

“IT’S OUR MENTAL HEALTH, IT’S NOT THEIRS!” A PATIENT-ORIENTED APPROACH
TO WOMEN’S INTAKE MENTAL HEALTH ASSESSMENTS IN CANADIAN
CORRECTIONAL INSTITUTIONS

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By

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ABSTRACT

The mental health assessment tools currently used during institutional intake within Canadian correctional settings have been constructed on all-male samples. By drawing on the gaps in the literature, this research demonstrates the need for a gender-informed mental health assessment process for incarcerated women. This study draws on feminist standpoint theory and applies a patient-oriented research framework to engage women with lived experience throughout the research process. Fifteen phone interviews were conducted with two sample groups: five “Patients,” or formerly incarcerated women identified with mental illness; and ten “Service Providers,” or women from various chapters of the Elizabeth Fry Society. By drawing on feminist theory and applying thematic analysis, this thesis presents six identified themes in the data: first, participants called for incarcerated women to be in a safer, more comfortable environment during the mental health assessment; second, they discussed the components and measures that would be ideal for a women’s mental health assessment tool; third, participants suggested that the outcomes of the intake assessment should connect women to the necessary mental health services and programs; fourth, they identified the ideal individuals who should be conducting the assessment process, including their qualifications and credentials; fifth, participants discussed the components of a culturally informed mental health assessment process for incarcerated Indigenous women; finally, the last theme presented discusses participants’ ideas for implementing this process. Results were discussed in conjunction with the implications and directions for future research and concludes with an overview of the knowledge translation process. This thesis does not debate whether correctional systems are effective in reforming prisoners, but rather, critiques the valuation of the male perspective within correctional mental health assessments. Findings suggest how to improve outcomes for incarcerated women with

mental illness through a gender-informed mental health assessment process based on their lived experience.

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DEDICATION

This thesis is dedicated to Willi McCorriston, whose commitment, enthusiasm, hard work, and patience inspired me to complete this research.

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LIST OF ABBREVIATIONS

ASRS	Adult Self-Report Scale
BSI	Brief Screening Inventory
COMHISS	Computerized Mental Health Intake Screening System
CSC	Correctional Service of Canada
DHS	Depression, Hopelessness and Suicide Screening Form
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUNDRUM	Dangerousness Understanding, Recovery and Urgency Manual
EFS	Elizabeth Fry Society
GAMA	General Ability Measure for Adults
POR	Patient-Oriented Research
PTSD	Post-traumatic Stress Disorder

CHAPTER ONE: INTRODUCTION

1.0 Overview

Our understanding of the appropriate gender-informed interventions for incarcerated women, such as healthcare services and prison programming, is limited because of the dominance of the male experience in the criminological literature and its application to the broader criminal justice system (Caulfield, 2010; Cohen, 2015; Heidensohn, 1968). As women are the fastest growing population in Canadian prisons and jails (Lawson, 2020; Office of the Correctional Investigator, 2015; Savage, 2019), the need for gender-informed approaches to incarcerated women's care becomes increasingly apparent. Particularly, the management of incarcerated women's mental health and illness remains an ongoing issue across Canada's provincial (i.e., sentences within two years in duration) and federal (i.e., sentences that are at least two years in duration) correctional systems. In comparison to their male counterparts, female prisoners are twice as likely to be diagnosed with mental illness (Demers, 2014; Kouyoumdijan et al., 2016; Office of the Correctional Investigator, 2015). Of the nearly 80% of federally incarcerated women diagnosed with a mental illness (Correctional Service of Canada, 2017), 76% were diagnosed with alcohol and substance use disorders, 54% with anxiety disorders, and approximately one-third of women met the criteria for post-traumatic stress disorder (Derkzen et al., 2017).

Incarcerated women's mental health needs are unique from that of women in the community, as well as incarcerated men (Bartlett & Hollins, 2018; Friedman et al., 2019; Taylor et al., 2002). Women in prisons and jails are more likely to be survivors of abuse and trauma, have been diagnosed with substance use disorder, and/or have experienced economic marginalization (Lynch et al., 2013; Martin et al., 2012; Pollack, 2005; van den Bergh et al.,

2011); these social factors contribute to their mental health status. While prison and jail environments are likely to detriment a person's subjective well-being and mental health, the literature suggests that incarceration may have a heightened effect on women's mental health as it may cause feelings of re-victimization in their past experiences of trauma (Bill, 1998; Pollack, 2005). Additionally, incarcerated mothers are more likely than incarcerated fathers to be their children's primary caregivers (Glaze & Maruschak, 2008; Martin et al., 2012; Strauss, 2020). As incarceration isolates a mother from her children, she is subject to further mental and emotional hardship (Martin et al., 2011), which is unique from incarcerated fathers (Covington, 2003).

The guiding philosophy for the management and care of women in federal prison is *Creating Choices*, a report commissioned by the Correctional Service of Canada (CSC; i.e., federal corrections) and the Canadian Association of Elizabeth Fry Societies (1990; i.e., a stakeholder group which advocates for incarcerated women). Informed by current and former female prisoners, the report has paved the way for CSC to develop women's mental health programs and lead gender-informed research projects. For example, *Creating Choices* highlighted the importance of the relationship between a mother and her child, and how isolation from imprisonment negatively impacted incarcerated mothers' mental health (Brennan, 2014). A direct outcome of these findings is CSC's Mother-Child Program, which was established in 2001 (Ibid.). As substance use disorder is the most commonly diagnosed mental illness among federally sentenced women, CSC engaged with female mental health and addictions experts to design a gender-based substance abuse model that attempts to promote "connection" and "community" throughout the intervention (Hume, 2015). Additionally, in response to the critique that federal risk assessments are not compatible for incarcerated women (Office of the Correctional Investigator, 2018), CSC has conducted research which explores the use of gender-

informed variables in women's security classification; these findings have been favourable for the inclusion of gender-informed variables to offer a more holistic approach in women's case management (Derkzen et al., 2019). Put together, the literature suggests that engagement with stakeholders and women with lived experience of incarceration are critical to identifying the areas for advancing their mental health care, programming, and evidence base.

A gap in the literature is the construction of a women's mental health assessment tool for incarcerated women at institutional intake. In addition to mental health programming and case management, treatment for women with mental illness is also contingent on the outcomes of the screening assessment (Martin et al., 2018). Despite the emergence of feminist theories and methods (e.g., Becker, 1998; Naples, 2007; Sprague & Zimmerman, 2004), however, the aforementioned inclusion of women as participants in CSC-led mental health research, as well as the recognition of sex and gender differences in mental illness symptomology (Afifi, 2007; Drapalski et al., 2009), prevalence (Gagné et al., 2014; Linzer et al., 1996), and drug effects (Howard et al., 2017; Simon, 2005), the assessment procedures for mental health in incarcerated populations continue to be the same for men and women. Traditionally, these mental health assessments have been constructed using all-male samples and then applied to incarcerated women – in most instances, without first having been piloted or validated with women (e.g., Leschied, 2011; Stewart, 2009). This research critiques this pattern and ongoing practice, in consideration of the prevalence of mental illness among incarcerated women. Thus, it is argued that the course and outcomes of these assessments are not compatible for women because they have not yet incorporated incarcerated women's lived experiences in their conception and construction.

