Report on Self-Injurious Behaviour in the Kingston Prison for Women

Submitted to: The Correctional Service of Canada

Prepared by: Jan Heney, M.S.W.

January, 1990 (revised).

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Abstract

A study was conducted at the Kingston Prison for Women to guide the development of a therapeutic programme for women who self-injure. 44 prisoners and 41 security staff personnel were interviewed about three programme goals: injury response, injury reduction and suicide identification. Results indicate that self-injury may best be reduced by considering it a sign of emotional distress rather than a security issue, and by shifting the responsibility for its reduction from security to counselling personnel. Results also indicate that self-injuring prisoners often seek emotional support from their peers, and that this support should be acknowledged and legitimized. It was recommended that a programme be developed to train prisoners as peer counsellors. This programme is designed to provide on-going support and skill development for these prisoner counsellors.

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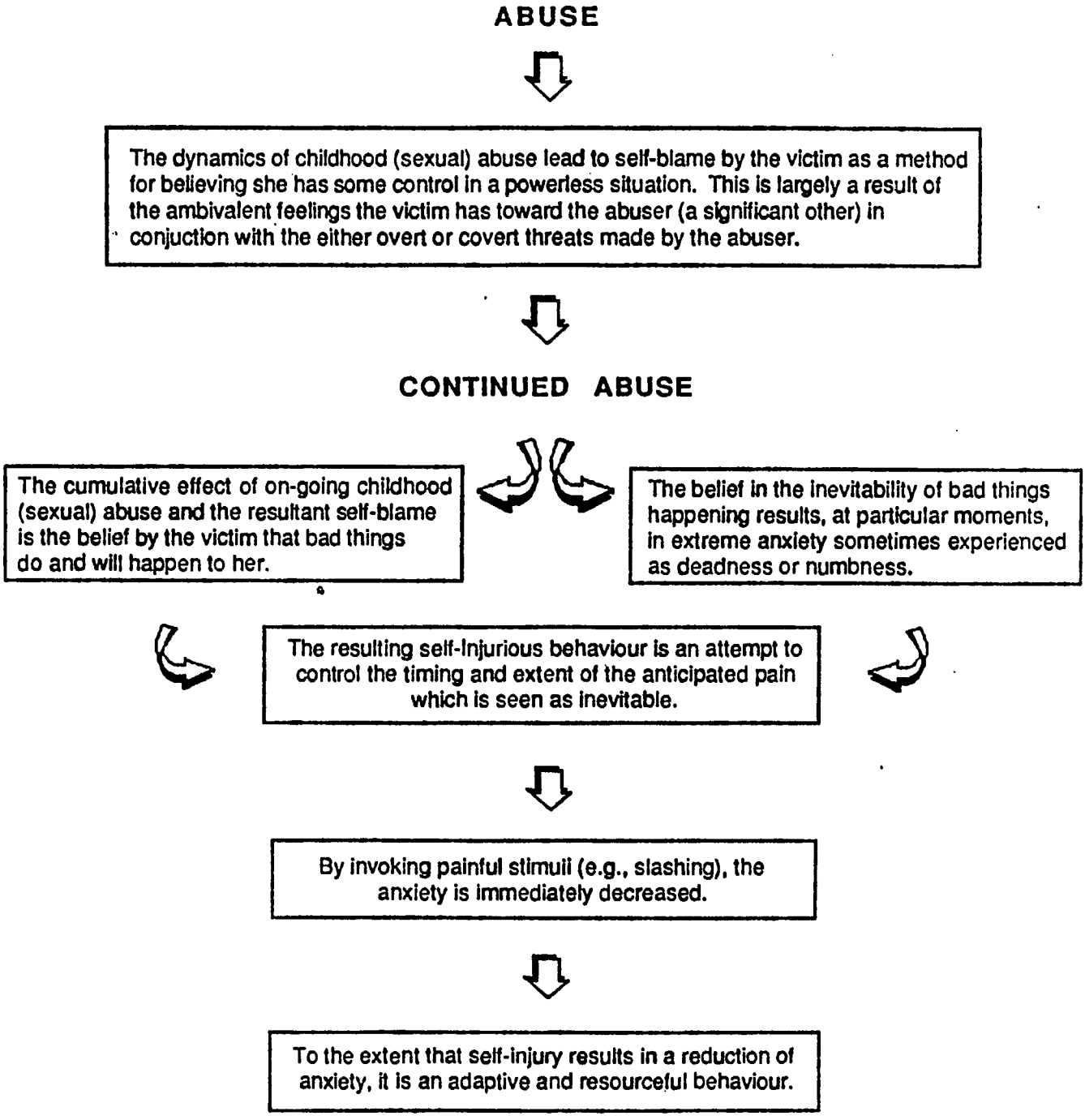
This report is based on a study conducted to guide the development of a therapeutic programme for women who self-injure at the Kingston Prison for Women. A preliminary study (February, 1989) determined that my definition of both the spectrum of self-injurious behaviour and the dynamics involved match the experience of those who work with this behaviour within the prison system. The model I work from is based on the understanding that self-injurious behaviour is a *coping strategy* that manifests itself as a result of childhood abuse (usually sexual). When a child is sexually abused she most often reconciles the abuse through self-blame. Self-blame allows the victim to believe she has some control in a powerless situation; if she is responsible for the abuse, she can also stop it. The cumulative effect of the self-blame coupled with on-going sexual abuse is the further belief that bad things do and will happen. The belief in the inevitability of bad things happening, at particular moments, results in extreme anxiety. Self-injury is an attempt to control the extent and the timing of the anticipated pain which is seen as inevitable. Once pain is invoked (e.g., through slashing), the anxiety is immediately decreased. Thus, to the extent that self-injury results in a reduction of anxiety it is an adaptive and resourceful behaviour (see figure 1 for a schematic representation of this process).

Through the February 1989 preliminary study on self-injurious behaviour, I identified *injury response, injury reduction,* and *suicide identification* as the major issues needing to be addressed. To examine these areas, the present study involved the following:

* Prisoners were interviewed to acquire a thorough understanding of the experiential aspects of self-injurious behaviour within the prison context.

Figure 1. Self-Injurious Behaviour as a Coping Strategy



In total, 45 prisoners were interviewed. The results of one interview were not included due to a language barrier.

- Security personnel (CX staff) were interviewed to assess front-line issues and concerns regarding self-injurious behaviour among prisoners. In total, 41 members of the security staff were interviewed. An additional three individuals were contacted but refused to be interviewed.

