

Corrections Research:
User Report

**The Treatment of Incarcerated
Mentally Disordered Women
Offenders: A Synthesis of
Current Research**

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Alan W. Leschied Ph.D., C. Psych.

University of Western Ontario

Abstract

This synthesis of the research evidence in relation to the treatment of mentally disordered women offenders is prompted by recent reviews of correctional practice in the Canadian federal correctional system, and the growing awareness of the impact research can have on programs for women within the correctional system. Women offenders, in part as a function of their pre incarceration histories, will display more elevated risky behaviours as expressed through aggression, self-injury and multiple emotion-related disorders. With sex-specific programming and research-informed practice along with support for training in the context of providing adequate resources, correctional practice can have a positive impact both in the institutional management of behaviour as well as with longer-term positive outcomes. However, research also indicates that without the guide of informed practice and staff support, correctional practice tends to resort to traditional punitive measures such as the use of segregation as a means of managing the challenging and high-risk behaviours of mentally disordered women offenders.

Authors' Note

The views expressed are those of the authors and not necessarily those of Public Safety Canada.

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Introduction

What happens within the broader community eventually filters into the correctional system. Historically in Canadian corrections, this fact has been most notably reflected in policies regarding substance abuse and HIV status inmates. It has also been acknowledged in the context of the prevalence and etiology of mental disorder and women within corrections.

Epidemiological studies beyond the correctional system in regards to mental disorder and women consistently show that rates of mental health disorder are higher for women relative to men, and there is uniqueness for women in the nature of these disorders. There is also ample evidence that these findings transcend culture. The recent review by the World Health Organization (2008) reflects the broader literature in concluding:

- Gender is a critical determinant of mental health and mental illness
- Gender influences the rates of depression and anxiety
- Unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women
- Gender specific risk for common mental disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, and low or subordinate social status
- Lifetime prevalence rates of violence against women range from 16% to 50%
- High prevalence of sexualized violence to which women are exposed and the correspondingly high rate of Post Traumatic Stress Disorder (PTSD) following the violence renders such women the single largest group affected by this disorder

How do these concerns with respect to women translate into the correctional system? Perhaps to no surprise, and consistent with community-level epidemiologic studies, the prevalence rate for mental health disorder is higher for women relative to men when they enter the correctional system. Studies differentiating male from female offenders indicate that, with respect to comorbidity of violence and risk with men, women report higher levels of depression and suicidal ideation and higher scores on measures of aggression with depression rates close to 40%. Veysey (1997) reports that in US prisons, the prevalence estimates for women for overall mental health disorder is 18.8%, a rate greater than twice that for males, with acute emotional disorder three times the rate, and more than four times the rate for serious depressive disorder. Over 1 in 5 women are diagnosed with PTSD.

The rate for mental health disorder within Canada's federal correctional system is increasing for both genders, and while the focus of this review relates to women, it is important to draw on data from the Correctional Service of Canada's (CSC_ Review Panel (2008) that indicate this increase is significant for both genders,

“In 2006, 12% of men offenders were identified at admission as having diagnosed mental health problems, an increase of 71% since 1997. For women, the 2006 rate was 21%, an increase of 61% since 1997.”

Gendered Pathways for Women into the Correctional System

Why do women experience higher rates of mental health disorder, which may in certain cases, be expressed through violent and antisocial behaviour? Consistent within the literature is the reporting that women are at much higher risk for being victimized physically or sexually in both their families of origin as well as through stranger contact; a fact that relates prior victimization to the subsequent perpetration of violence and other anti social acts (Leschied, 2011). Women will also experience marginalization in ways that will influence their mental health status such as through lower socio economic status and child-rearing responsibilities within less than supportive contexts. What is important to note is that the pathways for women into the correctional system may or may not be a direct function of the presence of a mental disorder. However, a history of victimization/mental health disorder will play an important role in a woman's response to a correctional environment and the nature of the programming that is provided. The nature of programming that is offered will in turn relate to a women's adjustment while incarcerated, their benefit from programs and the probability of success from correctional treatment and the potential for recidivism.

The most oft cited range of disorders and prior histories for women that will challenge planning and management in the correctional system include substance abuse, borderline personality disorder (which heretofore will be referred to as a 'disorder of extreme stress'), child sexual abuse, self-injurious behaviour, and the cumulative effects of multiple sources of stress resulting from victimization through physical and sexual violence.

While a number of epidemiologic studies document the representation of mental health disorder among women within the corrections system, the report by Lewis (2006) is typical of the findings: substance abuse/dependency - 65.4%; PTSD - 40.8; major depressive disorder/dysthemia - 40.8%; antisocial personality disorder - 32.3%; anxiety related disorders - 9.2%; schizophrenia/manic disorder - 6.5%. This section summarizes the nature and presentation of mentally disordered women mindful that many women will have concerns that fall across categories. An appreciation of the nature of these most frequently experienced disorders provides an important context to the following sections that discuss the assessment and treatment of mentally disordered women offenders.

Substance Abuse

Grant and Gileno (2008) report that 80% of women offenders in Canadian federal institutions have substance abuse problems. CSC is fortunate to have a recent and very comprehensive reporting of substance use with women offenders (Matheson, Doherty, & Grant, 2009). This report also provides a very clear statement of the extent to which gender informed programming through the Women Offender Substance Abuse Program (WOSAP) and its evaluation as an integral part of CSC's response to substance use and women offenders. As these authors state: "[WOSAP] program is gender responsive, which, in this context, refers to an environment (program content, staffing and culture) that reflects a comprehensive understanding of the realities of women's lives" (p. ii).

The evidence shows that although women reflect a lower rate of alcohol and substance consumption relative to males, they will have more substance abuse related disorders reflected in a higher co-occurrence rate with general health related concerns, mental health disorder, a quicker course of addiction, and greater social isolation and higher death rates as a result of their abuse (Najavits, Rosier, Nolan, & Freeman, 2007; Sarteschi, Christine, & Vaughn, 2010). Once again, and consistent with an appreciation of the gendered context within which certain disorders arise, Covington (2008) and her colleagues at the *Centre for Gender and Justice* suggest a differential and gendered informed appreciation of the ways in which women will experience substance and alcohol abuse which necessitates an appreciation for:

- Alcoholic women being more likely to have been abused sexually, physically and emotionally by more perpetrators, more often and for longer periods of time than their non-alcoholic counterparts
- The experience of interpersonal trauma increasing a women's risk for substance abuse

The relevance of research with respect to alcohol and substance abuse singularly emphasizes substance misuse as a necessary condition for consideration of specific treatment approaches, an appreciation of the context of trauma in how women enter into a lifestyle of alcohol and substance abuse. The *British Columbia Centre for Excellence in Women's Health* (2006) outlines the gendered differences not only between men and women who enter into abuse, but also highlights the different effects certain drugs will have with women, again emphasizing the necessity of a women-centered appreciation for programs and policies that can more adequately address these concerns. They suggest, " [there is an] immediate need for more understanding of the relationship for women between a lack of social supports, trauma, and other upstream factors in mediating problematic substance use across the life course." (p. 23).

Borderline Personality Disorder

Estimates with women offenders for the prevalence of borderline personality disorder (BPD) suggests up to 20% of women in the correctional system will have a BPD diagnosis compared to 2% in the general non-offender population (Nee & Farman, 2005). BPD is a serious mental health disorder characterized in the DSM-IV diagnostic criteria as reflecting pervasive symptoms including instability in mood and difficulties in interpersonal relationships, self-image and behaviour. Such difficulties are pervasive and disruptive across all domains including family and working life. It also reflects the inability of an individual to be involved with long term planning, compromising an individual's sense of self-identity and influencing the ability to regulate emotions.

