CAEFS' Response to the Correctional Service of Canada's Proposed Mental Health Strategy for Women Prisoners (2002 draft version)

In addition to reiterating our previous submissions with respect to earlier versions of the mental health strategy, we offer the following comments on the content of the updated Strategy.

We suggest that the following two principles should guide the development of mental health services for women by the Correctional Service of Canada (CSC).

1. Mental health services are best delivered in a community setting.

It is our view that women with mental health problems do not belong in prisons and that the treatment, support and assistance they need should be provided to them in the community, rather than in prison. Accordingly, while it is recognized that CSC cannot control who enters their federal prisons in the first place, any strategy must start with a clear recognition and acknowledgment of the manner in which the prison environment as a whole, particularly staff interactions and prisoner isolation, creates and exacerbates women's mental health concerns.

2. Health services should be delivered by community-based professionals service providers.

CAEFS believes that any treatment, support and assistance that women prisoners need should be provided by public and community-based health service providers, whose primary focus is the health of the women prisoners. Despite the best intentions of CSC staff, their primary focus is security, not health. The focus of the CSC's work with women is the imprisonment and community supervision of women sentenced to terms of imprisonment of two years or more. It has been our observation that the CSC is not well situated to assume the core business of delivering mental health services.

Given that the 2002 draft is considered an "update" of the 1997 Strategy, we wish to receive clarification from you with respect to the following.

- We question whether the validity of this approach is verified by external, peer-reviewed research and evaluations?
- Has the strategy been successful in achieving its objectives?
- Considering the last five years of its implementation, what changes does CSC believe should be made to the strategy ? What should be retained? What should be refined? What should be discarded? What should be added?

The 1997 strategy included a timeframe of three years for full implementation. Given this time frame, there should, in our opinion, have been an evaluation of the Strategy conducted by now. This should have included external evaluation. No such evaluation has been provided to CAEFS.

Although no evaluation of the 1997 strategy has been provided, the final paragraph of the draft 2002 Strategy, sub-headed **Conclusion**, does contain a very brief, but important, reflection on problems with implementation of the 1997 policy:

In 1997 when the first Mental Health Strategy for Women Offenders *was published, it was believed that a three-year time frame for full implementation of the continuum of care would be sufficient. However, despite some significant developments… limitations relating to both fiscal considerations and the ability to recruit and retain staff with the necessary expertise to work with women offenders have, especially in some of the more remote locations, extended the implementation period."*

Despite the brevity of this passage, and its position at the end of the document, it identifies two critical areas that, in our view, should be addressed as threshold issues in any evaluation of CSC's strategies for providing mental health services to women; namely, 1) fiscal considerations, and 2) recruitment and retention of appropriate staff.

1. **Fiscal considerations**

Some of the evaluative questions we consider relevant in this regard are:

- What are the fiscal constraints that have limited the implementation of appropriate mental health services for women prisoners?
- In what ways have they limited implementation? What impact have they had?
- What are their causes? and;
- How can the limitations imposed by fiscal considerations be overcome?

It is CAEFS' submission that the provision of mental heath services to federally sentenced women is not considered a sufficiently high funding priority in budget processes, at both the political and bureaucratic level, especially in comparison with the priority afforded to funding for expansion of prison infrastructure and enhancement of security.

We submit that a frank and thorough examination of budget processes needs to be carried out in order to determine what, precisely, the obstacles to adequate funding of mental health services for women are, so that they may finally be addressed. However, it is also our submission that there is little point in promulgating "unresourced" strategies, given the reality that the priority should be placed upon the development of community-based resources.

As the *Board of Investigation Report with respect to the February 5, 2000 Suicide of Saskatchewan Penitentiary prisoner, Earla Brass* found that:

The level of mental health services provided to BRASS did not conform to the requirements of the Mental Health Strategy for Women Offenders, approved by the Service in 1997. **(Finding 19, p. 44)**

As you are undoubtedly aware, Ms Brass was a 28-year-old Aboriginal woman who died by hanging in a segregation cell after nearly 2 months' segregation. She had extensively self-harmed and spoken of suicide in the days leading up to her death. The nursing and other staff were unaware of her diagnosis with a serious psychiatric

illness. The mental health nurse who saw her on her daily rounds had been working at the segregated maximum security unit for women at the Saskatchewan Penitentiary for a mere three weeks. The psychologist assigned to Ms Brass' case was unaware she was supposed to be working as a psychologist and thought she had been hired as a "counsellor". There was no formal communication or coordination between any of these mental health professionals or with security personnel in the unit.