- Relevant groups of individuals were interviewed to determine the best strategy for establishing a structure in which to implement recommended actions. These groups included staff from the psychology department, staff from health care services, and staff from the Regional Treatment Centre. Discussions with these individuals focused on programme implementation, programme delivery, and training requirements.

Interview questions were designed to gather information relevant to formulating policy in each of the three identified areas (i.e., injury response, injury reduction, and suicide identification).

The report is presented in six sections. The first section involves an examination of the extent of the problem of self-injurious behaviour in the Kingston Prison for Women. This discussion is based on responses from both prisoners and security personnel and includes data pertaining to outbreaks of self-injury in the prison. In the second section, the current response to self-injury is outlined followed by a presentation of reactions of prisoners and security personnel to this protocol. The third section of the report focuses on injury reduction. This begins with a presentation of data relating to the frequency of childhood sexual abuse among prisoners followed by an analysis of the factors identified as exacerbating self-injury. The fourth section focuses on suicide identification. The conclusions of the study are presented in the fifth

section of the report, followed by the sixth and final section which outlines suggested direction for the remainder of the contract period.

Policy recommendations are provided throughout the report. These recommendations were designed to reflect the spirit of the Mission Statement of the Correctional Service of Canada (February, 1989). Three core values outlined in the Mission Statement were particularly relevant, and directed the recommendations:

> **Core Value 1:** We respect the dignity of individuals, the rights of all members of society, and the potential for human growth and development.
>
> **Core Value 2:** We recognize that the offender has the potential to live as a law-abiding citizen.
>
> **Core Value 3:** We believe that our strength and our major resource in achieving our objectives is our staff and that human relationships are the cornerstone of our endeavour (p. 4).

Wherever possible, I will identify the way in which the particular recommendation operationalizes the guiding principles or strategic objectives of the core values.

Section 1: Extent of the Problem

1.1 Prisoner Responses

Of the 44 prisoners who completed the interview, 26 (59%) indicated that they engage in, or have engaged in self-injurious behaviour. Of these respondents, 24 (92%) have used slashing as the method of self-injury. Many of these women reported using headbanging, starvation, burning and/or tattooing in addition to slashing. The remaining eight percent primarily reported headbanging as the method of injury.

It is difficult to determine from this data the exact extent of the problem of self-injurious behaviour in the Kingston Prison for Women. The interview responses and the number of women with scars on their bodies indicate that a large number of this prison population self-injure at one time or another. However, not all of these women (60%) do so on a regular basis. In addition, some of the respondents reporting self-injury (16%) have not recently engaged in this behaviour. It may be the case that the latter group of women have resolved the issues leading them to self-injure, and as such, should no longer be included in the figures relating to self-injurious behaviour. On the other hand, in September and October of this year, there were slashing incidents among women who had not self-injured in years. These slashings took place during a time of particular stress in the prison. This suggests that although a woman may find alternatives to self-injury, in times of severe stress without appropriate treatment, the potential for self-injury still exists. This reasoning argues for the inclusion of these respondents in the figures on self-injurious behaviour. Regardless of whether the extent of self-injury is defined by behaviour occurring within a specified time period or by the behaviour ever being exhibited, it is obvious that self-injurious behaviour is a problem for a large number of prisoners at some point in their incarceration. It is interesting to note that 100% of the prisoners endorsed a programme for self-injury whether or not they themselves self-injure.

1.2 Security Personnel Responses

The CX staff hold widely divergent views on the extent to which self-injurious behaviour occurs within the prison. Some personnel reported that only 2 - 3 % of the prison population engage in this behaviour. Others believe the rate to be as high as 70%. The mean response was 18% (S.D. = 16.8%). This discrepancy is most likely explained by differences in the definition of self-injury. Some CX staff use scars as an indication of self-injurious behaviour while others identify self-injurious women only as those who have recently engaged in the behaviour. In addition, some CX staff use degree of injury to differentiate between self-injurious and non-self-injurious women. In these cases, only deep wounds are considered indicative of true self-injurious behaviour. More superficial wounds are considered to be a form of manipulative or attention seeking behaviour.

There was no correlation between length of employment at the Prison for Women and estimated frequency of self-injury. In addition, there was no correlation between reactions to self-injury and estimated frequency of occurrence.

It is important to note the disparity between prisoner reports of self-injury and many of the security personnel reports on the number of occurrences. In some cases, prisoners who report self-injury may have engaged in this behaviour prior to being at the Kingston Prison for Women. This undoubtedly accounts for some of the discrepancy. In addition, a number of women who injure themselves do not report their actions to staff for fear of being taken to segregation. The prisoners refer to these cases as *quiet slashings*. Therefore, some of the incidences of self-injury are not open to public scrutiny. Finally, the prisoners report that the degree of injury is not important in the definition of the behaviour. Thus, discrepancies in definition may account for a portion of the difference between the prisoners' reported rates of occurrence and the estimates reported by many of the CX staff.

1.3 Outbreaks of Self-Injury

During my visits to the Prison for Women in February, a number of individuals mentioned that there appear to be outbreaks of self-injury. Both prisoners and CX staff were questioned on this and asked why they thought these outbreaks occur.

1.3.1 Prisoner Responses Regarding Outbreaks of Self-Injury

Fifty percent of the prisoners stated that outbreaks of self-injury are due to tension in the prison. Policy changes, the attitudes of certain CX staff, and mass punishment were most often cited as the reasons for the tension. Seventeen percent of the respondents reported that when a self-injury occurs it adds to their own pain and this increases the probability that they, in turn, will self-injure. One prisoner summed up these sentiments by stating:

> Friendships are intensified in the prison. When someone you care about slashes, it upsets you because you are already upset about the same shit she is. When your friend slashes it tilts you because of her distress. So you're dealing with the shit and now you're dealing with your friend's pain and it's just too much.

Fourteen percent of the prisoners said they don't know what causes outbreaks of self-injury. The remaining responses did not suggest any particular patterns. Thus, most prisoners identify situational factors as responsible for the precipitation of outbreaks of self-injury.

1.3.2 Security Staff Responses Regarding Outbreaks of Self-Injury

Thirty percent of the CX staff identified tension in the prison as causing outbreaks of self-injury. These responses were similar to those of the prisoners in that policy changes, the attitudes of certain CX staff, and mass punishment

were cited as being responsible for the tension. Drugs were mentioned as a causal factor in outbreaks of self-injury by 15% of the CX staff. An additional 15% of the respondents believe that muscling/peer pressure is the cause of self-injury outbreaks. Ten percent of the CX staff stated that there is a "copy cat" phenomenon that occurs with self-injury. Anger (7.5%), and solidarity (7.5%) were other reasons identified by the respondents. The remaining responses did not suggest any particular patterns. Although many security personnel support the fact that situational factors are involved in self-injury, the majority identified these situations as being personal (drugs, copying another's behaviour, anger), or interpersonal (muscling/peer pressure, solidarity).

