has worked with the Council Since 1984. She is a founding member of the Board of Directors of Aboriginal Legal Services of Toronto and is a member of Correctional Service Canada's Aboriginal Advisory Committee for Ontario.

She served on the Women's Issues Task Force which produced the report, "Women's Voices, Women's Choices" 1995.

Carol Received her Master's Degree in Criminology from the University of Toronto and was a member of the research staff at the Centre for Criminology. She is the author of several publications in the area of Aboriginal justice as well as in mental health.

ABORIGINAL WOMEN IN CONFLICT WITH THE LAW

CAROL MONTAGNES

Grandfather I give you thanks for women.
Give us strength and guidance
To find the ways
To heal ourselves
and our women.

Art Solomon
Nishnawbe Spiritual Teacher

SUMMARY

This section profiles Aboriginal women offenders in comparison with other women inmates.

Areas of particular concern are addressed:

- Family
- Spirituality
- Healing and health issues
- Alcohol
- Diabetes

INTRODUCTION

It is common knowledge for those working in the field of correctional services that the rate of Aboriginal[1] people incarcerated and under community supervision far exceeds that of non-Aboriginal people. There is little available literature, however, on working with Aboriginal offenders.

The purpose of the current article is to try to give a better understanding to correctional service workers, so that they might more effectively meet the needs of Aboriginal women in their care and custody.

The article opens with a prayer, which is considered the proper way to begin a meeting of minds.

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[1] The terms "Aboriginal" and "Native" are used interchangeable; both include status and non-status Indians, Metis, and Inuit.

PROFILE

Generally, women are under represented in the prison population; within the female inmate population however, Aboriginal women are greatly over-represented. In Ontario, for example, in 1995-1996, admissions of Aboriginal women made up 10.9% of all female admissions on sentence. (In the general population, Aboriginal women make up 2% of all women. Ontario has the largest number of Aboriginal people in Canada: 243,550.)

The most common offences for female sentenced admissions in 1995-1996 were:

	Native		Non-Native
1.	Assault & Related 23%	1.	Fraud & Related 20%
2.	Theft/Possession 15%	2.	Theft/Possession 16%
3.	Fraud & Related 12%	3.	Traffic/Import Drugs 10%
4.	Break, Enter & Related 8%	4.	Serious Violent 7%

Studies comparing Native and Non-Native female inmates have found the following:

- Native women have much lower levels of education
- more Native women have children and have more children
- more Native women were receiving welfare
- more Native women had no previous employment
- more Native women indicate alcohol was involved in their offence
- Native women were more likely to be repeat offenders, and to have more previous convictions
- more Native women are victims of abuse
- Native women are less likely to have contact with their families while in prison.

FAMILY

The profile presented notes more Native women have children, and have more children, than non-Native women. Studies also show that many Native women are single mothers. This separation from the children and the consequent powerlessness to ensure their care is a pressing concern for incarcerated mothers. Family visits to Native inmates are often not possible due to distance, cost or transportation problems. The result is Native women are less likely to have contact with their families while in prison than non-Native women. This adds to the high degree of personal and cultural isolation experienced by Native women in correctional institutions. For these reasons, telephone contacts should be encouraged and facilitated.

For Aboriginal people, the concept of family is very broad and extended. Also, because of extensive family disruption in the Aboriginal community, it is common for someone to have been raised by a grandmother, aunt or someone unrelated by blood, and to therefore regard this care-giver as a parent. Correctional personnel should take this into consideration and be flexible in the interpretation of family in regard to requests for visits, for attendance at funerals and similar situations.

SPIRITUALITY

Aboriginal spirituality is seen as a source of strength for Native inmates. Native programs such as the Native Daughters and Native Sons groups at various correctional institutions have the development of spiritual awareness as a keystone. These self-help groups are supported by Native Inmate Liaison Workers through contracts between the Ministry and Native community agencies.

The Adult Institutions Policy and Procedures manual contains a policy encouraging and supporting Native spiritual services, and directive 37/96 on the subject of "Aboriginal Spirituality" is designed to ensure consistent application of this policy.

A "Native Spirituality Kit" has been provided to all correctional facilities for reference. The kit describes in text and photographs the sacred plants and articles used in ceremonies, briefly what their meaning is and how they should be treated by correctional staff.

HEALING

For Aboriginal people, health encompasses physical, mental, emotional and spiritual well-being. Programs developed by Aboriginal people or with their input reflect this view.

An example is the Healing Lodge for federally sentenced Aboriginal women which was recently opened near Maple Creek, Saskatchewan. In a section on "Aboriginal Women and The Healing Lodge", the Arbour report notes:

> The holistic, community-oriented approach to healing used by Aboriginal people does not fit easily into Western cultures and their penal environments. The reliance on elders, ceremonies (such as sweat lodges and sweetgrass Ceremonies) and the use of traditional medicines for spiritual guidance has been historically excluded from correctional settings.