Complex Trauma (CT) or a 'disorder of extreme stress' are now commonly used terms of a symptom cluster expressed by many survivors of past abuse, and in particular, child sexual abuse. CT refers to disorders related to changes regarding a sense of personal safety, trust, response to power and authority, self-esteem and an inability to relate in intimate relationships (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). CT research with child sexual abuse victims, in accounting for their presentation across the life span, reflects the characteristics of the child and the context within which they were abused. Factors that will influence their presentation in symptoms will include, but not be limited to, the age at which the abuse occurred, the sex of the perpetrator, the extent of family support (i.e., "was I believed?"), relationship to the perpetrator (i.e., was it a relationship based on trust?), who the adult believed was aware of the victimization at the time, the nature of the victimization, and the frequency and length of time during which the violence occurred.

Child Sexual Abuse

The range in estimates for women offenders who have been physically and/or sexually abused, as cited by Silberman (2010), ranges from slightly less than 50% to close to 90%. Estimates vary widely due in part to the lack of reliability when self-report is the sole source of data or in the inconsistencies in sourcing formal records within child welfare agencies for the women being studied. Regardless, the rate is considerable and its impact devastating.

The trend within the literature relating to the long-term effects of what Childhood Sexual Abuse (CSA) will mean into adulthood is increasingly focused on select factors related to events at the time of the victimization and the extent and nature of social support that the woman will have experienced over the

longer term. While disorders specific to CSA relate to many of the symptoms of Post Traumatic Stress Disorder (PTSD is discussed in the following section) noteworthy, are the findings in the study by Leve-Wesiel (2008) that pay particular attention to dissociative disorders and emotion regulation. The nature and strength of the range of disorders resulting from CSA will have significant consequences for treatment.

Such outcomes related to CSA will be a function of when the victimization occurred during childhood, which in turn is related to an on-going mistrust of others. Child victims, compared to children who were not sexually abused, will have higher rates of alcohol abuse, marijuana use, difficulty expressing feelings of sexuality and intimacy or the expression of hyper sexuality in an effort to please others. Recent research with respect to what the effects of trauma arising out of childhood sexual abuse consists of a) a loss of optimism, b) a loss of a sense of self, and c) the significance in the loss of childhood (Murthi & Espelage, 2005).

Self-Injurious Behaviour/Suicide

The prevalence rate of self-injury in the general population, accounting for the limitations due to self-report and how Non Suicidal Self Injury (NSSI) is defined ranges from 10 to 20 percent with gender differences showing much higher rates among women relative to men in clinical populations (Heath, Toste, Nedecheva, & Charlebois, 2008). However, the rate of self-injurious behaviour for women offenders has been estimated at over half of the inmate population (Milligan & Andrews, 2005). Reviews regarding women who self-harm suggest that the meaning underlying such behaviour is significantly more complex than traditionally conveyed. The traditionally accepted view considered self-injurious behaviour as primarily reflecting the purposeful manipulation of others for the intent of provoking a response, or as a means of deflecting negative affect away from the self. However, Klonsky (2007) and others (Hastings & Noone, 2005; Kilty, 2006) have identified at least seven separate functions of deliberate self-harm. These include the alleviation of acute negative affect or aversive affective arousal; ending the experience of depersonalization or dissociation; replacing, compromising with, or avoiding the impulse to commit suicide; asserting one's autonomy or a distinction between self and other; seeking help from or the manipulation of others; derogating or expressing anger towards one's self; and / or generating exhilaration or excitement. The most frequent factor linked to NSSI relates to past childhood trauma, rooted in either physical, or more commonly, sexual maltreatment. However, other preconditions can influence the possibility of NSSI such as interrupted attachment or insecure or anxious attachment styles within the family of origin, or certain genetic preconditions. Etiologically, the person with NSSI will either not have developed affect regulation through the normal course of developing a variety of coping styles to an effective degree, or if learned, will no longer find them sufficient. The physical pain serves as a possible distraction, a means for personal punishment, minimization of dissociation when feeling isolated or missing a loved one, or sensation seeking and a source of self-stimulation (Klonsky, 2007).

The relevance to corrections with respect to NSSI is profound, and Thomas, Leaf, Kazmierczak, & Stone (2006) have focused this profundity in the context of whether NSSI is a correctional issue to be managed or a mental health issue with the attendant need for particular mental health intervention. They state "...viewing self injury primarily as individual pathology leads to policies that emphasize control and punishment, rather than to an understanding of the broader context of the behaviour" (p. 194). This approach has two consequences. First, policy responses to self-injury primarily seek to control or penalize it, rather than to address broader institutional factors that may contribute to it. Second, prison officials typically ignore the role played by the debilitating environment that both motivates and facilitates self-injury, thereby creating prison policies that retain a myopic thrust that may in fact encourage such behaviours. Additional commentaries reflect that self-injurious behaviour for women in the correctional system can be considered a reaction to the conditions of confinement, what Dell and

Beauchamp (2006) refer to as the “pains of imprisonment” or a reaction to factors that preceded the woman’s placement in custody such as the legacy of assault.

Post Traumatic Stress Disorder

Wolff and Shi (2009) summarize that fifty per cent of persons in the general population will experience an event that will be of a traumatic nature, with an estimated 15-24% subsequently experiencing one or more PTSD symptoms. Citing the work of Breslau amongst others, Wolff, Blitz and Shi (2007) report that while males have a slightly higher rate of direct exposure to a traumatic event, women will more often experience the ancillary impact of a PTSD symptom(s). Within the prison population of women offenders, the rate for abuse-specific trauma is twice the rate in the general population; the experience of PTSD however is three times the general population rate (Teplin, Abram, & McClelland, 1996).

PTSD consists of symptoms or a symptom cluster that reflects extensive intrusive thoughts connected to the past trauma, dissociation, emotional numbing, hyperarousal, anxiety in response to past recollection of the trauma, and defensive avoidance, characterized as a history of aversive internal experiences to past trauma such as reliving past painful memories related to trauma and victimization. These three areas of PTSD are considered the “classic posttraumatic presentation” since they encompass both intrusive as well as avoidant aspects of PTSD. In addition, there is also escape or avoidant patterns of behaviour that are an attempt to suppress or avoid the overwhelming sense of immobilization of the experience of PTSD symptoms. These can include endorsements of arousal through anxiety and irritability.

Of course, not everyone who experiences a traumatic event will also experience PTSD. John Briere, arguably the most significant contributor to research and assessment regarding PTSD, suggests that persons who experience PTSD do not do so as “the result of a single event but [is] experienced by persons who have had a cumulative pattern of horrifying events, most likely dating to early childhood. Almost inevitably, early traumas, even [after] controlling for all other trauma, are the ones that produce the most severe effects” (as cited in Bates, 2003, p. 1).

Cumulative Effects of Multiple Trauma

It is important to acknowledge the cumulative effects of multiple traumas, as many women entering the correctional system may have experienced the combined effects of child sexual abuse, adult sexual assault and other forms of intimate partner violence. Indeed, there is now considerable evidence suggesting the higher likelihood of individuals, victimized as children, being revictimized as adults. The review of this literature by Classen, Palesh and Aggarwal (2005) indicates that two of three individuals who are sexually victimized will be revictimized. Such revictimization is associated with higher levels of distress with an increased reporting of certain psychiatric disorders along with other disorders of coping including problematic interpersonal relationships, self-representations, and affect regulation, greater self-blame and shame.

Assessment Strategies

Integral to planning with respect to treatment and service allocation is the critical importance of assessment. Two issues are addressed regarding assessment with MDWO, the place of gender in risk assessment and a means of assessing mental health disorder.