The importance of these assessments is in the outcomes: the interpretation of these measures dictates the prisoner's risk and security level, which affects the allocation of the mental health resources and supports that she receives during her imprisonment. In consideration of this need for advancing incarcerated women's mental health care, this study draws on a patient-oriented approach to explore what constitutes a gender-informed mental health assessment which can be used in Canadian prisons and jails. This chapter serves as an introduction to incarcerated women's mental health needs, and provides further context and relevant definitions to the research area.

1.1 Patient-Oriented Research

Patient-oriented research (POR) is a research framework that upholds the patient perspective in defining research priorities when evaluating the care and treatment options for patients (CIHR, 2021). This approach emphasizes “meaningful collaboration,” which is to engage patients, researchers, health professionals, and decision-makers at every stage in the research process to develop practical solutions to healthcare issues (CIHR, 2019). With regards to this project, the main competency of POR is its transformative potential; as Mallidou and colleagues (2018) propose, “POR itself is a paradigm shift in the research process,” whereby patient and healthcare provider relationships evolve “from a paternalistic and provider-centred model to a patient-centred model characterized by patient autonomy” (p. 2).

Within the POR framework, “the term, ‘patient’ is overarching and is inclusive of individuals with personal experience of a health issue and informal caregivers, including family and friends” (CIHR, 2021). In contrast to expert-led studies, POR considers the patient as an equal partner in the research process, who has valuable insight to the healthcare experience (Shaywitz et al., 2000). POR involves the collaboration of patients from inception to the end of

the research process; this includes: determining research priorities and the methodology, engagement in data collection and analysis, and outlining the knowledge dissemination process. As a result of this involvement, these research partners with this lived experience of illness are considered as “patient partners” (CIHR, 2021). In contrast to previous research which has examined the gender-informed limitations of the current mental health assessment procedures used in Canadian prisons and jails, and the research which has validated expert-derived knowledge on all-female samples, this project will contribute to the literature by being the first to incorporate the lived experience and voices of formerly incarcerated women into the conception of a women’s correctional mental health assessment.

For this research, recently released women with incarceration experience that have been diagnosed with a mental illness diagnosis have been recruited to participate, along with staff members from various chapters of the Elizabeth Fry Society (EFS) who are service providers for currently incarcerated women. In Canada, incarcerated populations are a difficult group to access for research study, as there are significant security considerations to overcome. For example, some research projects may be misaligned with the institution’s mandate or threaten the safety of the prisoner population. Moreover, prisoners are a vulnerable population, whereby their participation may feel coerced to partake and therefore are unable to provide their informed consent (Dugosh et al., 2010; McDermott, 2013). Thus, Hatton and Fisher (2011) propose that an advantage of including women with incarceration experience, or women in the community, as participants is their similar levels of experience and knowledge as current prisoners, and moreover, they are not under the influence or at risk for retribution by their superiors if incarcerated. Similarly, EFS service providers were recruited to provide in-depth perspectives of a population that is high-risk and understudied (Johnson et al., 2014). As Johnson and colleagues

(2014) suggest, “because providers work with a broad range of incarcerated women, they are able to identify facilitators and barriers to care on individual and system levels, issues with gaps between services, issues affecting quality of care, and struggles to provide services to a complex population” (p. 433).

1.2 Research Question

The focus of this research is to draw on the lived experience of previously incarcerated women with mental illness and staff from various EFS chapters to explore what would constitute an intake mental health needs assessment process for women in prisons and jails. By applying a POR approach to this topic, this project considers women who have undergone the correctional mental health assessment processes, and the EFS staff members who have collectively worked with hundreds of women from federal prison and provincial jail, as having experiential knowledge that can be used to improve the current assessment procedures. Within a healthcare context, “processes” refer to the activities by staff and patients that are aimed at achieving a desired outcome; and healthcare “procedures” refer to the activities conducted on an institutional level (Sein Myint et al., 2021). As such, this research suggests that incorporating gender-informed considerations in mental health assessment processes can enhance the broader assessment procedures in correctional systems. This approach of understanding correctional mental health care practices based on the experience of these women and service providers may contribute towards informing evidence-based practice within corrections and forensic psychiatry.

This research demonstrates that there is a need for an assessment process for incarcerated women’s mental health that is distinct from incarcerated men’s mental health. Previous attempts to address incarcerated women’s mental health needs are limited as the development of assessment processes have not previously incorporated women’s lived experiences (Head, 2017;

Mills & Korner, 2004). Conversely, they have either relied on male prisoner's accounts in conjunction with "expert" knowledge, such as that derived from mental health professionals and scientific researchers. Thus, by drawing on the gaps in the literature, this exploratory, patient-oriented research study is guided by the following questions: i) *What would a gender-informed intake mental health assessment process be for female prisoners in a correctional setting?*; ii) *How could this process be carried out within the criminal justice system?*; iii) *How did the correctional assessment process shape women's perceptions of the criminal justice system?*; and iv) *How did this process shape their perception of themselves, as former prisoners in the correctional system?* It is proposed that a women's intake mental health assessment process, which draws on the lived experience of previously incarcerated women with mental illness and prisoners' service providers, is necessary for addressing currently incarcerated women's mental health needs.

1.3 Structure of Thesis

This thesis contains five chapters. The first chapter, which serves as an introduction to the study, discusses the overview of the phenomena of study, the mental health needs of incarcerated women, the utility of POR in evaluating forensic mental health assessments, and the project's research questions. The second chapter provides a review of existing literature pertaining to the research topic, a discussion of previous sociological theories that have been employed to study the research topic, and details a feminist standpoint theory as the theory of choice to guide the analysis of the data. Then, the third chapter discusses the methodology used in this study, including the research design, the application of POR, sampling procedures and participant information, the data collection processes, a description of the data analysis procedures, the lessons I learned from this process, data rigour and adoption of a constructivist epistemology,

and the ethical considerations for this study. The fourth chapter presents the results of this study. Finally, chapter five summarizes and discusses the findings, the conclusions, and proposed recommendations for future areas of research, including a summary of the knowledge translation process.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This section includes a review of the relevant literature pertaining to the research topic. First, this section will contextualize the research topic by introducing the current mental health assessments used in Canadian correctional institutions. Then, to support the proposition that current mental health assessment tools and processes are gendered, the existing findings on the sex and gender differences in mental health will be discussed. This argument is supported by the literature that follows on the need to explore what a culturally informed mental health assessment process could be for Indigenous incarcerated women. Next, there will be an explanation of the scope and application of POR for this study. This section will conclude with a discussion of two theoretical alternatives to the analysis of the current research question, followed by a summary of feminist standpoint theory, and how this theory will be applied in the context of this research.

2.1 Current Correctional Mental Health Assessments

The goal of correctional mental health assessments is “to identify signs and symptoms associated with serious mental illness” for the development of an “intervention that includes necessary mental health programming, throughout an offender’s sentence” (Public Safety Canada, 2015). Within federal institutions, prisoners’ health at intake is screened within 24 hours of admission through the Immediate Needs Interview and Intake Health Status Assessment, which are conducted by correctional staff and nursing staff (CSC, 2012). Within 14 days of admission, the Comprehensive Nursing Assessment is administered by nursing staff, and the Computerized Mental Health Intake Screening System (CoMHISS) by those at the Psychology

Department (Ibid.). Cut-off scores from this process designate whether referrals to Psychological Services should be made.