> Cultural alienation in the correctional environment has a damaging impact on assessments for classification and risk, particularly in the context of the clinical assessment of risk.[2]

A policy on Aboriginal Healing has been drafted for the Ministry's consideration. This policy would allow for alternatives to Western medicine and would expand the definition of health beyond that of physical health.

ALCOHOL

Although a huge literature exists concerning alcohol treatment programs, work addressing Native treatment programs are rare. A significant body of work concerning the treatment of female alcohol abusers exists, but there is little, if any, account of Native female treatment groups or strategies.

As well, given the association between Natives, alcohol abuse, and crime noted in the literature concerning Native people and the criminal justice system, it is surprising that the correctional treatment of alcohol abuse and the Native inmate is neglected. In part this omission can be explained by the tendency of criminologists and other correctional experts to view the treatment needs of the inmate population as homogeneous. While there occurs occasional recognition of the existence of different cultural or ethnic populations within institutions, this awareness is seldom translated into culturally or ethnically appropriate treatment programs. There is ample evidence, however, that patterns of alcohol abuse and the nature of addiction itself, varies greatly cross-culturally.

One study that does deal with the Native inmate and alcohol treatment is Breaking the Cycle: A Report on the Native Inmate Liquor Offender Project.[3] This report addresses the myth of "Indians' biological predisposition" to alcoholism, discusses the differences between "White" and "Indian" drinking, and concludes that given the same social conditions, then the range of drinking styles, number of abstainers and number of alcoholics appear to be comparable in Native and non-Native communities. The study also describes the Native Inmate Liquor Offender Program, which focuses on Native identity and emphasises the inter-relatedness of the mental, physical, emotional, and spiritual aspects of the inmate's life. A central tenet of the Program is that personal and cultural identity are integrally linked. It is through knowing Native ways -values, traditions, ceremonies - and through an understanding of the modern realities of being Native in Canadian society, that an individual can begin to understand herself and begin a journey of self-awareness, self-fulfilment and self-expression. The program emphasises total abstinence from alcohol.

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[2]Commission of Inquiry into Certain Events at the Prison For Women in Kingston. Commissioner: The Honourable Louise Arbour (Ottawa: Canada Communication Group - Publishing, 1996), pg. 221.

[3]. W. Warry, Breaking The Cycle: A Report on the Native Inmate Liquor Offender Project (Toronto: Ontario Native Council on Justice, 1986), pp. 3-7, 64.

DIABETES

On average, aboriginal people in Canada die earlier than other Canadians and sustain a disproportionate share of the burden of physical disease and mental illness. Even such a conservative publication as the Canadian Medical Association Journal (December 1, 1996, Vol. 155, No. 11, page 1577) states "This burden is associated with unfavourable economic and social conditions that are inextricably linked to native peoples' history of oppression." Of the Aboriginal population of Canada 15 years of age or older, 31% have been informed that they have a chronic health problem. Diabetes mellitus affects 6% of Aboriginal adults, compared with 2% of all Canadian adults. Native people living in urban areas, women, and particularly Native people living in southern Canada have been found to have an increased risk.

Undiagnosed diabetes is of special concern with regard to the situation of Native inmates, since many of the symptoms of diabetes - thirst, frequent urination, dizziness - are not dramatic and may therefore not be considered seriously by correctional personnel when an inmate complains.

There are healers in the Aboriginal community who specialize in the treatment and control of diabetes.

QUESTIONS AND ANSWERS

Q. How do I know if someone is Native?

A. Ask her. Self identification is the recommended way to determine if someone is of Aboriginal ancestry. Although a Native woman who is registered as an "Indian" with the government of Canada will have a "status card", a Metis woman or a Native woman who is not registered will have no similar document. Native women as well as Native men in prison are under-identified by staff.

Q. What is the preferred terminology: Native, Aboriginal, First Nations?

A. "First Nations" conveys the meaning of the original inhabitants of the land as well as the fact there are many different nations; however, members of the general public tend to think only of people on First Nations territories or reserves. "Aboriginal peoples" is the term used in the Constitution Act, 1982 and includes "the Indian, Inuit and Metis peoples of Canada." "Native" is also an inclusive term. In statistical reports pertaining to the criminal justice system, "Native" is most frequently used.

Q. What can I do to have a reticent Native inmate become more verbal about herself and her needs?

A. The many obstacles and barriers in cross-cultural counselling and therapy are outlined in the literature. In studies dealing with Native people in the United States, clients cited fear, mistrust, insensitivity of personnel and doubts about the effectiveness of the intervention. Differing views as to the causes of the problem being addressed was also indicated as a barrier.

In addition to communication problems based on culture and language differences, the past experience of the Native women with non-Native authority systems - government, welfare, Children's Aid, police, courts, corrections - must be taken into consideration.

A recommendation to Correctional Services workers wanting to establish better communication with Native women inmates is to act and speak with respect.