1. Awareness of Gender in Risk Assessment

Commentary on the RNR and LSI-R

Blanchette (2000) unequivocally stated the relevance of the Level of Service Inventory-Revised (LSI-R; Andrews & Bonta, 1995) and Risk, Need and Responsivity (RNR) model (Andrews & Bonta, 2010) as fundamental aspects of service planning for women offenders. This belief was again stated by Fortin (2004) four years later. No other model of service in the correctional literature over the past 20 years has had the impact on research, assessment or systems planning within corrections regardless of gender than the model of RNR. It should also be added, that the model not only advanced a model of service, but encouraged a way of thinking about what we know in research and how knowledge should be used. It is in this spirit that this section on the RNR and the LSI-R is considered with mentally disordered women's correctional planning and treatment. In addition, this section is developed conscious of the debate that has pitched feminist centered criminologists and what can be considered broadly as the empirically-based writers. As Jolley and Kerbs (2010) suggest "The RNR is not an example of a singular evidence-based intervention that has been shown to decrease the likelihood of recidivism for a particular population of offenders located within a narrowly defined sociocultural context. Rather, the RNR model is a prescription of evidenced-based principles for what will reduce the likelihood of recidivism if RNR's testable principles of effective intervention are applied with integrity" (p. 281).

It is also timely in acknowledging the recent special issue of *Criminology and Public Policy* (2009) dedicated to the debate on the LSI and its use with women offenders. This series of four articles featured a commentary by Morash (2009), a data review of LSI-R profiles of women offenders by Smith, Cullen and Latessa (2009), an overview of risk assessment in the context of gender by Hannah-Moffat (2009), and what can be considered a reformulation of the debate regarding women and assessment by Taylor and Blanchette (2009). Since the purpose of this review is to provide a snapshot of the momentum of research in relevant areas, it is acknowledged that within certain confines, the debate continues regarding the place of gender within the LSI-R and consequently the RNR. However, as the purpose of this review is to also cast a broader net examining research and treatment with mentally disordered women offenders, there are certain assumptions reflected in the literature that can be addressed, and a presentation of these assumptions will follow.

In what will be among the last of Don Andrew's (Andrews, 2011) published summaries regarding RNR, we are reminded that the RNR principles were intended to be expansive to the extent they would accommodate additional psychologically informed and empirically substantiated input with respect to promoting effective correctional practice, improve outcomes and lessen human suffering. To restate as Andrews did in this publication, the major principles from RNR that have direct relevance to the treatment of MDWO include:

1. Respect for the person in the normative context. Agencies working with women offenders will want to place a premium on attending to trauma
2. Non-reliance on sanctions but emphasize human service
3. Employ cognitive, social learning principles
4. Adapt the style and mode of service to account for individual differences that include gender
5. Build on strengths and reduce barriers that prevent participation in treatment
6. Target where required non-criminogenic risk

Hannah-Moffat (2009) has voiced the frustration of the historical absence of attention given to women within the correctional system, and how policies and practice have been disproportionately punitive and suppressive towards women. Despite what Bonta (1996) suggests is the third wave of correctional assessment, there continues to be a relative dearth of research specifically addressing assessment with women offenders, although there is strong evidence by research teams led by Patricia van Voorhis amongst others that this is beginning to shift. However, the majority of participants in correctional research still include primarily men, in part since they remain the predominant gender within the correctional cultural, but also a research lens is only now appreciating the unique aspects of culture as it relates to women in the correctional system. In other words, the unique pathways for women into crime that include suppression and violence to a far greater degree relative to men is only now being honoured in research with the degree of sensitivity required. Additionally, in struggling to achieve “gender-sensitivity” in correctional programming in both the youth and adult correctional systems, there has been a tendency to anchor girl or woman friendly programs in concepts rooted in male research and a male appreciation of the model and theory related to crime and violence. In other words, again the pathways into the correctional system for women have not been fully acknowledging of the systemic contributors to why women may have committed crime or why women experience a heightened degree of mental health disorder.

Yet, data regarding the concepts of assessment rooted in the LSI-R have generated information on a number of important criminogenic concepts that relate to the concurrent and predictive utility of the measure (Smith, Cullen, & Latessa, 2009). Nevertheless, what is apparently lost in the discussion related to the LSI-R relative to gender is that when a study is made at the item and construct level of the LSI-R, many of the core criminogenic concepts turn out to be inclusive of both male and female offenders. In other words, the LSI-R does not, nor has it ever been viewed, as a means to track the pathway of an individual into the correctional system, but to reflect the conditions under which individuals commit crime in and of themselves. Note for example, the study by Heilbrun, DeMatteo, Fretz, Erickson, Yashura and Anumba (2008) that reflected gender differences on the LSI-R in the areas of companions and financial deficits; findings that are consistent with a relational perspective for women and suppression and financial marginalization, although the authors emphatically state their study was atheoretical in nature and not oriented to “focus on particular areas of risk-relevant to need identified by feminist criminological scholars, or others whose theoretical model drives the identification of relevant domains”(p. 1394).

The conclusion in regards to the LSI-R as a criminogenic measure relevant to both genders is an acknowledgment dating from the review by Andrews and Dowden (1999) through to the summary ten years later by Smith and her colleagues (2009) that the LSI-R provides a necessary, psychometrically robust basis of information that is an important and integral part of correctional service planning. However, while *necessary*, the question is whether the LSI is *sufficient* as an information base on which to assess the needs of women offenders in order to make optimal service and treatment decisions. In clinical terms for example, is it relevant if part of a woman’s criminogenic profile involves the use of illegal substances, without also acknowledging that her use of illegal substances is rooted in her early history of childhood sexual victimization; the use of such substances serving as a means of coping with on-going intrusive thoughts and PTSD related symptoms associated with her victimization? While an acknowledgment of the use of illegal substances would be a treatment target based on an LSI-R profile, it may not be a sufficient basis of information if the fact of the contribution of childhood victimization were not also recognized within a case management or treatment plan.

One issue clearly reflected in the current research from this overview of the LSI-R is the necessity to reflect a more gender responsive means of assessment and/or interpretation (Reisig, Holtfreter, & Morash, 2006). This is reflected in the call for a differential weighting or appreciation of the use of instruments such as the LSI-R (Hollin & Palmer, 2006). These reviewers suggest there may be two levels of

consideration of a risk instrument in the context of women offenders such as the LSI-R. The first providing a listing of “Mutual Criminogenic Risks”; the second, “Women-Specific Criminogenic Needs”, where differential weighting with an appreciation of adverse life course events can be accounted for in making clinically relevant decisions for women. Further, as underscored by Caulfield, (2010) there is concern that without a gender informed appreciation for the meaning behind certain criminogenic needs, some women-specific needs “could be falsely translated into criminogenic risks, perhaps due to a lack of understanding of what constitutes a criminogenic need.” (p. 323). Van Voorhis, Wright, Salisbury and Bauman (2010) recently reported there is a differential weighting of prediction for future outcome within certain domains in the LSI-R and this fact should reflect particular areas of priority of service for women relative to men.

In accord with the reading of the literature for this review, there is support for a shift in what has come to be traditionally characterized as high risk for certain women by virtue of their life course outcomes resulting from, for example, intimate partner violence or child sexual abuse. That while a consequence in part due to these experiences may contribute to higher criminogenic risk, it does not speak for the necessity to increase punitive measures but for the provision of an increase in correctional resources addressing the underlying cause of the disorder. Patricia van Voorhis and her colleagues report on the development of two alternative methods of assessment that focus on the risk/need perspective based solely on the needs of women offenders. This understanding holds implications for addressing the potential of over estimating risk in mentally disordered women offenders based on what could be a misinterpretation of what constitutes a criminogenic need (Farr, 2000).