The CoMHISS is the first component of federal mental health care and is used to improve access to mental health services and treatment (CSC, 2007). It is identified by CSC as a self-report assessment that provides an objective measure of the prisoner's mental health (CSC, 2007), based on 132 questions which derive from four tools: the Depression, Hopelessness and Suicide Screening Form (DHS; Mills & Kroner, 2004); the Brief Symptom Inventory (BSI; Derogatis, 1993); the Adult Self-Report Scale (ASRS; Kessler et al., 2005), and the General Ability Measure for Adults (GAMA). The DHS and BSI assess the prisoner's psychological well-being, and 6 of the 18 items on the ASRS correspond directly to the Diagnostic and Statistical Manual of Mental Disorders (DSM). An examination of the CoMHISS by Archambault and colleagues (2010) revealed that women in prison were more likely to require a follow-up assessment than their male counterparts and report a higher rate of psychological distress. Among a sample of federal female prisoners, Stewart and colleagues (2013) found their CoMHISS scores had an overall accuracy rate of 58.2% in comparison to the diagnosis provided by a mental health professional, with 40% of false positives. I argue that these discrepancies may be attributed to the development of the DHS, which was previously mentioned to be developed according to a male sample from medium security Canadian prisoners.

In a review of the mental health assessment tools used in federal prisons and provincial jails, Leschied (2011) found that "while certain of these instruments show promise in differentiating mental health disorder[s], as a general statement, the reliabilities and validities are more satisfactory for males as opposed to females" (p. 9). For example, the Brief Jail Mental Health screen, which is used to efficiently identify a DSM diagnosis among prisoners (Ford et

al., 2007), has been associated with a high false negative rate for females and higher accuracy for identifying mental illness among males. The General Health Questionnaire, which is used to identify emotional distress, has been found to exhibit adequate internal consistency but whether the tool is appropriate for women is debated in the literature (Leschied, 2011; Smith & Borland, 1999). Fitzgibbon & Green (2006), authors of the Offender Assessment System, concluded the tool was not sensitive to gender and did not produce results that were sufficient to recommend programming decisions. Finally, the Brief Mental Health Screening Instrument for Newly Incarcerated Adults is not sensitive to gender (Brennan, 2007).

The mental health assessment tools which are sensitive to women tend to contain items pertaining to trauma (Leschied, 2011). This includes the Life Stressor Checklist (Wolfe & Kimerling, 1997), The Distressing Life Event Scale (Weiss & Marmar, 1996), and the PTSD Checklist (Weathers et al., 1994). Within the Canadian literature, only two tools have been validated on female samples. Nicholls and colleagues (2012) found that the Jail Screening Assessment Tool, which takes form in a 20-minute semi-structured interview, was deemed effective in identifying British Columbian female prisoners' needs for mental health treatment and specialized institutional placement. Most recently, the Dangerousness Understanding, Recovery and Urgency Manual (DUNDRUM) was the first assessment tool to successfully determine the need for prison to hospital transfers among provincially-sentenced women in Ontario (Jones et al., 2019). In consideration of the presented literature on the male-constructed mental health assessments across federal prisons and provincial jails, this research highlights the incompatibility of these tools among female prisoner populations, and the subsequent need for a women's mental health assessment process.

2.2 Sex and Gender Differences in Mental Health Needs

This study considers incarcerated women's mental health needs as unique and distinct from that of incarcerated men. These differences have both an underlying biological and social foundation (Afifi, 2007; Fitzgerald & Dinan, 2010; Green et al., 2016; Kimerling et al., 2018; Riecher-Rossler, 2017a; World Health Organization, 2002). Within the context of biology, women may experience symptoms of mental illness, such as anxiety or depression, as a result of sex hormone changes, which, for example, can occur after pregnancy, on certain days of their menstrual cycle, or during menopause (Freeman et al., 2004; Li & Graham, 2017; Riecher-Rossler, 2017b). It should be noted, however, that while biological factors can influence a woman's mental health status, they are not the sole determinant of her mental illness. Moreover, while such factors can be used to identify and treat a woman's diagnosis, this emphasis on biological determinants have rooted negative stereotypes and contributed to women's marginalized social position. The social factors that contribute to women's mental health include the increased likelihood of experiencing poverty and unemployment (Strandh et al., 2012), interpersonal stressors, trauma, violence, and sexual abuse (Covington, 2008; Jina & Thomas, 2013; Pico-Alfonso, 2006; World Health Organization, 2000). Further when compared to men, women's more frequent victimization of gender-based violence is associated with higher diagnoses of post-traumatic stress disorder, anxiety, and depression (Oram et al., 2017). While CSC (2017) recognizes security classifications based on gender as opposed to biological sex, this process classifies transgender prisoners according to their physiological sex at the time of admission. That is, if a prisoner's gender identity and biological sex are not the same, CSC requires an institutional psychiatrist to verify the claim of gender dysphoria (Ibid.). Additionally, prisoners will be held in the institution that is congruent with their biological sex until they have

undergone sex reassignment surgery (Ibid.). Thus, cis-gender female participants were recruited for this study.

The World Health Organization (2008) identifies the gender-specific risk factors for mental illness which disproportionately affect women to be: gender-based violence, socioeconomic disadvantage, low income and inequality, and subordinate social status. Similarly, while women in prison commit less serious offences than their male counterparts, they have a longer history of physical and/or sexual victimization (Johnson et al., 2014; Leschied, 2011), are more likely to be the primary caregiver of minor children (Covington, 2003; Johnson et al., 2014), are more likely to be at an economic disadvantage with lower levels of education and employability skills (Leschied, 2011), and have higher rates of substance abuse (Ward, 2003). Altogether, these lived realities have an impact on their criminal offending and re-offending (DeHart et al., 2014; Holtfreter et al., 2004; Richie, 2001; Robertson & Murachver, 2007; Salisbury & Van Voorhis, 2009). Accordingly, the literature suggests that gender-informed mental health assessment and programming are needed to address women's mental health needs and help with the healing process of their victimization experiences (Cabeldue et al., 2019; Derkzen et al., 2019).

2.3 Culturally Informed Mental Health Assessments

Indigenous groups are overrepresented at all levels of the Canadian criminal justice system (Department of Justice, 2019; LaPrairie, 2002; Office of the Correctional Investigator, 2020), including women's provincial and federal correctional centres. Between 2013-2019, Indigenous admissions increased from 699 to 868, accounting for 64% of all new Indigenous admissions to federal custody (CSC, 2019). The Correctional Investigator of Canada (2020) has referred to these statistics as “more troubling” for Indigenous women, who currently account for

42% of the female prisoner population. The literature attributes these trends as resulting from Indigenous peoples' experiences of colonization and residential schooling (e.g., LaPrairie, 1996; Monchalin, 2016; Rumboldt, 2019; Truth and Reconciliation Commission of Canada, 2015). Correspondingly, this collective loss of culture and disruption of family dynamics places incarcerated Indigenous women in a more vulnerable social position than their non-Indigenous counterparts, with heightened rates of various mental health and illness concerns, such as depression, anxiety, substance abuse, and suicide (Derkzen et al., 2013). Dell and Kilty (2012) further explain that this loss of culture places female Indigenous prisoners in a difficult social position, as they may not consider themselves as victims of intergenerational trauma or abuse, and incarceration may exacerbate feelings of shame among those that are mothers. In consideration of these findings, CSC has implemented programming for Indigenous women to specifically address their mental health needs, and help connect them to their culture (Bell et al., 2004). It should be noted that correctional programming is used to indicate progress and rehabilitation; as this programming continues to receive high participation and completion rates (Public Safety Canada, 2012), these women's strengths, resilience, and determination to heal from their traumas may be evident.