In short, as the CSC investigation found, the "multi-disciplinary team" approach set out in the 1997 Mental Health Strategy was not followed. At page 35 of their report, the Board of Investigation into Ms Brass' death stated:

Considering the relevancy of this strategy to the operation of the Women's Unit at Saskatchewan Penitentiary, there does not appear to be any action plan to either adopt or ensure compliance (with the strategy) at the Women's Unit.

The Board points out that the process for tracking the implementation of this strategy was through a series of national meetings and committees which represented the regions and the women's institutions. In this case, the Board believes the primary tracking process appears to have been verbal update reports by those staff representing the Women's Unit at Saskatchewan Penitentiary at these meetings. The National Headquarters staff advised the Board that there was no indication to suggest that there were any difficulties with the process at the Women's Unit at the Saskatchewan Penitentiary.

The Board recommended that:

There is a need to determine the resource levels required at the Women's Unit at Saskatchewan Penitentiary in order to provide mental health services to the women as dictated by the provisions of the Mental Health Strategy for Women Offenders.

In our submission, this incident, as reported by the CSC's own Board of Investigation, provides persuasive evidence both of the necessity for an effective, adequately resourced Mental Health Strategy for federally sentenced women, and the utter futility of publishing another un-resourced Strategy. It is our view that a significant issue is the lack of line authority and clarity with respect to the manner in which the strategy is implemented. Amongst other things, this has resulted in responsibility being batted endlessly between head office, the regions, the institutions and institutional staff. Ultimately, no body is identifiable as being responsible for implementation and every body is able to plead ignorance and/or lack of responsibility or resources.

2. **Ability to recruit and retain staff with the necessary expertise and independence to work with women prisoners**

Once again, this point goes to the heart of effective implementation of any mental health strategy. Unfortunately the information provided is insufficient; however, it is CAEFS' submission that a thorough exploration of this question should take place. Some of the issues raised are:

- What type of staff should be targeted for recruitment?

- What educational standards, professional qualifications, work and life experience, personal and professional values and ethics should they have?
- What level and mix of staffing would be the "ideal" for the various institutions and units?
- What, if any, are the barriers to recruitment of these staff?
- How can these barriers be addressed and removed?
- Does CSC offer comparable remuneration and working conditions to that offered in other types of mental health work?
- Does additional incentive need to be offered to attract skilled and experienced staff to this work?
- Why do some experienced and expert mental health professionals object to working in a prison environment? What are their concerns? (for example, not wanting to be involved in security duties) Can they be addressed?
- What are the reasons that exiting staff identify for leaving CSC employ? How can these concerns be addressed?
- Is it possible to open the requisite resources in the community, as opposed to within the prisons?

In our 1996 submission we proposed that a complementary strategy paper be developed on this topic. We submit that a study of this nature remains urgent and could be easily conducted, perhaps with the assistance of human resources specialists who could, for example, consult the various professional organizations that represent mental health professionals and conduct exit interviews for staff that resign or move out of coalface service provision.

An important part of this analysis would be a review of the involvement of non-corrections staff, from other Government Departments and community organizations. How can non-corrections organizations and personnel be utilised more effectively to deliver mental health services to federally sentenced women?

Content of the 2002 Strategy
Key Principles

CAEFS is in basic agreement with the principles set out starting at page 15 of the document. As we pointed out in our 1997 submission on this point, however, we note that the 2002 document, once again, does not address the problems associated with implementing these principles (wellness, access, woman-centred, client-participation and least-restrictive measures) in a prison or correctional setting.

Many of the principles that underlie a security-driven prison system are in direct contradiction to principles enunciated in this Mental Health Strategy. In our view, even if it is assessed that these contradictions cannot be overcome, they should at least be acknowledged and named.

The principles and values underlying the "security-first" model of corrections are far older and more entrenched than the principles underlying an approach that "maximizes well-being" for the women. In our experience it is still the "security-first" values that come into play, especially in times of crisis for women with mental health issues, not the newer principles enunciated in this Strategy. There must be conscious leadership from CSC if the traditional values and principles are to be challenged.

Evaluation

Apart from the comments we have made, above, regarding evaluation of the Strategy, we remain concerned about the lack of detail in the document regarding evaluation of CSC mental health programs overall. The Strategy provides that responsibility for the development and evaluation of programs lies with "every mental health professional".