2. Assessing for Mental Health Disorder

The goal in assessing for mental health disorder is to identify, for the purposes of treatment, the nature and extent of the possible disorder. The most common sources of information for women or men where there is concern for one of the above-cited disorders rests in a fairly well established set of psychometric instruments. These can include, for general screening purposes, measures such as the Personality Assessment Inventory (PAI), and for specific related disorders such as PTSD, Briere’s Trauma Screening Inventory (TSI) and/or The Inventory of Altered Self Capacities (IASC). The use of the Standardized Client Information System (SCID) is also frequently used which can generate a DSM IV relevant diagnosis. However, there is an argument on practical terms that the use of such measures, despite their robust psychometric properties, may not be appropriate for the assessment of mental health disorder in incarcerated women offenders. Grisso (2006, p.5) said it, “budgets could never afford enough psychiatrists or psychologists to meet the demand [for correctional mental health assessment], so a tool must be designed for use by nonmental health professionals.” Also, Krespi-Boothby, Mulholland, Cases, Carrington and Bolger (2010, p. 93) indicate that more proactive measures are needed for screening early in the correctional system, preferably in the first week in custody, and “self-report measures offer a better alternative to lengthy clinical interviews given the large number of prisoners”. While there appears yet to be a holy grail that can provide a brief, reliable and relevant assessment to screen for offender mental health, there are measures that have been created or re-standardized to be applicable for measuring such disorders. Five different screening instruments are summarized. Noteworthy, while certain of these instruments show promise in differentiating mental health disorder, as a general statement, the reliabilities and validities are more satisfactory for males as opposed to females.

Brief Jail Mental Health Screen (BJMHS)

This extremely brief assessment form (it takes an average of 2.5 minutes to administer) correctly classified 61.6 percent of females as cross-validated on a SCID diagnoses (Steadman, Scott, Osher, Agnese, & Robbins, 2005). It is considered a practical and efficient screening tool that correctional

officers can give detainees on intake screening. However, it has an unacceptably high false-negative rate of mental health assignment for female detainees.

Jail Screening Assessment Tool (JSAT)

The JSAT is a brief semi-structured interview designed to identify mental health problems and risk for suicide, self-harm, violence, and victimization among new admissions to jails and pretrial facilities (Nicholls, Roesch, Olley, Ogloff, & Hemphill, 2005). While not a psychometric instrument that generates a quantitative estimate of mental health, the JSAT does generate a subjective index of concern by virtue of the endorsement on a range of concerns that are consistent with the needs of MDWO.

Offender Assessment System (OASys)

The British Home Office developed OASys to examine “whether such an assessment protocol [could] lead to more effective and sensitive management of mentally disordered offenders and assist practitioners to reduce their risk of re-offending and risk of harm to themselves or others” (Fitzgibbon, & Green, 2006, p. 36). These authors concluded that it was not sensitive to gender nor generated results considered as an adequate basis to translate assessment findings into programming decisions (i.e., it lacked adequate detail).

General Health Questionnaire (GHQ)

Twelve items from the GHQ formed this self-report inventory developed to assess for clinically significant emotional distress with inmates. Application of the assessment inventory has shown that inmates with test scores reflecting significant mental distress were appropriately triaged into a variety of mental health services with sensitivity to self-harm and suicide or mental health problems requiring long-term care (Krespi-Boothby, Mulholland, Cases, Carrington, & Bolger, 2010). Psychometrically, the GHQ had adequate internal consistencies. What remains is future research investigating its appropriateness with a female sample of offenders.

Brief Mental Health Screening Instrument for Newly Incarcerated Adults (BMHSINIA)

The BMHSINIA is comprised of only eight questions and requires a maximum of 3 minutes for administration. However, there are distinct gender differences, with accuracy for males identifying mental disorder at a rate of 74% with a considerably less accurate rating for females (Ford, Trestman, & Wiesbrook, 2007).

In addition to the above offender-based mental health assessment strategies, a number of brief assessment strategies for women exist that focus on trauma and trauma-related disorders. And, while they show sensitivity to the concerns of women, they have not been researched within the offender system. These include measures such as the Life Stressor Checklist (Wolfe & Kimerling, 1997), The Distressing Life Event Scale (Weiss & Marmar, 1996), and The PTSD Checklist (Weathers, Huska, & Keane, 1994) to name a few. What all of these checklists share in common at an item content level is information regarding the potential presence in a woman’s history of a certain potentially traumatic event. As aforementioned, the fact of exposure to a traumatic event in itself will not necessarily be evidence for an appreciation of the nature or degree of trauma that may have been experienced and how that trauma exposure will be played out within each woman’s experience (Kimerling, Prins, Wrestrup, & Lee, 2004).

Finally, the fact that brief methods of assessment for mental disorder seem not to address the unique context for women offenders may speak to the need, as summarized in a lengthy review by Brennan

(2007), of a more person-centered and contextually driven means of data gathering for assessment purposes for this group of vulnerable women.

Evidence-based Treatment Programs

Livingston's (2009) extensive review of the minimum standards of practice in creating correctional environments that can deliver effective services to mentally disordered and substance-abusing offenders include:

1. Providing a comprehensive and balanced continuum of services,
2. Integrating services within and between systems;
3. Matching services to individual need;
4. Responding to population diversity; and
5. Using evidence to make system-wide improvements.

Consistent with these standards, the following section summarizes evidence-based programs that support certain interventions in the context of the specific challenges in working with incarcerated mentally disordered women offenders. These include engagement in treatment, relationally based interventions and cognitive-behavioural programs.

Motivational Interviewing

Engagement in treatment is of critical importance and exceptionally challenging with offenders in general. However, within this group of MDWO, one of the products of early histories of abuse and victimization is the creation of significant defences surrounding an openness to and investment in treatment. A loss of trust and increasing suspicion in the motives of others who in the past have betrayed personal trust are important factors in appreciating women victims' reluctance to engage in treatment. Research suggests the dropout rate from treatment in community samples of women who experienced prior histories of victimization is over 80%, underscoring the challenge of engaging women survivors in any form of treatment (Webster, Rosen, Krietemeyer, & Mateyoke-Scriver, 2006). Acknowledging this fact, there has been a resurgence of interest in ways of engaging these clients in treatment.

As a general statement, most offenders are reluctant participants in treatment and ultimately their involvement in community treatment is often court mandated or part of the conditions of parole. With incarcerated offenders, there is a more limited range of options to compel participation in treatment. Yet, in the correctional literature, research has been conclusive that the motivation to engage in and take active participation with correctional programs is related to later recidivism (Stewart & Millson, 1995).

Prochaska's work in appreciating the extent to which individuals are available, indeed interested in taking part in any kind of therapeutic change has been a helpful addition to appreciating whether and to what extent individuals are willing to engage in treatment (Prochaska, DiClemente, & Norcross, 1992). There is now a considerable literature appreciating the importance of the stages of change and treatment engagement (McMurrin, 2002). While the majority of this literature has focused on motivating another very resistant client group, male perpetrators of intimate partner violence (Musser, Semiatin, Taft, & Murphy, 2008) there is also research that addresses the potential for Motivational Interviewing (MI) engaging MDWO (Murphy, 2004; Hodge & Renwick, 2002), women in substance programs (South

Dakota Department of Corrections, 2009) and women with prior histories of victimization from intimate partner violence (Oregon Health Centre, 2010).

The rationale with respect to the stages of change and Motivational Interviewing (MI) reflects an appreciation that a woman's reluctance to engage in treatment or manage within a correctional environment is a reaction both to the repressive conditions of the correctional environment along with an effort to avoid reconnecting to their experience of prior victimization. In part, so much of both behavioural and cognitive processes, from emotional numbing to dissociation, are an effort by a victim of past trauma to distance themselves from memories or experiences directly related to the trauma. MI works particularly well with offenders who are at the earliest stages of change, referred to as the pre-contemplation stage, reflective of persons who undervalue the benefits of treatment, are in denial regarding the consequences of their behaviour, demoralized at the failure of previous attempts, underestimate the benefits of changing and overestimate the costs to change. Components of MI that relate to treatment engagement include the use of empathy, development of discrepancy, avoidance of argumentation, utilization of resistance and support for self-efficacy (Miller & Rollnick, 1991).

Relational-Based Therapies

Over the past ten years, there has been an emphasis on programs that draw on an appreciation that women, relative to men, seek out and benefit from what Jordan (2010) describes as a belief in "growth through and toward connections." (i). Relational cultural theory (RCT) as advanced by Jean Baker Miller, and summarized in the work of Jordan, influenced an appreciation for, and relevance to, women who have experienced various forms of violence within intimate relationships. RCT has emphasized that victimization disconnects women not only from the experiences of other women, but also from their own experience as victims of violence evidenced through dissociative and other PTSD related disorders. In part as acknowledgment and appreciation of the research into this area, community-based treatment programs, informed through RCT, have been developed for women with histories of trauma (Hartling, 2004) and are summarized in the edited collection of articles by Walker and Rosen (2004).