Simpson and colleagues (2013) suggest that the increased rates in mental illness prevalence in Canadian prisons may be linked with the growing Indigenous prisoner population. CSC (2010) data further suggests that the assessed mental health needs of Indigenous women at intake have steadily increased with regards to prescription psychiatric medication, and the management of previous and current mental health diagnoses. The literature, however, is divided over the utility of a culturally informed mental health assessment process for incarcerated women. For example, an analysis of the Computerized Diagnostic Interview Schedule by

Derkzen and colleagues (2013) found that alcohol dependence is a particular concern for incarcerated Indigenous women. Gutierrez and colleagues (2016), however, question whether correctional assessments may actually apply to incarcerated Indigenous women as they continue to be overrepresented in this population. Conversely, Stewart and colleagues (2013), propose that there may be no need to develop separate mental health intake assessments for Indigenous females, as they reported similar levels of emotional distress as their non-Indigenous counterparts according to the aforementioned CoMHISS. Finally, a recent systematic review of the literature suggests that there is no high-quality evidence on the impact of interventions designed specifically for male and female Indigenous prisoners with mental health concerns (Perdacher et al., 2019). In consideration of these varied conclusions, further examination into the relevance of a culturally informed mental health assessment process for Indigenous incarcerated women is necessary.

2.4 Patient-Oriented Research with Incarcerated Women

This study drew on the patient-oriented research (POR) approach, which upholds the patient perspective in defining research priorities when evaluating the health care and treatment options for patients. POR aims to democratize research and works towards a paradigm shift in research to empower patients and promote their autonomy (Aubin et al., 2019; Carroll et al., 2017). This framework was applied to the current study by engaging a patient partner throughout the research process to identify research priorities and outcomes that would be relevant to incarcerated women with mental illness. Through meaningful engagement and collaboration with patients and families, as well as stakeholders in research to produce meaningful outcomes to facilitate change (Ibid.), POR shares similarities with participatory action and community-based methods. POR, however, remains unique as it is a research framework that aims to improve

healthcare systems and delivery (CIHR, 2021), whereas the former could be applied more broadly to research areas outside of healthcare (Frisch et al., 2020). That is, there could be overlap in which a patient-oriented approach to research could incorporate community-based research methods, but these terms are not interchangeable as research that draws on community-based methods may not necessarily fit within the POR paradigm.

Previous studies analyzing incarcerated women's mental health assessments have not applied POR approaches. Typically, research in this area draws on quantitative methods to validate standardized assessment tools on female prisoner populations. Although POR in a forensic correctional setting is a relatively new concept, community-based and participatory action research endeavours may unintentionally include POR elements in their projects due to the similarity of these approaches. For example, in Kjelsberg and colleagues' (2006) analysis of correctional psychiatric service providers' experiences of providing treatment to prisoners, it was suggested that patients' lived experiences should be incorporated in research to further understand the successes and challenges to these interventions. Additionally, Van Den Tillaart and colleagues (2009) included women prisoners as active research partners in a study that aimed to identify prisoners' mental health priorities, according to the women themselves. The importance of POR in this area is highlighted as participants identified a struggle to effectively communicate with or be taken seriously by healthcare providers when discussing their mental health needs (Ibid.). Further, Martin and colleagues (2009) drew on the voices of incarcerated women and correctional staff within a women's provincial jail in British Columbia to identify their health priorities. Through this engagement, they were able to identify the programs needed, and moreover, suggested that this approach could be healing for the women, as their involvement allows for their voices to be heard and can create meaningful impacts (Ibid.). The authors stated

that they incorporated community-based participatory action methods rather than a POR approach, despite involving incarcerated women in the research design, data collection and analysis, and knowledge translation processes. Whereas previous research has examined the gender-specific limitations of various mental health or psychiatric assessment tools used in Canadian prisons, and other endeavours have validated expert-derived knowledge on all-female samples, patient voices have not yet been incorporated into the development of an intake mental health assessment process for incarcerated women.

2.5 Theoretical Framework

In this section, I will introduce two theories that have been previously used to conceptualize the research question: i) biological positivism and postpositivist approaches to criminalized women's mental health and illness; and ii) Parsonian functionalist theory on women's gender roles and mental illness. I will also discuss the limitations in applying each theoretical approach to the research question. Then, I will identify feminist standpoint theory as the theoretical framework that I drew on for this study. Finally, I will justify the use of this theory and explain how it has been applied to this research, including the conceptualization and operationalization of key terms.

2.5.1 Theoretical Alternatives which Previously Addressed the Research Question

2.5.1.1 Biological Positivism and Postpositivist Approaches

The goal of positivist research is to explain observations, as well as make predictions with the intent to control social phenomena (Guba, 1990). Within the early criminological literature, Lombroso and Ferrero (1958) applied the theory of biological positivism to criminalized populations, which subsequently emphasized women's inferiority to men, as they

are underrepresented in acts of deviance and crime. As biological positivists alleged that female criminals exhibited similar characteristics to their male counterparts, such as atavistic characteristics, masculine stature, and dark hair (Ibid.), the various means by which women exhibit deviance, crime, and victimization are neglected within this framework (Heidensohn, 1968).

Analogous to how female prisoner's criminogenic factors are not regarded as independent from males within biological positivism, women's mental health needs continue to be managed in the same way as their male counterparts. The literature on gender and mental health indicates that female participants have been historically, and to an extent, are currently excluded from mental health research (Holdcroft, 2007). For example, despite the growing evidence towards sex and gender differences in mental health and illness, the aforementioned Depression, Hopelessness, and Suicide Screening Form and Mental Health Need Scale serve as testaments as to how the mental health assessment procedures currently used in Canadian prisons remain the same for their male and female populations (Brennan, 2007; Hardyman & van Voorhis, 2004). The consequence of this practice of developing universal research findings based on all-male samples is the implication that the core characteristics and behavioural expressions of mental illness exhibited by men are also transferable to women (Cale & Lilienfeld, 2002; Rogstad & Rogers, 2008; Wynn et al., 2012).

The postpositivist paradigm advanced from critiques of the positivist conceptualization of criminality. Whereas traditional positivist epistemology is grounded on expert observation and experimentation to guarantee certainty in findings, postpositivist scientists recognize that social reality can never be fully known, and so they attempt to understand reality through "imperfect" interpretations (Guba, 1990, p. 20; Popper, 1963). Postpositivists acknowledge that humans are

limited in their capabilities to comprehend social realities, and research questions must therefore be positioned from multiple perspectives (Wynn et al., 2012). As perspectives are historically influenced, postpositivist researchers consider that knowledge is open to further scrutiny (Guba, 1990).