Our concerns with this approach may be summarized as follows:

1. We submit that it is inappropriate for therapists to design, deliver and evaluate their own programs. Such a process does not provide the requisite degree of objectivity or comparability of results. For example, how can results be compared if different professionals use different evaluative models?
2. There is no discussion of the resources that are required for effective evaluation processes to take place. Presumably the professionals involved are expected to carry out this work along with their other duties. In our opinion this is unrealistic.
3. We submit that it should be the responsibility of the CSC to develop guidelines for the objective and rigorous evaluation of mental health programs and to resource the carrying out of these evaluations by qualified and independent professionals.
4. There is no discussion of the use to which CSC will put the results of evaluations. In our submission there needs to be an ongoing review process in the organisation so that there can be organisational learning from the results of program evaluations. This information is potentially extremely valuable and should be shared across the organisation and with outside researchers and agencies.

Interdisciplinary mental health teams

The Strategy reiterates that each institution must have an interdisciplinary mental health team that coordinates the delivery of services to women with mental health needs. We agree that this is vital, however we are concerned that there is no strategy enunciated for ensuring that it occurs.

Clearly no such team was in existence at the Women's Unit at Sask. Pen. in 2000 (Investigator's Report referred to above). What steps will CSC take to ensure that all institutions comply with the strategy and that the teams are properly resourced, supported and trained in a teamwork approach?

We are also concerned that the 2002 Strategy refers only to CSC staff as comprising the compulsory core of the Interdisciplinary Team. In our view it is critical that the team also include at least the psychiatrist(s) and representatives of the community health providers, including elders, therapists and counsellors, that provide mental health services, traditional medicine and support to the women at the institution.

The strategy refers to the non-CSC team members as "ad hoc" and to be included "as appropriate". In our submission they should be seen as critical, their involvement should be mandatory and resources should be made available to ensure that they are able to attend and participate in any team meetings or other processes.

Staff Training and Education

This section of the Strategy remains extremely sketchy, in our view. Whilst the document is clear that training and support *must* be provided, it does not state where responsibility for this lies nor what type of programs are envisaged. We refer to our earlier comments on recruitment and retention of staff and submit that there is a need for a separate strategy document on this important issue.

Intensive Intervention Strategy

CAEFS strongly disagrees with the tendency of both the 2002 Mental Health Strategy and the Intensive Intervention Strategy to conflate the notions of "mental health needs" and "security risk". A woman who is assessed as "high needs" in terms of her mental health is not automatically a "high risk" of either escape or violence.

We submit that it is inappropriate to devise or apply one strategy to both "high risk" and "high need" women. We also point out that whilst there worrying numbers of women in prison who have serious mental health issues, there is an extremely small number who pose a high risk of violence.

In our submission the notions of "high risk" and "high needs" must be disentangled in the minds of both correctional administrators and operational staff. Until this is achieved, women with mental health needs will continue to be seen as "security" or "discipline" problems and will continue to be "treated" with the segregation, deprivation and punishment that so exacerbates their conditions - and even creates new ones.

Intensive Healing Program - Churchill Unit, RPC Saskatchewan

Previous submissions from CAEFS have outlined the problems we see with the operation of the unit. These include:

- The location of the unit within a larger men's facility;
- The confused legal status of some inmates as both psychiatric patients and prisoners; and
- The commitment of the unit to cognitive behaviouralism, and particularly Dialectical Behaviour Therapy (DBT), a treatment regime that we are concerned "individualizes crime and pathologizes prisoners" and may be used to 'invalidate women's legitimate protests and blame them for the failures of the prison system." (*Dialectical Behavioural Therapy with Women Prisoners*, Pollack and Kendall, 2001)

In our 1997 submission we wrote:

…What we have observed at the RPC in Saskatoon is not reflective of the healing environment you envision. For that reason we have many reservations about the possibility for something creative, holistic and therapeutic to be developed in that setting.

Our experience working with women at RPC in the five years since 1997 have borne out these concerns. We remain convinced that

- The Churchill Unit should be closed; and
- Women prisoners who are certified mentally ill should be treated in psychiatric facilities, under the care of Health authorities and not the CSC;

At page 26 of the 2002 Strategy also states that "acutely mentally disordered women", as distinct from women who are certified as mentally ill, are placed in RPC on a "voluntary" basis. We dispute this statement as we have had contact with several women who were involuntarily transferred to the unit although they were not certified mentally ill.

In other cases women have been transferred to the unit on the basis that it was the only place they could receive the treatment they require before the National Parole Board will consider them suitable for parole. In several cases women have been transferred to the unit for sexual abuse counselling on the basis that this could not be provided anywhere else and have arrived to find that it was not going to be provided for them at RPC. It is our submission that other treatment options in such cases should be provided, so that there is not, effectively, coercion to transfer to RPC.