RCT has also informed women-centered offender programs, and the literature refers directly to either RCT or programs premised on RCT as 'relational' or 'therapeutic communities' (Eliason, 2006). Primarily, evidence in support of RCT-based offender programs for women have focused on substance abuse and overall criminogenic risk reduction (Mosher & Phillips, 2006) and serious mental health disorder (Bloom, Owen, & Covington, 2008; Sacks, Sacks, et al., 2008).

Cognitive, Social Learning Approaches

Cognitive, social learning principles continue to play a prominent role in effective offender treatment strategies. Two CBT derivate strategies are profiled in the following section, Mindfulness Based Therapy (MBT) and Dialectical Behaviour Therapy (DBT), as they have received considerable recent attention in the offender literature and appear particularly relevant with MDWO.

Mindfulness Based Therapy

Of relevance to this review is the literature developed specifically related to Mindfulness Based Therapy (MBT) as a component of an overall cognitive therapeutic approach to women offenders. MBT as a strategy assists persons with ruminations of negative thinking styles, depression, low level PTSD, and stress reduction. It has received increasing attention as an effective intervention for a variety of presenting concerns consistent with women sharing profiles similar to those summarized in the current review (Grossman, Niemann, Schmidt, Walach, 2004), with women offenders with substance abuse problems

(Messina, Grella, Cartier & Torres, 2010) and psychiatric disorders including Bipolar Disorder (Zaplin, 2008).

The recent reviews regarding MBT focus on its effectiveness primarily with stress and anxiety related disorders in both clinical and non-clinical populations. The recent meta-analysis by Hofmann, Sawyer, Witt and Oh (2010) summarizes the impact across 39 studies of MBT revealing that robust effect sizes were found in improving anxiety and mood symptoms irrespective of the number of treatment sessions and were maintained after treatment termination. While in themselves these targets of service are not criminogenic in nature, they are necessary preconditions for effective participation in more targeted programs.

Why is the MBT literature of relevance in the current discussion on MDWO? Mindfulness based therapy assists individuals in managing their internal cognitive processes. This goal relates to the management of personal distress that manifests itself in behaviour that can be extremely debilitating, indeed in the case of self-injurious behaviour, life compromising. Women whose histories of trauma reflect symptoms consistent with PTSD are responsive to MBT specifically in its effectiveness in helping with emotion regulation. Zlotnick, Najavits et.al., (2003) have tested MBT with women who experience trauma related to prior physical and sexual victimization in the context of being incarcerated. Messina et al. (2010) found positive effects within a randomized clinical trial for incarcerated women for substance abuse. Zlotnick, Najavits, Rohsenow and Johnson (2003) have also reported positive effects for substance abuse and PTSD symptoms.

Dialectical Behaviour Therapy

No intervention consistent with the needs of women with mental disorders who present in correctional systems has received the same level of research interest as dialectical behavior therapy (DBT). DBT was developed by Marsha Linehan of the University of Washington. She is credited with the development of DBT. DBT is premised on the working assumptions drawn from the effectiveness of cognitive and behavioural therapies in altering perceptions and beliefs in regards to the meaning behind and alteration of reinforcement strategies and contingencies of behaviour. However, traditional cognitive behavioural strategies according to Linehan are perceived by seriously disordered persons, particularly women, as “invalidating and critical” reflected in high dropout rates from therapy (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006).

DBT, while building on many CBT concepts, draws on acceptance and mindfulness in the context of establishing what are viewed as the three primary components of therapeutic change: increasing conscious control over self-awareness; integration of rational and emotional thinking; and development of an increased sense of unity and oneness with themselves and all that surrounds them (Feigenbaum, 2007; Linehan, 2000). DBT has focused on the challenges of primarily treating individuals characterized as having BPD, along with other disorders consistent with the needs of incarcerated women including suicide and NSSI (Harned, Chapman, Dexter-Mazza, Murray, Comtois, & Linehan, 2008), emotion dysregulation (Linehan, Bohus, & Lynch, 2007), substance abuse (Linehan, Dimeff, Reynolds, Comtois, Welch, Heagerty & Kivlahan, 2002), comorbid personality disorders (Lynch & Cheavens, 2008) and complex trauma (Wagner, Rizvi, & Harned, 2007).

Not only has the clinical focus for intervention of DBT caught the attention of policy makers and practitioners who work with MDWO, but DBT has been the focus of significant research interest in exploration of its validation as a treatment. In addressing the empirical basis of DBT, this review selected research studies where DBT was tested with targeted samples presenting with disorders consistent with women who are the focus of correctional practice. The literature searched for studies that met the following criteria 1) treatment target was BPD, suicide and/or NSSI, substance abuse and or complex

trauma, 2) outcomes were tracked to a point beyond the formal termination of treatment, and 3) the majority of participants were female. These search terms excluded published accounts of narrative descriptions of what DBT was and evaluations from participants on their belief about the therapy, all of which, it should be said, turned out to be considerable in number.

Thirteen studies were identified (Appendix A). A breakdown of the studies show five Randomized Clinical Trials (RCT), four quasi experimental designs, two pre–post test with no comparison group, and two qualitative reports. Outcome reporting periods ranged from 4 weeks to 2 years. Outcomes were measured through self-report on standardized inventories, clinical interview and admissions/readmissions to hospital. All but two studies used a dedicated female sample. In all respects, DBT-treated persons showed greater reductions in symptom distress, improved behavioural adaptation and fewer admissions for subsequent psychiatric care. Of particular importance, RCTs revealed more improved outcomes relative to usual service and/or other cognitive, behavioural, psychopharmacological and psychoanalytic interventions.

Delbert Elliot (1997) established in his *Blueprints Series on Effective Programs* a rubric evaluating the correctional treatment literature. Elliott’s focus was on youth corrections but the principles he used in measuring effectiveness are relevant in the current context. His measures included the extent to which there is a treatment effect with a strong research design, benefits of treatment are sustained, there are multiple site replications, and that the generalization of treatment is managed through manualized delivery. We would also add to this list, program adherence and treatment fidelity. Using a broad stroke in measuring the DBT literature against Elliott’s yardstick, DBT has fared better than any of the competing treatment methodologies (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004; Leichensburg, & Leiging, 2003). Further, DBT has an extensive narrative, non-empirical published literature that speaks to the clinical utility, means of well-established manualized treatment and training paradigm, and as aforementioned, implementation and manualization (Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997; Scheel, 2000; Swenson, Torrey, & Koerner, 2002). However, it should also be noted that the vast majority of the DBT empirical literature is either directly connected with Linehan or her contemporaries at the University of Washington and in fact, all but one of the RCTs generated in this review were associated with Linehan either directly or indirectly.

Summary

While there are encouraging advancements with respect to our appreciation regarding how to effectively resource treatment programs for women offenders with mental health disorder, there are some fundamental gaps in that knowledge. Perhaps the most glaring relates our inability to appreciate how to best translate findings from the literature into prison-based facilities and have those services delivered with integrity. The demand and need for treatment services for MDWO will always outstrip the ability to provide adequate space in specialized treatment facilities within any correctional system to deliver those services. It will be incumbent to depend on mainstream offender units to deliver services to, what are, numerous challenging women who possess histories of trauma and other serious disorders that are vested in violent pasts. This will entail insuring that:

1. Women with histories as outlined within this review are able to access a service or treatment program within facilities that are relevant to their needs.
2. That the extent to which misunderstandings with respect to the intent surrounding the concepts of LSI-R/RNR are accurately interpreted will mean that women are not being considered as high risk, when their presentation belies their extreme need.