Health researchers have been increasingly employing postpositivist approaches to women's mental health assessment (Doucet et al., 2010). Within the postpositivist method, mental illness is diagnosed according to identifiable symptoms, and their presence or absence is assessed against standardized questionnaires or objective evaluations (Stoppard, 2000), which have been constructed by psychological experts. Additionally, these procedures include the term "female" to refer to the individual's biological sex at birth, thus neglecting to account for the social factors related to gender and mental health, such as women's experiences of poverty and victimization (Brennan, 2007). Further, the application of postpositivism to such assessments has recently garnered much critique due to increased recognition of mental health as a holistic construct (Doucet et al., 2010). Whereas a postpositivist approach to mental health assessment aims to predict or control factors that can contribute to women's mental health, feminist theorists argue that this process can work to oppress, instead of empower women with mental illness (Ibid.).

2.5.1.2 Parsonian Functionalism Approaches

In contrast to the biological positivist and postpositivist emphasis on biology and simultaneous disregard of gender differences in the construction of mental health assessments, structural functionalist theories have focused on the role of social structures in shaping gender and social role differences in the analysis of criminalized women and mental health. While Parsons (1967) aimed to maintain positivist methods in social science, his focus was to

strengthen structural functionalism by addressing its neglect of the subjective intention behind social action. He thus proposed a thesis that social action is grounded on structural elements, such as collectivity, norms, and values (Ibid.). Following this framework, Parsonian concepts of gender roles and socialization emphasize that women and men's social experiences are different, and draw on the gendered divide of roles within the traditional nuclear family (Parsons & Bales, 1955). As a result of the process of socialization, men have an *instrumental* role tied to economic contributions, and women an *expressive*, or nurturing, role in maintaining the structural functionalist notion of the social order (Ibid.).

Based on the Parsonian notion of collective societal values and the structural means for attaining them, deviant action is conceptualized as an individual's reaction to his/her own inadequacy to obtain these goals (Parsons, 1954). In consideration of female criminality, modern functionalist theory stresses the influence that social structures have on women which differs from men, such that they are placed in situations which evoke unique opportunities for deviance (Ibid.). Whereas male criminal behaviours are interpreted and centred on their motivation to attain economic achievements, such as establishing a career for themselves, Parsons (1951) and Cohen (1955) assert that females experience a different trajectory towards deviance, as their actions are confined within sexual and marital domains (as cited in Heidensohn, 1968). Although Parsons has been highly influential to the study of gender within sociological literature, his work has been criticized by the feminist scholar, Heidensohn (1968) as overly valuing a woman's gender role and disregarding women's agency in deviance. Specifically, she challenges the Parsonian emphasis on a woman's role to act through men in order acquire their social and economical status (Ibid.).

In conjunction with the functionalist literature on deviant behaviour, Parsons (1951) considered mental illness as a form of deviance because the sick person “fail[s] in some way to fulfill the institutionally defined expectations of one or more roles in which the individual is implicated in the society” (p. 146). That is, he proposes that mental illness takes away from the person’s role in contributing to the functioning of society. Through this notion of the “sick role,” Parsons recognized social factors in addition to biological factors in his analysis of mental health and illness (Busfield, 2000). Despite the critique of his narrow conception of women’s deviance, however, his consideration of social influences in mental illness persists as a valuable contribution to medical sociology research, and is significant in the current context of identifying a mental health assessment process for incarcerated women.

2.5.2 Feminist Standpoint Theory

To answer the research question and examine what would constitute a mental health assessment specifically designed for incarcerated women, this research will draw on feminist standpoint theory. As the correctional system has historically focused on the confinement and reformation of men, criminality was primarily concerned with the specific characteristics observed in male offenders that could be used to predict or explain deviant behaviour (Heidensohn, 1968). With the growth in the female prison and jail populations in Canada, however, research has established there are greater differences between women and men than there are similarities (Bumiller, 2013). Despite increasing attention towards criminalized women within the discipline of criminology, as well as the mental health research that establishes sex and gender differences, correctional systems continue to use the same mental health assessment processes for men and women.

Whether gender-neutral assessments are sufficient to validate and identify women's risks and needs for classification is debated. Currently, gender-neutral assessment methods used in corrections rely on linear models for security classification (Brennan, 2007), and have been criticized for neglecting the holistic view of the individual and the relevant factors which contribute to her classification score (Ragin, 2000). Conversely, some alternatives that claim to incorporate gender-informed approaches, instead use deviant typologies to regulate women's behaviour and ensure that they conform to societal expectations. Thus, women who deviate from the traditional female role would be more likely to be diagnosed with a mental illness (Wright & Owen, 2008). In consideration of the limitations of the current empirical method used in the mental health needs assessment, this study will draw on feminist standpoint theory with the intent to incorporate women's lived experience of incarceration to inform a women's mental health assessment process.

2.5.3 Feminist Standpoint Theory and the Importance of Women's Experiences

By drawing on the POR framework, this research highlights the importance of engaging women with incarceration experience from the community and incarcerated women's service providers such as those found at the EFS. Feminist standpoint theory similarly upholds these experiences, and is grounded on the following claims: i) knowledge is socially situated; ii) in comparison to their male counterparts, women belong to a marginalized group, and are in a social position that makes it possible for members to be aware of and question specific phenomena; and iii) research should begin with the standpoint of women (Brooks, 2007; Smith, 1990). The requisite to conduct feminist standpoint research is to therefore place women's experiences as the starting point in knowledge production (Brooks, 2007), which consequently

challenges the claim that science must be objective in order to contribute to knowledge production. As Smith (1990) proposes:

“women’s standpoint...discredits sociology’s claim to constitute an objective knowledge independent of the sociologist’s situation. Sociology’s conceptual procedures, methods, and relevances organize its subject matter from a determinate position in society. [...] This reorganization involves first placing sociologists where we are actually situated, namely, at the beginning of those acts by which we know or will come to know, and second, making our direct embodied experience of the everyday world the primary ground of our knowledge” (pp. 21-22).

By drawing on classical Marxism, feminist standpoint theory critiques the sociological pursuit of objective truth and places this within the context of defining women’s interests (Hawkesworth, 1999). Thus, standpoint theory is a means of understanding social reality that begins with, and is directly derived from women’s experiences.

Smith (1990) further contends that a woman’s experience is “necessarily different” from that of the researcher (p. 28). This challenges the dominant sociological method which places the researcher as the expert and sole source of knowledge, despite the various contributions made by study participants. Similar to the POR framework, this perspective calls for a shift in the research method, whereby the researcher must frame their analysis “in the site of [the participant’s] bodily existence and in the local actualities of her working world” (1990, p. 28). She identifies women as the “authoritative speakers of [their] experience,” which entails that standpoint inquiry must “begin always from women’s experience as it is for women” (Ibid.).

Within the feminist standpoint lens, criminalized women are an oppressed social group. As a prisoner, the experience of incarceration works to retraumatize women with histories of trauma or prior mental health diagnoses, and can perpetuate suicidal ideation or behaviour (Harding, 2004). As a community member, their class position will limit their ability to access economic resources (Comack, 1996). Considering that a woman’s prison security classification

is contingent on mental health assessments derived from all-male samples (i.e., Mills & Kroner, 2005; Wilton et al., 2015), Pollack (2020) argues that these processes can work to reproduce the patriarchal constructions of women's criminalization.