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ADOLESCENT FEMALE OFFENDERS

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ADOLESCENT FEMALE OFFENDERS

DEBORAH RIDDLE

SUMMARY

- The adolescent female offender has the same issues as any other teenage woman with the additional problems of also being in conflict with the law.
- Those working with young women in conflict with the law have noted an increase in violent behaviour.
- Most adolescent female offenders are ill informed about health issues, including pregnancy. They need considerable support and guidance if they have children.
- Those adolescent females who have been working as prostitutes prior to incarceration may or may not return to the streets upon release; their connection to their pimp should not be taken lightly.

INTRODUCTION

•All teenagers are a bundle of emotions, self doubt, anger, confusion, happiness, and guilt. This is the transition time when you are no longer a kid nor yet an adult and constantly struggle between these two perspectives.

•Adolescent development can be broken down into three areas which can provide insight into that awful word "teenager". Chronological age does not guarantee maturity, insight into one's behaviour or control of one's actions.

•The Physical and Physiological aspects of adolescence are also deceptive in determining maturity. How many people have looked at a teenage girl and thought she looked like someone in her late teens or early twenties and then find out she was 14-16 years old? The thought processes of the adolescent female are a mystery to many. The adolescent believes that their personal perceptions are identical to reality. It does not occur to them that other people may perceive the same event differently. The thinking patterns of adolescents fluctuate with startling unpredictability, ebbing into childish concrete thinking on some occasions and displaying advanced intellectualism on other occasions.

•The Legal concepts of being an adolescent have certain ramifications and contradictions as viewed in the Young Offender Act , and the Child and Family Services Act. Adolescents are also viewed differently in the Education System and the Social Assistance System all of which have their own interpretation of age and

service eligibility. As a Youth Officer working within these systems it is at times frustrating in trying to access services for young female offenders.

The adolescent female offender has all of the same problems and concerns as other young teenage women plus the additional issue of being in conflict with the law, and having the sense of no control over her life. The following will hopefully provide some insight into the female adolescent offender and her special needs.

YOUNG WOMEN AND VIOLENCE

It is becoming obvious to all who are working with female young offenders that their behaviour is increasing in violence. Acting out behaviour such as fighting, bullying and overt threatening, typically attributed to young men as unacceptable behaviour are now becoming quite common in young women. No longer is the young offender female reacting passively, she is much more likely to react in violent and destructive ways.

Research is currently being compiled on the issue of violence – gang related and peer on peer. Some research indicates that the increase in violence is because the young women are acting out a deeper anger against the world around them. They have often been physically, sexually or emotionally abused by family members. They are unable to articulate their anger in acceptable ways.

Other experts believe that the young women today are the same as the young women twenty years ago, except that they have stopped repressing or disciplining their emotions.

MOTHERHOOD - PARENTING ISSUES FOR THE FEMALE YOUNG OFFENDER

As outlined in the section Motherhood, Parenting Issues for Women Offenders, these issues are also relevant to Female Young Offenders.

Special attention needs to be paid to young offenders who are mothers. This is crucial as they do not normally have the patience nor the skills required to be effective parents. Also most young mothers are unprepared for the all consuming role of "motherhood".

Parenting classes and parenting support groups are necessary for teenage mothers to receive proper direction and support.

SEX EDUCATION AND HEALTH

Most young female offenders, whether on probation or in custody, are poorly informed about many aspects of the female body and related health issues. It is important that the Youth Officer has correct information and dispels common and misleading myths (e.g. ' You can't get pregnant the first time you have sex'.) This is still a common belief for many young women.

An excellent resource is the book " Our Bodies Our Selves, The Teenage Years". This book is easy for most young women and correctional staff to read with quick factual information. As well, the local Public Health Department and the Health Care Unit in your institution should have information on infections, birth control options and other sex and health education questions.

PROSTITUTION AND THE FEMALE YOUNG OFFENDER

Prostitution is a difficult topic for staff to deal with because of their personal beliefs. The propose of this section is not to debate the morals of prostitution but is to provide some information on the topic and some insight into the options available for female young offenders.

Staff need to be aware that when female young offenders have utilized prostitution for survival whether it is working for a 'pimp' - 'their man', or working on their own, they may or may not return to the streets or 'their man' after completion of their custody disposition or term of probation.

The connection to a 'pimp' or 'their man' or to the streets should not be ignored or taken lightly. It is naïve to believe that because a female young offender is incarcerated that the connection has been severed.

PIMPS AND CONTROL ISSUES

- Pimps make prostitutes feel important, loved and accepted.
- Young women will defend their pimp if you put him/her down even though they may put the pimp down themselves.
- Pimps can control 'their girls' from great distances and can influence their behaviour while in custody.
- Breaking away from pimps is difficult and may be dangerous.

PROTECTION *(for those young women returning to prostitution)*

- Condom use needs to be discussed.
- A list of free clinics in their area should be given.
- They need to develop a safety plan when working the streets.
- Encourage them to develop options for when they decide to leave the streets.

RESOURCES

Covenant House, 70 Gerrard St E, Toronto M5B 1G6
Tel: 416-593-4849
Youth Without Shelter, Warrendale Court, Etobicoke, M9V 1P9
Tel: 416-748-0110

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