Section 2: Injury Response

At present, a woman who engages in identified self-injurious behaviour is taken to health care services (or outside hospital services where required) for medical attention and is then taken to segregation. The prisoner must remain in segregation until an assessment by a psychologist indicates the absence of suicidal ideation. In addition, the woman most often has to appear before the Segregation Review Board. As psychologists are primarily available only during normal business hours Monday to Friday, and the Segregation Review Board meets only on Mondays and Fridays, there can be a considerable delay in releasing a non-suicidal individual from segregation.

There appears to be some confusion as to whether this protocol is in fact policy. The Warden indicated that all that was required for release from segregation was a positive assessment by a psychologist. The psychologists indicate that it has been only recently that their assessment alone has resulted in release from segregation and at this point are unclear whether this practice is stated policy and will continue. Even if this policy is clarified and supported, it

does not address the situations (e.g., weekends) where a psychologist is not available to provide immediate assessment.

In extreme cases of self-injury, the woman can be referred to the Regional Treatment Centre at the Kingston Prison. However, this is a limited facility with only 10 beds. The programme at this facility has been developed to deal with a wide range of mental health problems and is often filled to capacity. Further, although there has been some success in reducing self-injury within the Regional Treatment Centre context, this behaviour often reappears when the woman is transferred back to the Prison for Women. Thus, the Regional Treatment Centre is not a viable option for self-injury in the majority of cases.

2.1 Prisoner Responses Regarding Existing Protocol

Protocol is used here to refer to the most prevalent response to self-injurious behaviour (as outlined above). Whether this response actually reflects formal protocol is irrelevant to this discussion.

Despite the fact that prisoners were not questioned directly on the appropriateness of segregation in response to self-injury, 39 of the 44 prisoners interviewed spontaneously addressed this issue. Of these prisoners, 97% (38) argued that segregation is an inappropriate response to self-injury. The only woman who endorsed segregation as an appropriate response had never engaged in self-injury and regarded such behaviour as a suicide attempt. This prisoner stated that segregation was necessary for monitoring purposes.

The fact that so many prisoners discussed segregation in the absence of direct questioning indicates the extent of the distress over the existing protocol. Although the transfer to segregation is for monitoring as opposed to punitive purposes, experientially it is perceived by the women as punishment. A number of women commented that "you are treated the same [taken to segregation] whether you hurt someone else or hurt yourself." Despite the different nature of these acts the consequences are the same. Thus, at present, the intention

behind the transfer to segregation notwithstanding, the women experience the transfer as punishment.

A second issue raised by a majority of the women was the isolation imposed by segregation. Many of the prisoners (78.3%) stated that after a self-injury, the woman involved needs someone to whom she can talk. Although there was some disagreement about whether this person should be a counsellor (49%), a friend (9.8%), another prisoner who had "been there" (2.4%), or just anyone to communicate with (17.1%), the necessity of someone being there was of utmost importance for most.

A frequent concern expressed by the women was the possibility of segregation evoking suicide attempts. Isolation and punishment (whether intentional or not) imposed on someone who is experiencing emotional difficulty, as evidenced by the self-injury, may overwhelm the individual leading to more drastic measures to stop the pain.

2.2 Security Personnel Responses Regarding Existing Protocol

The majority of the CX staff (77.5%) support the transfer to segregation as a necessary action in the case of self-injury. Of these respondents, 80% stated that this transfer was necessary due to the monitoring capabilities in this area. However, many (45%) noted that in an ideal situation, the individual should be moved to a place where immediate counselling is available. A number of security staff mentioned that the lack of counselling services results in women being released from segregation in the absence of problem resolution.

Overall, the security staff responses indicate that the possibility of self-injury puts inordinate stress on the staff. Many reported that a self-injury is very difficult for them to deal with emotionally because of the stress involved (59%) or because of the feelings of helplessness (21%) it evokes. Others (10%) noted that the frequency of self-injury had caused them to become hardened in order to cope.

It must be noted that although the CX staff are not trained in psychological assessment they must often deal with women in emotional distress. Despite the fact that the CX staff may know a woman is in crisis, they often cannot take action until something occurs and, thus, are often placed in the situation of worrying that a woman in crisis may self-injure or suicide. One evening when I was conducting interviews on the Range post, a woman with a history of severe slashings was in distress. The CX staff increased their rounds from once an hour to once every 15 minutes to ensure she was safe. The anxiety and feelings of powerlessness of the CX staff were very apparent.

The CX staff, as the front-line workers, must without training deal with women in emotional distress. Ultimately, the responsibility for the women's safety lies with the security personnel. Both the concern that a woman may self-injure or suicide and the often encountered reality of dealing with a woman who has in fact self-injured or attempted/completed suicide creates an enormous emotional burden for the staff.

2.3 Recommendations:

* **It must be clarified that self-injurious behaviour is a mental health issue as opposed to a security issue.** As such, at the first indication that a woman is in emotional distress, the situation must move from the security domain to that of psychology/health care services. This will not only ensure that prisoners are provided with appropriate services, it will reduce stress among the CX staff by alleviating responsibility in areas they are not trained to handle. It is recognized that, at times, decisions will involve judgement calls by the CX staff and security issues will still have to be given credence.

* **It must be recognized that segregation, due to the isolation imposed and the perceived punishment aspect, is an inappropriate response to self-injury.** Given the reduction of anxiety that occurs with self-injury, the crisis is most often over once the act has taken place. Segregation can be expected to increase rather than decrease suicide potential due to the isolation it imposes. In fact, the National Task Force established by Health and Welfare Canada (1987) noted that a 1981 study conducted by the Correctional Service of Canada reported that **"suicide rates were more prevalent in dissociation areas than in general cells" (p. 35).** This recommendation reflects a strategic objective of Core Value 1, 1.5: "To ensure that placement in general population is the norm and to provide adequate protection, control and programs for offenders who cannot be maintained in the general population" (p. 9).