In the Canadian criminological literature, Comack (1996) has applied feminist standpoint theory in her analysis of criminalized women's unique experiences before, during, and after incarceration. She critiques contemporary criminological research as "masculinist," due to its heavy influence from findings based on research on incarcerated men, and its "often use [of] male-centred assumptions about the nature of the world" (1996, p. 11). Further, the criminalized woman has been constructed against the normative and stereotypical notions of what constitutes femininity and women's nature: "what becomes known about women is very much framed through a male gaze" (Ibid., p. 11). By drawing on standpoint theory in her analysis, she claims that the incorporation of incarcerated women's stories in her work emphasized the importance of hearing the voices of a marginalized social group, and the importance of the knowledge shared in the exchange (Ibid.). Furthermore, she equates the use of this theory as a means of validation: "the standpoint...endeavours to explore what each woman's life has been like to this point in her history; it includes a sensitivity to biography which enables us to grasp how the structures which confront each woman have been worked out in her everyday experiences" (Ibid., p. 34). Similarly, this research applies feminist standpoint theory in conjunction with the POR framework to apply participants' experiential knowledge in the conceptualization of a mental health assessment process for incarcerated women.

2.5.4 Feminist Standpoint Theory and Mental Health Assessments

This research considers the prison and jail mental health assessment processes that have been constructed based on all-male samples to be incompatible with incarcerated women with

mental illness. Whereas correctional policies and programming are historically male-dominated, standpoint theory values women's voices as a unique perspective (Covington & Bloom, 2003; Hannah-Moffat, 1991). Thus, in placing women's lived experience of incarceration as the starting point of analysis, their voices are recognized as legitimate and a valuable source of knowledge (Ibid.). Whereas the separation between objective neutrality and subjective emotion is emphasized in positivist science, feminist epistemology challenges this oppositional relationship (Harding, 2004; Jaggar, 2004). Harding (2004) argues that empirical scientists consider their own research methods and results as value-free, without realizing that their position as the creators of knowledge reinforces their power over marginalized groups. Moreover, the feminist standpoint concept of strong objectivity values women's experiences as being "more objective and unbiased than the prevailing representations that reflect the standpoint of men" (Jaggar, 2004, p. 62). That is, the socially dominant views and ways of thinking are challenged, and the assertion of a woman's identity based on her own life and experiences is encouraged (O'Leary, 2008). By appreciating these merits, Harding (2004) proposes that standpoint theories "map how a social and political disadvantage can be turned into an epistemic, scientific and political advantage" (pp. 7-8).

To exemplify how correctional mental health assessments could be informed by standpoint theory, this research draws on Smith's (1978) argument that psychiatric case studies consider study participants as resources, instead of patients in need of healing. Within the context of mental health assessment, Smith's standpoint epistemology argues that the process of validating someone's mental illness is not clearly defined. She describes a mental health assessment as "a process in which the respondent works up and tests the status of her experience, knowledge, and definitions of events against the knowledge, etc. imputed to the interviewer as a

representative of the culture at large,” which implies that the “trusted teller of the tale” is the person who has written the account (Ibid., pp. 27, 32). That is, while a mental health patient’s narrative is rich in content, the mental health expert will present her account in an “ordered” fashion; this allows for the audience to read “coherence [that] was not present in the events” (Ibid., pp. 32-33). Consequently, due to the expert’s privileged standpoint in describing and then defining the patient’s behaviours, their consequent diagnosis is validated as fact (Ibid.). This research similarly challenges the correctional system’s construction and labelling of a mental illness diagnosis, and aims to bring forward the standpoints of women to inform the assessment process.

2.5.5 Application of Feminist Standpoint Theory to the Research Study

Feminist standpoint theory was used to answer the research questions, and to frame my analysis of former female prisoners and female service providers’ input as to what consists of a mental health needs assessment for incarcerated women. For my study sample, I drew on the lived experience of participants who were recruited based on their identity as a woman in biology and in gender. As respondents are women with lived experience of incarceration, and those who work with currently incarcerated women and those in the community, their accounts will be defined according to their past histories and knowledge based on their interactions with these groups.

By applying this framework to the research study, it is also acknowledged that the feminist sociological literature which has problematized the practice of psychiatry is extensive. Feminist scholars have highlighted the dominant ideologies which construct the classification of “abnormal” behaviour and how it should be addressed (Marecek & Gavey, 2013). Moreover, the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5;

used in the practice of psychiatry to guide the diagnosis of mental illness; American Psychiatric Association, 2013), does not address women-specific mental health issues and therefore lacks a women-specific diagnostic criteria (Wittchen, 2010). While it can be argued that sociology and psychiatry are differing and conflicting epistemologies (e.g., Bloom, 2005; Rogers & Pilgrim, 2010), there is also evidence that sociology can be relevant to, and impact the discipline within corrections. Specifically, the DSM-5 draws on a more flexible approach to diagnosis and treatment, encouraging cultural competence (i.e., acquiring and applying the skills and knowledge necessary to understanding the role that a patient's social background has on her illness; American Psychiatric Association, 2013). Kapoor and colleagues (2013) suggest that this would be ideal for application in prisons and jails, as the psychiatrist is encouraged to understand the patient's psychosocial environment, her cultural identity and its impacts on her definition of illness and perception of the patient-physician relationship, and how they could work together to develop a treatment plan (Ibid.). Although the feminist critiques of psychiatry and the historical construction of mental illness do hold validity, it should also be recognized that sociology has influenced the practice in the amended DSM-5 guidelines.

I acknowledge that a discussion on standpoint feminism would not be complete without introducing my own standpoint, in relation to the research topic. I identify as a cis-gender female, and as a feminist. As an advocate for incarcerated women and their families, I volunteered with EFS Saskatchewan for one year prior to starting this research project and have met several women with lived experience of incarceration and listened to their standpoints at various events, including their weekly Sharing Circle. On a more personal level, I have family members and friends who have been incarcerated or are currently entrenched in our criminal justice system. Through these experiences, I understand how incarceration and the consequent

separation from the broader community can affect the mental health and wellbeing of the prisoner, as well as their family. Further, I think that my identity as a woman predicated my sensitivity to how imprisonment affects the mothers, sisters, and daughters in the community, although I do not have lived experience of incarceration myself. I also observed how my family's history of mental illness and addiction has, on occasion, intersected with our criminal justice system. My privilege in pursuing a graduate-level education has provided the tools for me to critique the mental health assessments and tools currently used in Canadian prisons and jails with a gendered lens, and to evaluate this research area through a patient-oriented lens. I also realized how my education has identified how the stigmas and negative stereotypes about people with mental illness and addiction, as well as those with lived experience of incarceration, have been shaped by society, which challenged my pre-existing beliefs about these groups. Thus, under the guidance of my thesis supervisor, I adhered to a POR approach to this project with the aim to empower and strengthen the standpoints of women with lived experience of incarceration and mental illness, who I consider to be marginalized in society. These experiences and knowledge have moreover shaped my aspirations in pursuing a career in forensic psychiatry as I aim to approach my future patients with compassion and understanding of their social positions, and use the tools accessible to me to help address their mental illness concerns.

The utility of applying standpoint feminism to this study is its valuation of the significance of women's experience, knowledge, and identity (Smith, 1990). Moreover, it presents that the process of knowledge production is fulfilled when women's standpoints are visible (Ibid.). As an analytical tool, the theory encourages the consideration of differing accounts of the same phenomena (Hawkesworth, 1999), which, in this context is the correctional mental health assessment process. That is, as opposed to adhering to the notion that there is only

one way of addressing prisoners' mental health, this study will recognize the "plurality" of multiple standpoints (Ibid.). This approach ultimately benefits the analysis as claims by participants may contrast with the concepts derived from the tools that are currently employed in Canadian prisons and jails. Thus, embracing multiple standpoints can allow for new concepts to be adopted into the criminal justice system's operations and procedures.