It is also our view that sexual abuse and trauma support services should be provided by the women's groups whose initiative and expertise is recognized and validated by women survivors in the community. The significance of having external contracted therapists to provide services to the women in the regional prisons is directly related to their histories of abuse, much of which includes institutional abuse that in term breeds a healthy distrust of authority figures, especially correctional staff. This would be a much better treatment option than a transfer to a men's facility that is also a psychiatric hospital.

Cognitive and Dialectical Behaviour Therapy

We have referred, above, to just one of the critiques that has been made of this mode of therapy. We remain concerned that this particular therapeutic approach is given such a privileged position in the CSC Mental Health Strategy for Women. We share many of the concerns of critics of the approach and remain sceptical about the accuracy or usefulness of the diagnosis "borderline personality disorder" for women who are experiencing mental health challenges following years of severe abuse.

We note that the Strategy cites a 1993 paper by Marcia Linehan to support the proposition that DBT is effective for individuals diagnosed with BPD (page 27). In our view this information cannot be considered objective considering DBT was developed by Marcia Linehan and that she has a commercial interest in its adoption. We request a copy of this paper as well as any research conducted by CSC regarding the nature and results of the use of DBT with women imprisoned in the regional prisons, the OOHL and the segregated maximum security units for women in the men's prisons.

Monitoring and/or Support

We submit that this section, at p.29, is a) insufficiently detailed; and b) too focussed on monitoring adherence to DBT and PST, to be effective in ensuring the actual impact and results of the implementation of the Strategy. It is our view that "adherence to the treatment models" is the wrong focus for the support and monitoring role. Primary emphasis should be placed on supporting and monitoring

achievement of the strategic goals (a continuum of care, addressing varied mental health needs, maximization of well-being and promotion of effective reintegration), as well as the assessment of impact as assessed by the very women who are the subject of the "strategy".

We also submit that "staff of National Headquarters" is insufficiently specific to identify those personnel responsible for overseeing and accountable for the implementation results. Regrettably, our experience in this respect is that many local, regional and national staff consider it their role to monitor, but when matters deteriorate, it is virtually impossible to determine whom the decision-maker(s) is or are. Lines of authority and responsibility for decision-making must be clearly identified for all, especially the women prisoners and other CSC staff.

Suicide and Self-Injury

We are very pleased to see that this section of the strategy recognizes that self-injurious behaviour should not be seen as a security issue. Particularly in light of trends to the contrary, as exemplified by the recent reclassification, illegal involuntary transfer and subsequent segregation within a men's psychiatric centre and prison, of a woman who attempted suicide in one of the regional women's prisons, we are eager to see this approach actually operationalized by CSC.

The implementation of the strategy is impossible, however, unless the "security culture" of corrections is interfered with. The focus and priority of CSC on maintaining power and control over prisoners, is antithetical to the development of long-term, effective interventions, especially with and for those women prisoners who have mental and cognitive disabilities. Experience to date demonstrates the multitude of difficulties occasioned by trying to implement mental health services in prison environments. Even when staff are well-intentioned and trained, the norm is that security trumps all other matters in the prison environment.

To date, we have not seen reliable evidence that CSC has undertaken the task of achieving the sort of "cultural shift" that would be required in order to allow this or any other progressive mental health strategy to be implemented in the women's prisons. We agree that there is an urgent need for extensive early-intervention strategies for women at risk of self-harm. We also agree that the extensive involvement of non-security personnel if women do experience crises that lead to self-harm is vital. Moreover, as we are all experiencing, the absence of such an approach is leading to too many women continuing to be segregated, deprived and punished for harming themselves, and the vortex of self-injurious behaviour is not only continually perpetuated, but significant mental and cognitive disabilities are exacerbated.

It is insufficient to simply refer to "training", "appropriate intervention" and "paying close attention", to women whom the service and others have labelled as having "personality disorders". Whilst we recognize that your document is a strategy and not a correctional policy or an operational guideline, we still believe that, considering the centrality and seriousness of this issue at this time in Canadian corrections, at an absolute minimum, the strategy must explicitly identify who will be responsible for what. For example, CSC, the women and external groups such as ours should be able to clearly identify:

- who the staff are, what each does and why, as well as the nature and extent of their particular training and expertise;
- what role and responsibility, if any, is afforded the security personnel (correctional officers) with respect to women being treated under the strategy;
- methods whereby CSC can best support and promote contact and development of relationships with communities of support, family members, especially children, peers, et cetera;
- nature of externally based forensic and other mental health facilities that are available or should be developed for women in prison and others who are or might be criminalized.