* Given the above recommendation, **it is further recommended that a woman who self-injures be brought to health care services where either a psychiatrist, psychologist, nurse (if properly trained in these issues), or physician (if properly trained in these issues) can assess whether the woman is best served by remaining out of the general population. If the woman is assessed as being a high suicide risk, she should remain in the health care services area or be transferred to an alternative health care facility until adequate counselling enables her safe return to the general population.** This recommendation reflects the strategic objective of Core Value 1, 1.5: "To ensure that placement in

general population is the norm and to provide adequate protection, control and programs for offenders who cannot be maintained in the general population" (p. 9).

* **It is important in times of emotional distress that the women have someone with whom they can talk.** The person best suited will depend on the individual case, and as such should be determined/identified by psychology/health care services with input from the correctional supervisors. The woman concerned would, of course, have primary input into the identification of the individual(s). This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). This surely includes the right to emotional support in times of crisis.

* **Given that the nursing staff are often a prisoner's first contact after a self-injury, the nurses should be provided training in appropriate intervention.** This recommendation reflects the strategic objective of Core Value 3, 3.8: "To provide staff training and development opportunities that are based on achievement of our Mission, develop the full potential of staff members, and emphasize interpersonal skills, leadership and respect for the unique differences and needs of all offenders" (p. 13).

Section 3: Injury Reduction

To date, prison personnel have taken a reactive rather than a proactive stance toward self-injurious behaviour. If the frequency of self-injury is to be

reduced, it is imperative that a proactive stance be adopted. The first step in injury reduction is determining the situations and/or factors involved in evoking a self-injurious response. It should be kept in mind that self-injury is not a problem in and of itself, but rather, is a symptom or outward expression of more fundamental issues. As my working hypothesis is that self-injury is a coping strategy adopted in response to childhood abuse, responses relating to childhood abuse will be the starting point for this discussion.

3.1 Prisoner Responses Regarding Childhood Abuse

Seventy-four percent of the prisoners interviewed reported being victims of childhood abuse. Of these respondents, 50% reported experiencing both sexual and physical abuse, 28% reported exclusively sexual abuse, and 22% reported exclusively physical abuse. The figures relating to sexual abuse should be considered conservative for two reasons. First, as Russell (1986) indicates, women are often reluctant to reveal sexual abuse to a unknown interviewer (p. 20). This problem of non-disclosure can often be avoided by an interview format that is lengthy enough to ensure that rapport is developed between the interviewer and the respondent. The scope of the present study did not allow this luxury. Some interviews took no longer than 20 minutes. In addition, this is a highly studied population and many prisoners are quite fed up with answering questions for studies that they perceive ultimately do not result in positive change. Given these dynamics, it must be assumed that some women who were in fact sexually abused chose not to reveal this to me.

A defense mechanism often used to cope with childhood sexual assault is a second factor which impacts on disclosure rates. The dynamics of childhood sexual assault almost exclusively involve enforced silence on the part of the victim and often on any others who are aware of the abuse. Thus, the norm for this victimization is that it not be discussed. This enforced silence often encourages repression as a coping strategy. Obviously those who use

repression to cope with their sexual abuse will not be accounted for.

The obtained results on childhood sexual abuse are highly significant and very disturbing given the factors working against disclosure. The responses indicate that 58% of the prison population disclose childhood sexual abuse. This is over double the rate reported in the population outside prison where 1 in 4 girls experience sexual abuse before age 14 (Russell, 1986, p. 61). It is critical to keep in mind that the actual rate of childhood sexual abuse experienced by prisoners is presumably even higher than the reported 58%.

Of those women who reported childhood abuse, 76% reported that they are currently experiencing emotional after-effects from the abuse. Many who believe they have resolved the emotional issues resulting from the abuse, expressed concern for other individuals. For example, one prisoner stated that through counselling she had resolved the issues relating to her abuse but that she still struggled with her concern for her sister who had presumably also been abused.

Seventy-three percent of those women who self-injure reported childhood abuse. As indicated above, this figure is undoubtedly a conservative estimate. There was no significant relationship between sentence length and self-injury. In addition, self-injury was not dependent on previous incarceration(s). There was, however, a significant relationship found between the time spent in the Prison for Women and self-injury, t (42) = 3.12, $p < .03$. Those respondents reporting self-injury had, on average, been in the Prison for Women three times longer (M = 41 months) than had those not reporting self-injury (M = 14 months).

Although some would suggest that the above finding is indicative of self-injury being learned through association, two factors argue against this. First, there was no relationship between previous incarceration(s) and self-injury. Many previous incarcerations were spent at provincial institutions. Undoubtedly, self-injury also occurs at these facilities yet the behaviour does not seem to be learned there. Secondly, if learning is a key factor, 14 months

(the average time spent by non-self-injurors at the Prison for Women) would surely be enough time to learn this behaviour.

A more plausible explanation for the connection between time spent at the Prison for Women and self-injury is that over time, more and more of the coping strategies used previously are found to be ineffective in the prison context. It is possible that in the absence of effective coping strategies one does look to others to see how they cope. Such a phenomenon would reflect not so much a learning of self-injury by association, but rather an adoption of this coping strategy as a last resort after alternative coping strategies have proven ineffective. Thus, one needs to examine the situational factors at work which lead to self-injury. Through the identification of these factors, changes can be implemented which increase the range of effective coping strategies. This in turn will reduce self-injury.

Overall, the prisoners' responses indicated two areas that need to be addressed in reducing injury: *environmental issues* and *counselling issues*.

3.2 Environmental Issues

The majority of women who self-injure identified situations producing feelings of helplessness (47%), powerlessness (42%), or isolation (6.7%), as being those that make them want to self-injure. As noted in the introduction, the experience of childhood sexual abuse involves total control over the self, the body, and, indeed, over life and death being stripped from the child. In the absence of resolution of the feelings evoked by the abuse, situations in later life that approximate the feelings of defenselessness experienced as a child will be difficult emotionally for the individual. The reduction of self-injurious behaviour necessarily involves replacing the self-injurious attempts at control over the self with more constructive coping strategies. Until these alternative coping strategies are learned, every attempt should be made to provide the woman with feelings of personal control (efficacy).

The prison environment by definition strips a person of control (i.e., freedom of movement). The prisoners' responses reveal that, overall, this aspect is not a major determinant in feelings of lack of control. Only 3% of the respondents reported sentence length as being a motive to self-injure. In addition, as mentioned earlier, there is no significant relationship between sentence length and self-injury. The women by and large accept that due to their sentence they will have no control over where they spend their next years. Nonetheless, there are a number of aspects of the prison situation that the women do feel is/should not be inherent in the prison experience and it is these aspects which increase feelings of powerlessness and lack of control. Primarily these aspects are ones which create a sense of injustice. Repeatedly encountering injustice in the absence of strategies to right perceived wrongs may, over time, cumulatively escalate feelings of powerlessness. When a certain threshold is reached, the feelings of powerlessness may be so great that previously utilized coping strategies are rendered ineffective. At this point, self-injury may become the coping strategy of choice. Such a scenario would explain the significant relationship between time spent in the Prison for Women and self-injury. In order to understand self-injury, therefore, it is imperative to examine the situations which create the feelings of powerlessness/helplessness.