3. There is yet to be developed a brief, reliable and valid screening for emotional disorder with women offenders that would complement the LSI-R. Such a measure could inform front line staff and clinicians regarding the extent of an underlying emotional disorder. It is insufficient to assume, merely based on a previous history of victimization, that any particular woman offender will show symptom distress or if they do, what the nature of the disorder or symptom cluster will be, simply because of their trauma history. This observation is mindful of the challenge in developing such an instrument, as the psychometric properties of those measures employed by community clinicians for women who have experienced traumatic pasts have been years in the making. This is of particular relevance given the necessity of a differential appreciation for non-suicidal self-injury, information that is critical in being in the hands of case manager's soon after admission to a correctional unit (Klonsky & Glenn, 2009).
4. Although DBT has been identified as a best practice, there have been no studies reporting on the large scale transportability of DBT within the women's offender culture. Such studies would need to monitor for the adherence and treatment fidelity to the principles of DBT when it is being delivered. A similar statement could be made for other best practice interventions that have been the focus for recent research such as motivational interviewing, mindfulness-based therapy and relational-based interventions. This is a reminder that the implementation of effective practice within corrections is a science in its own right, and while the acknowledgment of what are effective services is a necessary first step, an awareness of what it takes to transfer that knowledge into practice should also be just as strong a priority (Bernfeld, Farrington, & Leschied, 2001).

References

- Andrews, D. A. (2011). The impact of nonprogrammatic factors on criminal-justice interventions. *Legal and Criminological Psychology*, 16, 1-23.
- Andrews, D. A., & Bonta, J. (1995). *The Level of Service Inventory-Revised*. Toronto, ON: Multi-Health Systems.
- Andrews, D. A., & Bonta, J. (2010). *The Psychology of Criminal Conduct (5th ed.)*. New Providence, NJ: LexisNexis Matthew Bender.
- Andrews, D. A., & Dowden, C. (1999). What works for female offenders: A meta-analytic review. *Crime and Delinquency*, 45, 438-452
- Bates, B. (2003). Few traumatized patients fit PTSD criteria found in DSM: Complex histories, *Clinical Psychiatry News*.
- Bernfeld, G. A., Farrington, D., & Leschied, A.W. (Eds.) (2001). *Offender rehabilitation in practice: Implementing and evaluating effective programs*. London, UK: John Wiley Press.
- Blanchette, K. (2000). Effective correctional practice with women offenders. *Compendium 2000 on Effective Correctional Programming*. Ottawa ON: Correctional Services of Canada.
- Bloom, B., Owen, B., & Covington, S. (2004). Women offenders and the gendered effects of public policy. *Review of Policy Research*, 21, 31-48.
- Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Bohme, R., & Linehan, M. (2000). Evaluation of inpatient dialectical-behavioral therapy for borderline personality disorder: A prospective study *Behavior Research and Therapy*, 38, 875-887.
- Bohus, M., Haaf, B., Simms, T., Limberger, M. F., Schmahl, C., Unckel, C., Lieb, K., & Linehan, M. M. (2004). Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: A controlled trial. *Behaviour Research and Therapy*, 42, 487-499.
- Bonta, J. (1996). Risk-needs assessment and treatment. In A. T. Harland (ed.) *Choosing Correctional Options that Work: Defining the Demand and Evaluating the Supply* (pp. 18-32). Thousand Oaks, CA: Sage.
- Brennan, T. (2007). Institutional assessment and classification of women offenders: From robust beauty to person-centered assessment. In R. Zaplin, (Ed.), *Female Offenders: Critical Perspectives and Effective Interventions* (2nd Edition) (pp. 283-322). Boston, MA: Jones and Bartlett.
- British Columbia Centre for Excellence in Women's Health (2006). *Improving conditions: Integrating sex and gender into federal mental health and addictions policy*. Vancouver, BC.
- Caulfield, L. (2010). Rethinking the assessment of female offenders. *The Howard Journal*, 49, 315-327.
- Clarkin, J. F., Levy, K. N., Lenzenberger, M. F., & Kernberg, O. F (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry*, 164, 922-928.

- Classen, C., Palesh, O., & Aggarwal, R. (2005). Sexual revictimization: A review of the literature. *Trauma Violence Abuse, 6*, 103-129.
- Correctional Services Canada (2008). *Review Panel*. Ottawa, ON.
- Covington, S.S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs, SARC Supplement, 5*, 377-385.
- Eifert, G. H., Schulte, D., Zvolensky, M. J., Lejuez, C. W., & Lau, A.W. (1997). Manualized behavior therapy: Merits and challenges. *Behavior Therapy, 28*, 499-509.
- Eliason, M. J. (2006). Are communities therapeutic for women? *Substance Abuse Treatment, Prevention, and Policy, 1*, 1-17.
- Elliot, D. (1997). *Blueprints for Violence Prevention*. Center for the Study and Prevention of Violence, University of Colorado, Boulder, CO.
- Farr, K. A. (2000). Classification for female inmates: Moving forward. *Crime and Delinquency, 46*, 3-17.
- Feigenbaum, J., (2007). Dialectical behaviour therapy: An increasing evidence base. *Journal of Mental Health, 16*, 51-68.
- Fitzgibbon, W. & Green, R. (2006). Mentally disordered offenders: Challenges in using the OASys risk assessment tool. *Journal of Community Justice, 4*, 35-46.
- Ford, J., Trestman, R., & Wiesbrook, V. (2007). Development and validation of a brief mental health screening instrument for newly incarcerated adults: *Assessment, 14*, 279-299.
- Fortin, D. (2004). *Program strategy for women offenders*. Ottawa ON: Correctional Services of Canada.
- Grant, B., & Gileno, J. (2008). *The Changing Federal Offender Population*. Ottawa, ON: Correctional Service Canada.
- Grisso, T. (2006). Review of the jail screening assessment tool (JSAT): Guidelines for mental health screening in jails. *Psychiatric Services, 57*, 1049.
- Grossman, A. P., Niemann, B. L., Schmidt, C. S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research, 57*, 35-43.
- Hannah-Moffat, K. (2009). Gridlock or mutability: Reconsidering “gender” and risk assessment. *Criminology and Public Policy, 10*, 209-219.
- Harned, M. S., Chapman, A. L., Dexter-Mazza, E.T., Murray, A., Comtois, K. A., Linehan, & M. M. (2008). Treating co-occurring Axis I disorders in recurrently suicidal women with borderline personality disorder: A 2-Year randomized trial of dialectical behavior therapy. *Journal of Consulting and Clinical Psychology, 76*, 1068-1075.
- Hartling, L. M. (2004). Prevention through connection: A collaborative approach to women’s substance abuse. In M. Walker & W.B. Rosen (Eds.), *How connections heal: Stories from relational cultural theory* (pp. 197-215). New York, NY: Guildford Press.