Further, this theoretical approach aligns with the POR mandate of collaborating with patients in research. As suggested by Rowland and colleagues (2017), patient engagement and the valuation of their perspectives mirrors the feminist standpoint concept of strong objectivity, and moreover, both these theoretical and research approaches focus on the practical applications of the findings, such as opportunities for actionable tasks and policy implications. By applying a POR approach, women with lived experience of incarceration could become empowered through their involvement as research collaborators or participants in this study (Brooks, 2007). As they are a socially marginalized group according to their status as women and former prisoners, their participation could also facilitate construction of their own identity as a mental health patient, as opposed to how that was constructed from experts or authority figures within correctional institutions. This approach therefore couples women's subjective experiences and the literature on women's incarceration, such that their personal accounts can be received as legitimate and valuable sources of knowledge (Casey, 2017). Thus, by starting from the position of these women to answer the research question, this study serves as a means to suggest improvements to the social problem of the less than optimal mental health needs assessments for women in prisons and jails.

2.5.6 Conceptualization and Operationalization of Key Terms

Based on my argument that there are gendered components to correctional mental health assessments, feminist standpoint theory will be used to frame women's experiences and their corresponding suggestions for the development of a gender-informed mental health assessment process. The broader literature defines "gender-informed" as acknowledging how an individual's gender identity influences their needs (e.g., Hill, 1998; Lindqvist et al., 2020). This definition can apply, and is not limited to females, males, transgender, and non-binary individuals. Within the context of this research, however, the term "gender-informed" holds a specific definition, pertaining to how a woman's identity influences her mental health needs. By adopting this view, this study conceptualizes incarcerated women's mental health needs as unique from men's, as their needs are influenced by social, historical, and cultural experiences (Anumba et al., 2012; Miller & Mullins, 2017), including the various instances of trauma and abuse that they are disproportionately subject to. I therefore reject the assumption that the same factors used in current instruments can apply to both incarcerated men and women (Chesney-Lind, 1989).

All participants were recruited based on their own cis-gender identification as women. The women with lived experience of incarceration identified as having a mental illness, regardless if they were diagnosed with a condition in the community before they were incarcerated, or if they received this diagnosis during their sentence. The women who are from the EFS were recruited based on their lived experiences working with women with mental illness who are currently incarcerated, or have been previously incarcerated. Altogether, these women's accounts were used for the process of conceptualizing and operationalizing "assessment," "mental health," and "mental illness." The feminist standpoint theoretical perspective provides the insight that the field of mental health assessment among criminalized populations has been

focused on research involving all-male subjects, such that the terms “assessment,” “mental health,” and “mental illness” have been patriarchally constructed. Additionally, the term “culturally informed” was used to define a mental health assessment process for Indigenous female prisoners, as the literature on the necessity and applicability for such a process is debated in the literature. This term was defined according to a health promotion framework (Betancourt et al., 2002; Campinha-Bacote, 2002), which highlights the importance of a woman’s cultural knowledge, beliefs, and traditions in providing mental health care.

Finally, the term “patient” is referenced throughout this thesis. Drawing on the POR framework, “patients” are individuals with experiences of illness, as well as their family and informal caregivers, whose engagement in research is integrated to improve healthcare systems (CIHR, 2019). I understand that while patient voices are rarely acknowledged to facilitate change in research (CIHR, 2021), the women who have been involved as participants and advisors/partners within this research are given the opportunity to share their experiences and insights. Correspondingly, this thesis defines “patients” as women with experience of incarceration and mental illness who feel empowered to draw on and share their experiences to suggest improvements for correctional mental health care systems.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter first explains how POR was applied to the research methodology. This is followed by the rationale for applying qualitative methods to suggest a mental health assessment tool for incarcerated women at institutional intake. Then, the sampling strategy and data collection procedure are described. Next, I explain how the data was analysed, with a discussion of the lessons learned from this process and on the quality of the data. Finally, this section concludes with a disclosure of the ethical considerations taken.

3.1 Patient-Oriented Research Application in the Methodology

The intended outcomes for POR projects are to give patients a voice in the treatment evaluation process, and co-construct meaningful interventions that may have promising results (CIHR, 2021). Patients are thus engaged at various levels of the research process, ranging from low engagement (i.e., sharing research about patients), to moderate engagement (i.e., consultation or collaboration with patients), to high engagement (i.e., partnership with patients that entails a shared power in decision-making), up to patient-led or patient-controlled research (Sunderji et al., 2019). Patient engagement has several benefits, including the dissemination and implementation of findings that can improve medical interventions, however, higher levels of engagement are not necessarily better than lower levels (Ibid.). Rather, the level of engagement employed in a study may depend on the research question and study purpose, as well as the setting available within which the research is conducted (Ibid.).

For this project, I chose a moderate level of engagement. This entailed that the research question was informed by my review of the literature and experience working with EFS

Saskatchewan's staff and clients. In my volunteerism, I participated in various events where women shared their life histories of mental illness and incarceration. Additionally, the research team included Dr. Colleen Dell, the project supervisor; Dr. Sharon Acoose, the project advisor; Willi McCorrison, the patient partner; and myself. Project planning was initially done in conjunction with EFS Saskatchewan, whereby a staff member was initially on the research team; however, this member had terminated her employment before data collection had commenced. Her intended roles for participant recruitment, data analysis, and knowledge dissemination were then passed on to Ms. McCorrison, who is a mother to a woman with lived experience in federal prison and provincial jail and mental illness. Our research was further guided by Dr. Acoose, whose lived experience informed project planning and participant recruitment, and will continue to inform the knowledge translation process. Thus, the women with lived experience in the research and advisory team were involved in several components of the research process, including project planning, participant recruitment, data analysis, and knowledge translation. Patient partners' involvement in this research were compensated according to the guidelines set by the SPOR Evidence Alliance (2019).

3.2 Rationale for Qualitative Approaches

This study drew on qualitative methods as uncovering the standpoints of female former prisoners and service providers is the focus of this research. This approach thus places value on women's understanding, opinions, and experiences or knowledge of the intake mental health assessment (Tewksbury, 2009), and provides the space for them to share details about the process and how it could better address the needs of currently incarcerated women (Palinkas et al., 2011). Thus, I aimed to gain a thorough detail of this issue from their lived experiences and

perspectives. As this is an exploratory study, I also considered qualitative methods to allow for the flexibility that a rigid methodological approach could not offer.

I considered the interview data to reflect the conversational dialogue between myself and the participants; the resulting outcome was very rich, detailed data. Thus, thematic analysis was employed to identify recurring patterns, or themes, within the data, and report on any commonalities across participants' experiences of being subject to prison mental health assessments, or their experiences directly working with incarcerated women (Braun & Clarke, 2006). This method was also useful in identifying points of contention between participants' perceptions and opinions of prison mental health assessments, and their experiences with interacting with incarcerated women with mental illness. As my sample included participants with a range of experiences and professional backgrounds from various provinces, thematic analysis was especially useful when considering the similarities and differences between participants and when analyzing unanticipated insights in the data (Braun & Clarke, 2006; King, 2004).