3.2.1 Regulatory Aspects

Many prisoners (51%) mentioned inconsistency and/or pettiness of rules as a difficult aspect of prison life. Many believe that charges are often unfairly laid and that there is no recourse. Although women who are charged are given a court appearance, the overall belief is that in these hearings their word as a "con" will not be taken over the word of security staff personnel. A woman can grieve a staff member's behaviour/actions, but the Warden indicated that the women most often did not take advantage of this option for fear of negative sanctions. The result is that the women believe they have little power in

responding to those CX staff members who are perceived to be treating them unfairly.

The security staff themselves recognize that some staff members act in an inappropriate manner. Many are disturbed by this, believing that the actions of a few reflect upon them all and that this creates a barrier between them and the prisoners. The possibility of improving prisoner/staff relations would, therefore, not only decrease the instances of feelings of powerlessness among prisoners but would strengthen relations with the CX staff that the women do respect and trust.

3.2.2 Recommendation:

* **Undoubtedly, some of the inappropriate treatment by staff is due to a lack of understanding of the impact of childhood sexual abuse. This should be corrected through on-going training in the dynamics of childhood sexual abuse.** Through training, security staff staff may gain an awareness of how their behaviour impacts on the prisoners. This, in turn, would allow them to relate to the prisoners in a more constructive manner thereby decreasing feelings of frustration among the CX staff. This recommendation reflects the strategic objective of Core Value 3, 3.5: "To ensure that those few staff who cannot deal with offenders are properly assisted" (p. 13).

3.2.3 Mass Policy Actions

A second issue identified by the women as creating feelings of powerlessness and injustice was the use of mass punishment. For example, it was reported that in December, 1988, a dance was cancelled because alcohol was found in one of the cells. A second often cited example was the recent hourly cell lock-up procedure implemented because of the fear of violence by a

few prisoners. In these situations, all prisoners suffered due to an attempt to limit the actions of a few. Feelings of injustice with no possibility of recourse decrease feelings of personal efficacy. This powerlessness escalates the need to gain feelings of control through self-injury as was evidenced by the increase in slashings following the implementation of the hourly cell lock-up.

3.2.4 Recommendation:

* **Given that any policy which will impact on all prisoners may have repercussions in terms of mental health issues, prior to the implementation of such a policy input should be solicited from psychology, health care services, and psychiatry.** This input should be a critical factor both in determining whether the policy is appropriate and the method of implementing the policy if it is deemed appropriate.

3.2.5 Impact of the Environment on Emotional Expression

A third environmental issue identified by the prisoners was the lack of opportunity to express emotion. If a woman requires time alone she can request permission to be placed in the quiet side of segregation. These cells, however, are often anything but quiet. In addition, the lack of privacy afforded by these cells is not conducive to a woman venting such emotions as anger or sadness.

Given the lack of training of CX staff, this personnel is not in a position to assess whether emotion is merely expressive or is indicative of an emotional crisis. Thus, the staff are often compromised by perhaps wanting to allow the women to emote and yet having responsibility for ensuring that the situation does not get out of hand. This results in the CX staff having a vested interest in emotions being suppressed.

There is also no systemic acknowledgement that emotional difficulties can

impact on work performance. Women are expected to carry on their daily duties regardless of what they are working on emotionally. In fact, women who do not report to work are placed on charge unless they have a sick pass. This is not an accepted norm in the population outside the prison. Society has come a long way in recognizing that mental health issues must be addressed. As such, many companies allow employees one mental health day a month. In addition, programmes for individuals who are in emotional distress not only acknowledge that emotional distress can result in an inability to work but provide a means of support while the individual concentrates on emotional issues.

3.2.6 Recommendations:

* **A time-out room should be established in which a woman can express emotions such as anger or sadness in privacy.** There must be no negative sanctions associated with the use of such a room. This area should be under the control/purview of psychology and health care services. This would ensure that a woman requiring more than just emotional release would have immediate access to support counselling. In addition, the implementation of this recommendation would relieve the CX staff of having to decide just when emotion is merely expressive and when it is indicative of the need for psychological intervention. This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). This guiding principle surely indicates that offenders should retain their right to emotional expression.

* **The stress of normal daily living (which is escalated in the prison context) should be acknowledged and validated through the sanction of sick passes to be used for mental health purposes as well.**

* **The impact of emotional difficulties on the ability to carry on with a normal work routine must be acknowledged.** Upon a recommendation from Psychology, women should be allowed to work on their emotional issues without being penalized by loss of pay or by charges due to an inability to work. This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). In addition, this recommendation reflects a strategic objective of Core Value 2, 2.1: "To ensure that the needs of individual offenders are identified at admission, and that special attention is given to addressing mental disorders [*sic*]" (p. 11).

3.2.7 Security Versus Mental Health

A fourth environmental issue glaringly apparent through my observations at the prison is the extent to which security issues supersede mental health issues. Two examples will illustrate this. During my time spent at the prison, one of the prisoners indicated to me that she was in emotional distress and needed counselling. As the prison psychologists were unavailable at the time, she asked if I would meet with her. Discussion with this prisoner revealed that a number of situational factors at the prison were overwhelming her emotionally. The prisoner was not suicidal but needed support to assure her that she was reacting normally to stressful situations and In fact, given what she was dealing with, was coping very well. In the midst of our discussion, a CX staff person knocked on the door to announce that the 4:00 count was going on and the prisoner had to immediately return to her cell. I believed that this woman needed to finish her conversation with me but the rules of the institution took precedence. That night, the prisoner in question slashed. I am confident that

this slashing could have been avoided had there been some forum to circumvent established count protocol, thus, allowing the counselling session to continue.

In a second case, while I was interviewing CX staff on the A Range post it became apparent that one of the women on the range was in emotional distress. A number of prisoners approached the barricade and requested that I be allowed to speak to the woman. After negotiations with the security staff on duty this was allowed, and I spent about an hour and a half counselling this woman. The prisoner involved has a long history of severe slashing and my intervention allowed her to talk about her feelings enough that she was able to make it through the night without incidence. It should be noted here that the security staff involved were most supportive of my actions. My point is not that the CX staff always conform to protocol despite the ramifications to the women, but rather, that to ensure the safety of the women, the security staff may have to make the decision to break with protocol. To place staff in a position where they must accept responsibility for breaking protocol is unreasonable and places an unfair burden on the CX staff.