Peer Support

We consider peer support as essential and an integral component of any valid continuum of care. We do not agree that peer support should be relied upon to "expand the counselling facilities of the facility" per se, however. Women prisoners can and do provide personal support to their sister prisoners all the time, not just in situations where professional counsellors are not available "ie evenings and weekends" (page 36). In fact, it is these personal relationships upon which the women and prison administration too often rely, without adequate or appropriate recognition of the importance thereof.

Women prisoners should have a choice of from whom they may obtain peer support services and staff should not be the gatekeepers of the Peer Support Teams (PST) in any of the women's prisons. Furthermore, we believe that the peer support teams should be accountable to the therapeutic staff from whom they receive support, guidance and training, not directly to the prison administration. Women prisoners have repeatedly and consistently expressed concern about the current PST model, as it relies on administrative control and limits the scope, abilities, not to mention the number of approved peer support team members, and therefore the effectiveness, of the PSTs in the women's prisons.

In our submission there must be professional mental health professionals support available at all times, on duty, or at least on call, preferably in mental health or psychiatric institutions nearest each prison. CSC would never contemplate a circumstance where security staff would not be rostered on duty at all times. We are of the view that mental and cognitive disabilities require at far more resources and are of greater concern than any security issues vis-à-vis women prisoners. Moreover, the provision of adequate health care should be afforded greater status than that which is provided for the maintenance of security.

Community Services

We are disappointed at the lack of detail in the Strategy document in relation to the development and maintenance of a continuum of care between the prisons and the community for women with mental and cognitive disabilities. We would also have liked to see some evaluation of how this vital component of the Strategy has progressed since 1997.

In addition, we believe that it should be mandatory for a Community Reintegration Manager to be assigned in each institution to develop, coordinate and monitor

community links. Presently the document says only that this "should" occur (page 37). Similarly, the Strategy provides for the establishment of linkages with community mental health agencies, supportive housing, employment and First Nation services et cetera, which "may" be included in institutional program activities (page 36). In our view, such program development is an absolute requirement if a "continuum of care" is ever to be achieved.

Other Issues

Finally, we would like to make the following points regarding two issues that are not currently addressed in the Strategy, or are touched upon only briefly:

- **Medication**

We submit that the Strategy should include discussion of CSC policy in relation to the use of medication in the treatment of mental health problems, and some analysis of current policies and practices. There are a multitude of issues that we believe need to be explored in this area. A few of these include:

1. Chemical Restraint - In a prison setting there is always a danger of over-use of medication to at best pacify, and, at worst, chemically restrain women prisoners. Both are due to demand from distressed prisoners and staff, and due to the security dictates of the institution. We submit that consciously developed and monitored policies are required to resist this tendency. CSC investigations of critical incidents in women's prisons have highlighted just some of the problems associated with these approaches. There should be a clear policy prohibiting the indiscriminate and non-prescribed distribution of medications to multiple women by "standing order".
2. Right to Refuse Treatment - CAEFS also believes that there needs to be greater clarity in relation to the women's constitutionally protected right to refuse treatment. Too often, especially at the Regional Psychiatric Centre (RPC) in Saskatoon, women who refuse treatment are forcibly "treated" following the commencement of sertification procedures pursuant to the provincial mental health legislation. Once treatment is administered, the certification procedures are abandoned. The result is that women are forcibly treated in the prison.

- **Classification**

We raised the matter of the significance of the classification scheme in our 1996 submission and we are disappointed that the updated Strategy still does not address this. We have long held grave concerns regarding the manner in which women with mental and cognitive disabilities are assessed and classified - particularly in light of the practical conflation of "mental health issues" and "security risk" which is a rather central feature of current classification policies and practices.

We reiterate that which we submitted in the past; namely, that women with mental health issues are routinely over-classified under the current system; and, that their placement in environments that are strongly security-focussed is counter productive to their healing. We urge CSC to make the necessary strategic commitment to ensure that women's risk of escape and violence are assessed free of discriminatory considerations pertaining to their mental and cognitive disabilities.

Desire to Develop Alternate Options

To conclude, we wish to reiterate that CAEFS would like to engage in a dialogue regarding the proactive path upon which we have already embarked with respect to women with mental and cognitive disabilities. While we recognize that CSC is attempting to provide mental health resources for women in prison, we respectfully submit that where the approaches are not deleterious to women prisoners, they are either too little too late or they are approaches that are inadvertently feeding the very problems they were established to solve.

CAEFS is committed to ensuring that all women receive the services and supports they require in order to return and/or remain in the community. We believe that the prison environment is not conducive to the establishment of such resources however. Accordingly, we are committed to the development of community-integrated, non-prison resources to assist criminalized women, as well as those who are at risk of being criminalized.