- Hastings, R. P., & Noone, S. J. (2005). Self-injurious behavior and functional analysis: Ethics and evidence. *Education and Training in Developmental Disabilities*, 40, 335-342.
- Hayes, S. C., Masuda, A., Bissett, R., Luoma, J., & Guerrero, L. F. (2004). DBT, FAP and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy*, 35, 35-54.
- Heilbrun, K., DeMatteo, D., Fretz, J., Erickson, J., Yashura, N., & Anumba (2008). How “specific” are gender-specific rehabilitation needs? An empirical analysis. *Criminal Justice and Behavior*, 35, 1382-1397.
- Hodge, J. E., & Renwick, S. J. (2002). Motivating mentally disordered offenders. In M. Murrin (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 221-234). West Sussex, UK: John Wiley.
- Hollin, C., & Palmer, E. J. (2006). Criminogenic need and women offenders: A critique of the literature. *Legal and Criminological Psychology*, 11, 179-195.
- Holtfreter, M., & Morash, M. (2003). The needs of women offenders: Implications for correctional programming. *Women and Criminal Justice*, 14, 137-160.
- Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). *Journal of Consulting and Clinical Psychology*, 78, 169-183.
- Jolley, J. M., & Kerbs, J. J. (2010). Risk, need and responsivity: Unrealized potential for the international delivery of substance abuse treatment in prison. *International Criminal Justice Review*, 20, 280-301.
- Kilty, M. (2006). Under the barred umbrella: Is there room for a women-centered self-injury policy in Canadian corrections? *Criminology and Public Policy*, 5, 161-182.
- Kimerling, R., Prins, A., Wrestrup, D., & Lee, T. (2004). Gender issues in the assessment of PTSD. In J. P. Wilson & T. M. Keane (Eds.) *Assessing Psychological Trauma and PTSD* (2nd ed.) (pp. 565-590). New York, NY: Guilford Press.
- Klonsky, D. E. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, 27, 226-239.
- Klonsky, D. E., & Glenn, C.R. (2009). Assessing the functions of non-suicidal self-injury: psychometric properties of the Inventory of Statements about Self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment*, 31, 215-219.
- Krespi-Boothby, M. R., Mulholland, I., Cases, A., Carrington, K., & Bolger, T. Towards mental health promotion in prisons: the role of screening for emotional distress. *Social and Behavioral Sciences*, 5, 90-94.
- Kroger, C., Schweiger, U., Sipos, V. Arnold, R., Kahl, K.G., Schunert, T., Rudolf, S., & Reinecker, H. (2005). Effectiveness of dialectical behaviour therapy for borderline personality disorder in an inpatient setting, *Behavior Research and Therapy*, 44, 1222-1217.

- Leichensburg, F. & Leiging, E., (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapeutic in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, 160, 1223-1232.
- Leschied, A.W. (2011) Youth Justice and Mental Health in Perspective. *HealthcareQuarterly*, 14, 58-63.
- Lev-Weisel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Child Abuse and Neglect*, 30, 665-673.
- Lewis, C. (2006). Treating incarcerated women: Gender matters. *Psychiatric Clinics of North America*, 29, 773-789.
- Linehan, M. M. (2000). The empirical basis of dialectical behavior therapy: Development of new treatments versus evaluation of existing treatments. *Clinical Psychology: Science and Practice*, 7, 113-118.
- Linehan, M. M., Bohus, M., & Lynch, T.R. (2007). Dialectical behavior therapy for emotion dysregulation. In J. Gross (Ed.) *Handbook of Emotion Regulation* (pp. 581-605). New York, NY: Guildford Press.
- Linehan, M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., Korslund, K., Tutek, D., Reynolds, A. S., & Lindeham, N. (2006). Two year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63, 757-767.
- Linehan, M., Dimeff, L. A., Reynolds, S. K., Comtois, K., Welch, S., Heagerty, P., & Kivlahan, D. R. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opiod dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence*, 67, 13-26.
- Livingston, J. D. (2009). *Mental Health and Substance use Services in Correctional Settings: A Review of Minimum Standards and Best Practices*. The International Centre for Criminal Law Reform and Criminal Justice Policy, Vancouver BC.
- Lynch, T. R., & Cheavens, J. S. (2008). Dialectical behavior therapy for comorbid personality disorders, *Journal of Clinical Psychology*, 64, 154-167.
- Matheson, F. I., Doherty, S., & Grant, B.A. (2009). *Women Offender Substance Abuse Programming & Community Reintegration*. Ottawa ON: Correctional Services Canada.
- McMurrin, M. (2002). *Motivating Offenders to Change: A Guide to Enhancing Engagement in Therapy*. West Sussex, UK: John Wiley and Sons.
- McMain, S., Dimeff, L., & Korman, L. M. (2001). Dialectical behaviour therapy and the treatment of emotion dysregulation. *Journal of Clinical Psychology*, 57, 183-196.
- McQuillan, A., Nicastroi, R., Guentot, F., Girard, M., Lissner, C., & Ferore (2005). Intensive dialectical behavior therapy for outpatients with borderline personality disorder who are in crisis. *Psychiatric Services*, 56, 193-197.

- Messina, N., Grella, C.E., Cartier, J., & Torres, J. A. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of Substance Abuse Treatment*, 38, 97-107.
- Miller, W. R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York, NY: Guilford Press.
- Milligan, R. J., & Andrews, B. (2005). Suicidal and other self-harming behaviour in offender women: The role of shame, anger and childhood abuse. *Legal and Criminological Psychology*, 10, 13–25.
- Morash, M. (2009). A great debate over using the Level of Service Inventory-Revised (LSI-R) with women offenders. *Criminology and Public Policy*, 10, 173-181.
- Mosher, C., & Phillips, D. (2006). The dynamics of a prison-based therapeutic for women offenders: Retention, completion, and outcomes. *The Prison Journal*, 86, 6-31.
- Mulholland, M. R., Cases, I., Carrington, A., & Bolger, T. (2010). Towards mental health promotion in prisons: the role of screening for emotional distress. *Social and Behavioral Sciences*, 5, 90-94.
- Murphy, A. (2004). The female offender: Existing gaps and underlying issues for female focused intervention. Department of Correctional Service. South Australia.
- Murthi, M., & Espelage, D. L. (2005). Childhood sexual abuse, social support, and psychological outcomes: A loss framework. *Child Abuse and Neglect*, 29, 1215-1231.
- Musser, P. H., Semiatin, J. N., Taft, C. T., & Murphy, C. M (2008). Motivational interviewing as a pregroup intervention for partner-violent men. *Violence and Victims*, 2, 539-557.
- Nee, C., & Farman, S. (2005). Female prisoners with borderline personality disorder: Some promising treatment developments. *Criminal Behaviour and Mental Health*, 15, 2-16.
- Nicholls, T. L., Roesch, R., Olley, M. C., Ogloff, J. R. P., & Hemphill, J. F. (2005). *Jail Screening Assessment Tool (JSAT)*. Burnaby, Bristich Columbia: British Columbia, Mental Health, Law and Policy Institute.
- Oregon Health Centre. (2010). *Reducing HIV & Domestic Violence Risk in Women Offenders*. Portland, OR.
- Perseus, K. I., O'jehagen, A., Ekdahl, S., Åsberg, M., & Samuelsson, M. (2003). Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using Dialectical Behavioral Therapy: The patients' and the therapists' perceptions. *Archives of Psychiatric Nursing*, 17, 218-27.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviours. *American Psychologist*, 47, 1102-1114.
- Reisig, M. D., Holtfreter, K., & Morash, M. (2006). Assessing recidivism risk across female pathways to crime. *Justice Quarterly*, 23, 384-405.
- Sacks, J. Y., Sacks, S., McKendrick, K., Banks, S., Schoenberger, M., Hamilton, Z., et al. (2008). Prison