3.2.8 Recommendation:

* **Mental health issues must be considered with security protocol.** In the event that action for dealing with an emotional crisis is at odds with established security procedure, there must be sanctioned methods to circumvent security protocol to ensure prisoners receive appropriate help. For example, in the case where I was counselling the woman at count time, the counselling should have continued with the prisoner concerned accounted for as being present and in a counselling session.

3.3 Counselling Issues:

It was almost universally agreed upon by prisoners (98%) and CX staff (93%) alike that existing counselling services are insufficient. The two psychologists on staff at the prison provide excellent services to the extent that their case load allows, but at present, both have an eight month waiting list. For years it has been known that women make more use of mental health services than do men. Women comprise almost two thirds of the adult population of general psychiatric, community mental health, and out-patient psychiatric facilities (Greenspan, 1983). This fact alone argues for the necessity of broad based mental health services in any facility dealing with women. In the case of the Kingston Prison for Women, the population is largely comprised of women who have experienced major physical, sexual, and/or emotional abuse. Existing mental health services do not reflect or address this fact.

A second issue reported by many of the prisoners is the availability of mental health services only during normal business hours. Unfortunately, emotional crises are not restricted to these hours. The psychologists at the prison have tried to be available for after-hour emergencies but this presents two problems. First, this alternative is premised on being able to contact a psychologist after hours. This is not always possible. Secondly, in times of severe stress at the prison, the psychologists can expect to be called quite often. This situation will soon lead to burn-out on the part of the psychologists.

At present, if a psychologist cannot be reached after hours, the CX staff has few alternatives but to put a woman in emotional crisis in segregation to be monitored. The isolation imposed by segregation and the perceived punishment mentioned earlier can only be expected to exacerbate a crisis situation.

A third issue relating to counselling services is the lack of services for native women. Although these women do have access to psychology services, cultural aspects may limit the ability of existing services to meet these women's needs.

The two prison psychologists provide excellent services and the prison should be commended for their wisdom in selecting two individuals who are so conscious of the women's needs and are so qualified in dealing with women's issues. I believe the prison was also wise in hiring female psychologists. Although some argue that male therapists provide positive male role models for women who have been abused by men, my experience has been that positive male role models are useful only in the post recovery period. In the recovery stage, it is much more important to provide positive female role models. Women who have been abused by men have been given the message that to be female is to be powerless. The misuse of authority by male abusers teaches those abused to respond to males in a submissive, and often fearful way. Regardless of the sensitivity of a male therapist, it is often difficult for an abused woman to relate to him in a way that preserves her adult status. Often the best that can be hoped for is a paternalistic relationship between a male therapist and an abused woman.

Despite the quality of services presently provided by the two prison psychologists, eight month waiting lists and the absence of evening services result in the majority of prisoners not being able to access appropriate mental health services. The responses from the prisoners indicate that, in large part, they rely on one another for emotional support and crisis intervention. Many spoke of talking friends down in a crisis, of strategies for removing "sharps," or of the emotional support they themselves have received from others.

3.3.1 Recommendations:

*** The fact that women make more use of mental health services in the general population combined with the overwhelming number of prisoners who have experienced physical, sexual, and/or emotional abuse must be reflected in the provision of mental health**

services. Additional counsellors should be hired immediately. (As noted above, it is recommended that these be female counsellors.) Prisoners requesting counselling should have to wait no longer than a week or two before being seen by a psychologist. This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). Offenders must retain their right to adequate counselling services.

* **Given the overwhelming number of prisoners sexually abused as children, Childhood Sexual Assault Survival Groups must be instituted immediately and must be an on-going aspect of the treatment services.** These groups should have no impact on parole proceedings a) to reduce the possibility that women be pressured to take part in these groups before they are ready to deal with the issues and b) to reduce negative repercussions if a woman finds, upon entering the group, that she is not yet emotionally ready to deal with these issues. The reward for joining such a group must be premised solely on the personal gains and achievement that participation in such a group brings. This recommendation reflects a strategic objective of Core Value 2, 2.2: "To ensure that the special needs of female . . . offenders are addressed properly" (p. 11).

* **The native population should have access to services by an individual (preferably native) who has an intense**

understanding of issues unique to the native culture. This recommendation reflects a strategic objective of Core Value 2, 2.2: "To ensure that the special needs of . . . native offenders are addressed properly" (p. 11).

* **Access to mental health services should be available on a 24 hour basis.** Failing this, evening access to counselling is imperative. This recommendation reflects a strategic objective of Core Value 2, 2.1: "To ensure that the needs of individual offenders are identified at admission, and that special attention is given to addressing mental disorders [*sic*]" (p. 11).

* **An alternative to segregation for dealing with women in crisis must be developed.** This recommendation reflects a guiding principle of Core Value 1: "All of our dealings with individuals will be open, fair, and humane" (p. 8). Segregation of a woman in emotional distress is neither fair nor humane.

* **The existing support network among the women must be recognized and legitimized.** This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). These rights surely include the right to peer support.

In accordance with the above three latter recommendations the following programme is proposed:

3.4 Support/Crisis Programme

At present, a good deal of the counselling/emotional support that takes place in the prison is provided by the prisoners themselves. Many services outside of the prison (e.g., Sexual Assault Crisis Centres) acknowledge the usefulness of peer support by training individuals to act in this capacity. These para-professionals are then available to do crisis intervention. Many times, these services are all that are required. In the event that these services are not enough, the individuals are trained in identifying situations that require professional services. Thus, these para-professionals engage in crisis intervention and where required, referral.

Such a programme would go a long way in augmenting existing services. Therefore, it is proposed that a number of prisoners be trained as support counsellors. It is suggested that this programme be under the joint domain of psychology and health care services. The selection, training, and implementation processes are outlined below.

3.4.1 Selection Process:

A team of women comprised of representatives from each living area of the prison (A Range, B Range, Wing) would take part in the training programme. The initial training programme could accommodate 12 women. The selection of these women should be based on the following criteria:

a) Expressed interest in the programme.

b) An indication that the individual possesses the qualities that after training will result in an ability to counsel such as empathy, good listening skills, and respect for confidentiality. This would be determined during a screening interview and through on-going evaluations both during and after the training process.

c) The ability of the individual to draw boundaries for herself such that she is able to refrain from counselling when she herself is undergoing particular

stress. Again, this would be assessed during a screening interview and evaluated both during and after the training programme.

d) As the best potential counsellors may not be individuals with the best institutional records, it is strongly advised that absence of charges or a specified charge free period not be a prerequisite for involvement in the training programme. In cases where it was questionable whether a particular woman was appropriate for the crisis/support team, psychology/trainers would be responsible for determining suitability with input from correctional supervisors.

3.4.2 Training:

The training programme would consist of 10 two hour sessions. The sessions would cover the following:

Session 1: The Role of the Support/Crisis Counsellor
Limitations of the Support/Crisis Counsellor
Session 2: The Impact of Childhood Sexual Abuse
Session 3: The Impact of Physical and Emotional Abuse
Session 4: Counselling Skills and Techniques
Session 5: Counselling Skills and Techniques
Session 6: Dealing with a Suicidal Individual
When to Refer
Session 7: Self-Injurious Behaviour
Session 8: Self-Esteem Issues
Session 9: Dealing With Anger
Session 10: The Impact of Counselling on the Counsellor

At the end of the training programme, an evaluation would take place. Upon successful evaluation, the individual would become part of the crisis/support team. This position would be in addition to whatever duties the woman

currently undertakes at the prison but there would be monetary recognition of the hours involved through paid absence from her other work duties. For example, if a woman engaged in two hours counselling during the evening or night, she would receive two hours paid leave from her regular work schedule to compensate for her counselling time.

Training will be conducted by the psychology department. It is important that the individual responsible for training be a specialist in childhood sexual abuse. At present, Julie Darke fulfills this requirement. Given the nature of the training programme it is expected that outside speakers and resources will be utilized. It is suggested that two training programmes be offered the first year. Demand should dictate how many programmes are offered in subsequent years. As prisoners gain experience as members of the crisis/support team they should become involved in the training process.

3.4.3 Implementation:

The services of the crisis/support team would be available to the prisoners on a 24 hour basis. A woman requesting the service would be brought to health care services where she would be screened by the nursing personnel. Once the nursing staff established that it was a situation which could be handled by a member of the crisis/support team, the member on call would be brought to health care services. Counselling could take place in the room presently serving as the isolation ward. If at any time during the support session a team member deems that additional help/support is required, the member would be responsible for contacting the nursing staff who, in turn, would contact a psychologist if required.

Once the counselling/support session is completed, the prisoners would return to their regular routine. In the event that the session takes place during the night, if it would cause too much disruption to return the women to their cells, alternative sleeping arrangements would be found. If space permits, the two

women could complete the night in the hospital area. If these beds are already filled, the women could be taken to segregation. In the latter case, the move to segregation would be for sleeping purposes only and both women would be released the following morning without the necessity of being seen by a psychologist or going before the Segregation Review Board.

3.4.4 On-Going Support for Team Members:

To ensure adequate support for crisis/support team members, their job description would include weekly meetings at which they could discuss difficulties encountered in the counselling/support sessions. As it is being recommended that this crisis/support team be under the auspices of both psychology and health care services, it is suggested that as the primary liaison, nursing staff be present at these weekly meetings. This would necessitate nursing staff also completing the training programme.

On the fourth weekly meeting of every month, psychology should also be present. This would allow for professional advice and direction that was outside of the nursing staff's expertise. In addition, psychology could use this monthly contact to arrange additional workshops to upgrade the members' counselling skills.

Section 4: Suicide Identification

As I outlined in my report of February, 1989, I have some hesitancy in dealing simultaneously with self-injurious and suicidal behaviour for fear of reinforcing the notion that these behaviours are one in the same. Nonetheless, the prevalence of the belief that these two behaviours are identical necessitates dealing with both. On the one hand, prison personnel need to be informed that self-injury is not a suicide attempt. This should reduce much of their anxiety in

dealing with these situations. On the other hand, it is possible that self-injurious and suicidal behaviour can coexist in the same individual; therefore, it is imperative that staff not be given the message through training that self-injury necessarily precludes suicidal ideation. Self-injury is a coping strategy that has developed due to a childhood filled with abuse. The impact of abuse of such magnitude will have many repercussions. Self-injury is but one indication of the trauma withstood. Individuals who have been grossly abused suffer from lowered self-esteem, guilt brought on by societal attitudes surrounding sexual assault, suppressed anger, and a multitude of other behavioural consequences which may result in suicidal feelings. Nonetheless, it is important to distinguish between self-injury and suicidal behaviour to ensure that appropriate intervention is provided. At present, the belief that these two behaviours are one in the same has, in many cases, resulted in an over reaction to self-injury.

As the existing protocol for a suicide attempt is identical to that outlined earlier for self-injury (cf. pp. 11-12) I will not repeat it here. The reactions of prisoners and CX staff to this protocol have also been adequately covered under the section relating to self-injurious behaviour (cf. pp. 12-14). It should be apparent that the majority of the recommendations regarding self-injury also apply to suicidal behaviour. For the most part, if the recommendations made with respect to self-injury are implemented, this will facilitate both suicide identification and appropriate treatment. By and large, the most important point with respect to suicide is that suicidal individuals should not be placed in segregation. As mentioned earlier, the isolation imposed by segregation increases rather than decreases suicidal ideation. It is worth repeating that the National Task Force established by Health and Welfare Canada (1987) noted that a 1981 study conducted by the Correctional Service of Canada reported that suicide rates were "more prevalent in dissociation areas than in general cells " (p. 35).

4.1 Recommendations:

*** As recommended in the case of self-injury, it must be clarified that suicidal behaviour is a mental health issue as opposed to a security issue. As such, at the first indication that a woman is in emotional distress, the situation must move from the security domain to that of psychology/health care services.** This will not only ensure that prisoners are provided with appropriate services, it will reduce stress among the CX staff by alleviating responsibility in areas they are not trained to handle. As in the case of self-injury, it is recognized that, at times, decisions will involve judgement calls by the CX staff and security issues will still have to be given credence.

*** It must be recognized that segregation, due to the isolation imposed and the perceived punishment aspect, is an inappropriate response to suicidal behaviour. Segregation can be expected to increase rather than decrease suicide potential due to these factors.** This recommendation reflects a strategic objective of Core Value 1, 1.5: "To ensure that placement in general population is the norm and to provide adequate protection, control and programs for offenders who cannot be maintained in the general population" (p. 9).

*** All suicidal individuals must have immediate access to counselling services.** This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). This must include the right to suicide intervention.