- therapeutic community treatment for female offenders: Profiles and preliminary findings for mental health and other variables (crime, substance use, and HIV risk). *Journal of Offender Rehabilitation*, 46, 233-261.
- Scheel, K. R. (2000). The empirical basis of Dialectical Behavior Therapy: Summary, critique, and implications. *Clinical Psychological Science and Practice*, 7, 68-86.
- Silberman, M (2010). Sexual abuse in childhood and the mentally disordered female offender. *International Journal of Offender Therapy and Comparative Criminology*, 54, 783-802.
- Smith, P., Cullen, F. T., & Latessa, E. J. (2009). Can 14,737 women be wrong? A meta-analysis of the LSI-R and recidivism for female offenders. *Criminology and Public Policy*, 10, 183-208.
- South Dakota Department of Corrections. (2009). *Guiding Principles for the Women's Methamphetamine Treatment Program*. Pierre, South Dakota.
- Steadman, J. Scott, J. E., Osher, F., Agnese, T. K., & Robbins, P. K. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56, 816-822.
- Stewart, L., & Millson, W. A. (1995). Offender motivation for treatment as a responsivity factor. *Forum on Corrections Research*, 7, 5-7.
- Swenson, C. R., Torrey, W. C., & Koerner, K. (2002). Implementing dialectical behavior therapy. *Psychiatric Services*, 53, 171-178.
- Taylor, K. N., & Blanchette, K. (2009). The women are not wrong: It is the approach that is debatable. *Criminology and Public Policy*, 10, 221-229.
- Teplin, L. A., Abram, K. M. & McClelland, G.M. (1996). Prevalence of psychiatric disorders among incarcerated women: pretrial jail detainees. *Archives of General Psychiatry*, 53, 505-512.
- Thomas, T., Leaf, M., Kazmierczak, S., & Stone, J. (2006). Self –injury in correctional settings: ‘pathology’ of prisons of prisoners? *Criminology and Public Policy*, 38, 193-202.
- van den Bosch, L. M. C., Verheul, R., Schippers, G. M., & van den Brink, W. (2002). Dialectical Behavior Therapy of borderline patients with and without substance use problems Implementation and long-term effects, *Addictive Behaviors*, 27, 911-923.
- Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18, 389-399.
- Van Voorhis, P., Salisbury, E., Wright, E., & Bauman, A. (2008). *Achieving Accurate Pictures of Risk and Identifying Gender Responsive Needs: Two New Assessments for Women Offenders*. Unpublished manuscript. University of Cincinnati, Cincinnati, OH.
- Van Voorhis, P., Wright, E. M., Salisbury, E., & Bauman, A. (2010). Women's risk factors and their contributions to existing risk/needs assessment. *Criminal Justice and Behavior*, 37, 261-288.

- Veysey, B. M. (1997). Specific needs of women diagnosed with mental illnesses in U.S. Jails. In B. L. Levin, A. K. Blanch, & A. Jennings (Eds.), *Women's Mental Health Services: A Public Health Perspective* (pp. 238-289). Thousand Oaks, CA: Sage.
- Wagner, A. W., Rizvi, S. L., & Harned, M. S. (2007) Applications of dialectical behavior therapy to the treatment of complex trauma-related problems: When one case formulation does not fit all. *Journal of Traumatic Stress, 20*, 391-400.
- Walker, W., & Rosen, W. B. (Eds.) (2004). *How Connections Heal: Stories from Relational Cultural Theory*. New York, NY: Guilford Press.
- Weathers, F. W., Litz, B.T., Huska, J.A., & Keane, T. M. (1994) *PCL-C for DSM-IV*. Boston: National Center for PTSD-Behavioral Sciences Division.
- Webster, J. M., Rosen, P. J., Krietemeyer, J., & Mateyoke-Scriver, A. (2006). Gender, mental health, and treatment motivation in a drug court setting. *Journal of Psychoactive Drugs, 38*, 441-448.
- Weiss, D. S., & Marmar, C. R. (1996). The Impact of Event Scale-Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399-411). New York, NY: Guilford.
- Wolfe, J., & Kimerling, R. (1997). Gender issues in the assessment of Posttraumatic Stress Disorder. In J. Wilson & T. M. Keane (Eds.), *Assessing Psychological Trauma and PTSD* (pp. 192-238). New York, NY: Guilford.
- Wolff, N., & Shi, J. (2009). Victimization and feelings of safety among male and female inmates with behavioral health problems. *Journal of Forensic Psychiatry & Psychology, 20*, 56-77.
- Wolff, N., Blitz, C. L., & Shi, J., (2007). Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatric Services, 58*, 1087-1094.
- World Health Organization (2008). *Report of the Proceedings on Gender and Mental Health*. Geneva, Switzerland.
- Zaplin, R. (2008). *Female Offenders and Critical Perspectives*. (2nd Ed). Mississauga ON: Jones and Bartlett.
- Zlotnick, C., Najivits, L., Rohsenow, D. J., & Johnson, D. M. (2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*, 99-105.

Appendix A

Summary of Dialectical Behaviour Therapy Outcome Studies with Targeted Groups Consistent with Mentally Disordered Women Offenders

Study	Design	Targeted population	Length and Nature of Follow-up	Outcome
Bohus, M., Haaf, B., et al. (2004)	N=31; Pre post two group comparison (no treatment waiting list); female	Borderline Personality Disorder	Four weeks post discharge; Indices of self mutilation; self report ratings of psychopathology	Improvements in 7 of 9 areas assessed; depression, anxiety, interpersonal functioning, social adjustment; global psychopathology; reductions in self mutilation
Bohus, M., Haaf, B., et al. (2000)	N= 24, female; Pre-post comparison, single group design;	Inpatient treatment for Borderline Personality Disorder; Parasuicide acts; Schizophrenia; Bipolar Disorder; alcohol/drug dependency	One month following discharge; multiple self report outcome measures	Improvement in ratings on: depression, dissociation, anxiety, global stress; decrease in parasuicidal acts
Clarkin, J. F., Levy, K N., Lenzenberger, M. F., & Kernberg, O.F (2007)	N=90 males and females; outpatient; RCT comparing DBT versus two alternate forms of therapy	Borderline Personality Disorder	One year at four month follow-up. BDI; GAF; SAS; OAS; BSI	DBT and transference focused therapy equal in reducing suicide risk, improved depression, anxiety, global functioning and social adjustment
Harned, M. S., Chapman, A. L., et al. (2008)	N=101 females; RCT with 'expert' delivered alternatives	Borderline Personality Disorder; Non suicidal self injurious behaviour	One year follow-up. SCID; DSM IV	DBT more likely to show total remission from Substance Dependence Disorder (SDD)

Appendix A continued

Study	Design	Targeted population	Length and Nature of Follow-up	Outcome
Kroger, C., Schweiger, U., et al. (2005)	N=50, 6 males, 44 females two group non-randomized comparison	Borderline Personality Disorder	15 month follow-up; Beck DI, SCID, SCL-90	Reductions in self report Global Severity Index, BDI and SCL-90; increases in General Adaptation Function
Linehan, M., Comtois, K., et al. (2006)	N=101; RCT; females	Borderline Personality Disorder; Suicidal; Self Injurious	12 month follow-up after treatment completion	Reductions in self injurious behaviour; fewer hospitalizations
Linehan, M., Dimeff, L.A., et al. (2002)	N=23; Two group; RCT	Personality Disorder; substance abuse	16 months follow-up Biological indicators; Self report standardized inventories; clinician interviews	Lowered rates of opiate use; No between group differences on personality measures
Linehan, M., Schmidt, H., et al. (1999)	N= 28; RCT with Usual Service; female	Borderline Personality Disorder	16 month follow-up	Reductions in drug use; increased functioning on measures of social adjustment
McMain, S., Dimeff, L., & Korman, L.M. (2001)	Single case qualitative design; female	Borderline Personality Disorder; Substance Abuse	18 months post treatment; interview based, clinician based reports of improvement	Lower rates of self harming; reduce substance use; reduced aggression; improved interpersonal communication

Appendix A continued

Study	Design	Targeted population	Length and Nature of Follow-up	Outcome
McQuillan, A., Nicastroi, R., et al. (2005)	N=127; 103 women, 24 men; Single group, naturalistic, multi-wave assessment; comparison of treatment completers and non completers	Borderline Personality Disorder	Follow-up at immediate completion of treatment. Self report standardized measures; Clinical interviews	Reductions in depression on the Beck DI with medium ES;
Perseus, K.I., O'jehagen, A., Ekdahl, S., Åsberg, M., & Samuelsson, M. (2003)	N=10; female; Qualitative design	Borderline Personality Disorder; Suicidal Behaviour	6 months follow-up. Clinical interview	Positive themed conclusions with respect to DBT
van den Bosch, L.M.C., Verheul, R., Schippers, G.M., & van den Brink, W. (2002)	N=58; Qualitative design; female	Borderline Personality Disorder; Substance Abuse	18 month follow-up; Standardized measures of addictive behaviour	Lower ratings on alcohol and drug use
Wagner, A.W., Rizvi, S.L., & Harned, M.S. (2007)	N=2; Qualitative design; female	Borderline Personality Disorder; Complex Trauma	Follow-up at immediate completion of treatment. Clinical Interview	Improved functioning