* **Given the above two recommendation, it is further recommended that a prisoner who is believed to be suicidal be brought to health care services and given immediate access to counselling support. Following this, a psychologist should assess whether the woman is best served by remaining out of the general population.** If a woman is assessed as being a high suicide risk, she should remain in the health care services area or be transferred to an alternative health care facility until adequate counselling enables her safe return to the general population. This recommendation reflects the strategic objective of Core Value 1, 1.5: "To ensure that placement in general population is the norm and to provide adequate protection, control and programs for offenders who cannot be maintained in the general population" (p. 9).

* **It is important in times of emotional distress that a woman have someone with whom she can talk.** The person best suited will depend on the individual case, and as such should be determined/identified by psychology/health care services with input from correctional supervisors. The woman concerned, of course, would have primary input in the identification of the individual(s). This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). These rights surely include the right to support in times of crisis.

* Given the above recommendations, **it is further recommended that a prisoner identified as suicidal be allowed access to the crisis/support team outlined earlier.** This recommendation reflects a guiding principle of Core Value 1: "Offenders, as members of society, retain their rights and privileges except those necessarily removed or restricted by the fact of their incarceration" (p. 8). These rights surely include the right to peer support.

* **Given that the nursing staff are often a prisoner's first contact after identification as a suicide risk, the nurses must be provided training in appropriate intervention.** This recommendation reflects the strategic objective of Core Value 3, 3.8: "To provide staff training and development opportunities that are based on achievement of our Mission, develop the full potential of staff members, and emphasize interpersonal skills, leadership and respect for the unique differences and needs of all offenders" (p. 13).

Section 5: Conclusion

The most important finding of this study is the extent to which security issues supersede mental health issues. With both self-injurious and suicidal behaviour, responsibility has largely remained with the CX staff. This situation has involved inordinate stress for these staff members who are not trained in mental health issues. The primary concerns to date have been security/administrational versus treatment.

The prison must begin utilizing the resources they have at their disposal.

Many of the recommendations made in this report are ones that have been voiced by the two prison psychologists and health care services staff for quite some time. The fact that these voices have not been heard or acted upon, reflects the historic trend towards a reactive rather than proactive stance to mental health issues. The psychologists have largely been relegated to a position of "putting out fires" as opposed to being included in policy making. This trend must end. It must be recognized that every policy has a potential impact on the emotional well-being of prisoners and, as such, the psychologists must have equal if not greater power than security in the policy process. Input from the psychology department could avert many of the problems presently experienced when new policy is implemented.

Secondly, the overwhelming number of prisoners who have experienced childhood abuse must be addressed. The prison system is dealing with women who have as children experienced loss of control/determination over the fundamental right to their bodies. Many of the current practices in the prison result in these women once again experiencing feelings of helplessness and powerlessness. This is a difficult situation for a non-victimized individual; for those who have been victimized, the replication of feelings of defenselessness experienced as a child is untenable. In the absence of systemic change, these women, upon completion of their sentence, will go out into the world doubly victimized. It is unreasonable to expect that after such an experience they can reach their full potential as citizens. In addition, it must be recognized that the recommendations contained in this report are interim measures.. Ultimately, provision must be made for those offenders who have experienced childhood abuse to be housed in facilities directed solely toward treatment. Until that point, any steps taken must be considered "band-aid" measures.

Addressing mental health issues must ultimately involve changes in the distribution of staff. The Mission Statement acknowledges that if offenders are assisted in developing social and living skills their potential to become law-

abiding citizens will be enhanced (p. 10). This goal can only be achieved by ensuring that individuals the prisoners come into daily contact with are trained in promoting these skills. The addition of social workers to complement the CX staff would provide positive interactions for the prisoners and would alleviate the stress the CX staff currently experiences from being forced into the role of social worker. As well, many of the recommendations made in this report involve the utilization of health care services personnel. The increase in use of this service through the implementation of the recommendations must be provided for through the addition of nursing staff.

By implementing the proposed recommendations, the number of situations which aggravate feelings of helplessness and lack of control will be reduced. This, in turn, will reduce the occurrence of self-injurious behaviour. The proposed shift from viewing self-injurious behaviour as a security/administrational concern to viewing it as under the domain of psychology/health care services should also reduce the rate of occurrence. The proposed transfer to health care services as opposed to segregation will provide structured opportunities for prisoners to work through emotional difficulties in a positive atmosphere with the person(s) best suited to meet individual needs. The possibility of immediate support from peers, nursing staff, and/or psychologists offers an alternative to self-injury as a method for coping. It has been my experience that when a woman who self-injures is provided with alternative ways to reduce anxiety and deal with feelings of helplessness/powerlessness she will utilize the more health-oriented option. Thus, I am confident that the proposed changes will be successful in the reduction of this behaviour.

Self-injury is a symptom of distress resulting from childhood sexual abuse. Its occurrence must be viewed by Correctional Service as an indication of the emotional pain experienced by many in the population it serves. The Mission Statement reflects a philosophy which has moved from a punishment

model to a rehabilitative model. To achieve this, the impact of such factors as childhood abuse must be taken into account, both as playing a part in the woman entering the penal system and as an important issue to be addressed in attempting to assure that upon release the woman does not return. It is only when the Mission Statement's philosophy is reflected in practice that offenders will be allowed the opportunity to serve their sentences in "a meaningful and dignified manner" (p. 7).

Section 6: Contract Proposal

As outlined in the Statement of Work, Appendix "D," Contract 89-90-ONT-280, 16 days have been allocated for implementation of the the proposed programme and for training of relevant personnel. It is proposed that these days be utilized in the following manner:

* 5 days for assisting the psychology department in outlining specific course content and support in training the first crisis/support team. It is assumed that given the current work load of the psychologists that they will need this support at least initially to ensure that the implementation of this programme does not put an unfair burden on them.

* 5 days for training health care services staff. As this department will be working closely with the crisis/support team, it is imperative that any concerns about meeting programme needs be addressed through adequate training.

* 6 days to monitor the programme and deal with the inevitable problems that will arise. It is important to acknowledge in advance that with every new programme there will be aspects of its implementation that have to be modified and/or changed. By ensuring in advance that there is a vehicle for addressing implementation issues, there will be a greater probability of programme success. Thus, I propose that I spend two days a month for the first three months meeting with the crisis/support team and with other relevant personnel to address concerns and/or problems that may arise in the early stages of the programme.

In closing, I would like to thank all individuals interviewed for their openness and honesty. In addition, the support I received while at the prison made a difficult task much easier to accomplish.

Section 7: References

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