In contrast to generating data that conforms to specific terms and language, this approach to data collection gave participants the space they needed to express their own voice, as well as speak for the women they have worked with in their organization, whose voices are less likely to be heard. Moreover, qualitative methods facilitated asking open-ended questions and following up on any points brought forward by participants that were not originally intended as the topic of inquiry, but supplemented inquiry into the research question. This allowed for me to explore this area further, which generated rich data and novel knowledge to the literature.

3.3 Sampling Strategy & Participant Demographics

In total, 15 participants were interviewed for this research. The “Patient” sample consisted of five women with lived experience in both federal and provincial corrections, and the “Service Provider” sample included ten women who were staff members of various chapters of EFS. EFS is a national prison abolitionist organization that advocates for the rights of women in prison, and operates out of various chapters/service locations in Canada (Canadian Association of Elizabeth Fry Societies, 2020). I recruited Service Providers through cold telephone calls and emails to each EFS chapter present in this sample. Each qualified participant was then recommended to participate in this study by the chapter Executive Director with whom I first made contact, depending on their experience and area of work. Participants in the Patient group were recruited via purposive snowball sampling through Ms. McCorrison’s and the participants’ networks. Each recruitment email contained a Letter of Information that described the study (see Appendices A & B), and a Recruitment Poster was used to advertise for recruiting the Patient sample (see Appendix C).

Participants with lived experience of incarceration who had recently been released into the community (i.e., within 3 years from the date of their participation) constituted the Patient sample. Ms. McCorrison and I chose to use the term “Patient” to describe this group because they were in the community at the time of the interview, and drew on their experiences as former prisoners seeking mental health assistance while they were incarcerated. Further, this research draws on the recommendations of *Creating Choices*, whereby women in prison and in the community advocated for prisoners’ mental health concerns to be addressed “like patients, not offenders” (CSC & Canadian Association of Elizabeth Fry Societies, 1990, p. 34) and similarly applies this terminology. It should be noted that the term “patient” is an all-encompassing term

which emphasizes the value of their lived experience towards improving mental health care for women currently entrenched in the criminal justice system (Canadian Institutes for Health Research, 2019). We chose to use the term “prisoner” to address women who are currently incarcerated, as we considered it to highlight the oppression and marginalization that women encounter while incarcerated (e.g., Covington, 2003; Hannah-Moffat, 1995; Pollack, 2009), and similarly, participants shared those same experiences. Additionally, by applying a strengths-based approach to this research, we understand the importance of highlighting the strengths and resilience of our participants in overcoming their traumas, to the extent that they were empowered to share their experiences with me and assist with knowledge translation to improve the mental health care delivery for currently incarcerated women. In the Patient sample, all identified as cis-gender women, four identified as Caucasian and one as Indigenous, and ages ranged from 23-44 years old at the time of the interview. Three Patients were from Western Canada (i.e., British Columbia, Alberta, Saskatchewan, Manitoba), and two were from Eastern Canada (i.e., Ontario, Quebec, Newfoundland, New Brunswick, Prince Edward Island, and Nova Scotia). All have lived experience in both federal and provincial institutions, with four who had their most recent sentence in federal prison and one in provincial jail, and all were released within three years from the date of their participation. Additionally, all identified as having a mental illness diagnosis as recognized by the Fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). All five Patients received psychiatric diagnoses in the community before incarceration, and they also all received additional diagnoses from institutional psychiatrists while incarcerated.

It should be noted that Patient 4 and Service Provider 10 are not accounted for in the data. Patient 4 was deemed ineligible as the research scope is correctional mental health assessments

in a Canadian context, and her experiences were based on federal and state prisons in the United States. She signed the Consent Form, participated in the first interview, and was given an honorarium. The audio recording of her interview and her signed Consent Form were destroyed. Additionally, Service Provider 10 signed the Consent Form but eventually withdrew her participation because of scheduling conflicts. Her signed Consent Form has been destroyed.

In the resulting sample, there was one participant who had lived experience from both federal and provincial prison, but was classified as a Service Provider participant for this study as she has been living in the community since 2002, and had been volunteering with her local EFS chapter for nearly two decades until she was hired as an employee. In the Service Provider sample, six participants were from Western Canada and four were from Eastern Canada. All participants in this group identified as cis-gender women, seven identified as Caucasian and three as Indigenous, ranged from 23 to 61 years of age, and had one month to 11 years of work experience in their respective EFS chapters at the time of the interview. Respectively, four participants worked with women with mental illness in provincial prison, and five worked with women in both federal and provincial institutions. One participant did not directly work with women in prison but supervised clinical programming for her chapter.

3.4 Data Collection Procedure

The data for this study was collected through semi-structured phone interviews that were conducted by myself. Prior to each interview, participants received a digital copy of the research Consent Form (see Appendices D & E) to review. At the time of the interview, I confirmed that each participant understood her rights as a participant, and collected her verbal or written consent. Whereas Service Providers were interviewed once, the participants in the Patient sample were interviewed twice. Among Patients, the first interview served as an introductory interview

to build rapport, whereas the second focused on their experiences with the correctional mental health assessment and processes. Interview questions were designed to be asked in a subsequent order (see Appendices F & G), but there was flexibility for this to be disrupted if I recognized that emerging topics needed to be addressed. The 15 interviews focused on: i) how women view “assessment,” and what that means to them; ii) what, if any, changes they would like to see in the assessment procedures for mental illness; and iii) how Patients would have wanted their mental health status to be assessed when incarcerated, or how Service Providers would want their clients’ mental health to be assessed. The interview questions drew on the literature and were shaped by my previous interactions with clients at EFS Saskatchewan where I served as a volunteer. At the end of each interview, participants were debriefed, and I explained what would be done with their personal information and the data they provided. Any outstanding questions participants had were answered at this time. The duration of the interviews with Service Providers ranged from 32-65 minutes. Among the Patients, introductory interviews ranged from 7-17 minutes, and the follow-up interviews ranged from 45-89 minutes. Each interview was audio recorded and transcribed verbatim to text by an independent body who operated from Regina, Saskatchewan and signed a confidentiality agreement. Each participant had the opportunity to review a digital copy of their transcript to make any amendments within a two-week time period, to ensure that they would not feel misrepresented in their participation. Of the 15 participants, one requested a change to her transcript: in our interview, she stated that she did not work with women who were recently released from jail but worked with women who have been in the community for at least two to five years. On the digital transcript she received, she noticed a typo that stated that stated otherwise. I made this change (i.e., from “women I am working with *are* like newly out of jail” to “women I am working with *aren’t* like newly out of

jail”) and sent the revised transcript back to her, which she then approved. In addition to the transcript, I took field notes during and after the interview, to refer to during data analysis. Each participant was compensated with an honorarium of \$50.00.

3.5 Data Analysis

In consideration of participants’ confidentiality and privacy, raw data was stored on a computer with password protection and on an external hard drive. Upon completion of each interview and corresponding transcription of the audio recording, a digital copy of the written transcript was shared with each participant. Each participant had temporary access to their transcript for two weeks, during which they had the opportunity to read over the transcript, and indicate whether they wanted like to revise, remove, or add onto anything that was said. This was done to ensure that participants do not feel that they are being misrepresented in any way through their involvement in the study (Lincoln & Guba, 1985).

Ms. McCorrison and I applied thematic analysis according to Braun and Clarke’s (2006) six phases to identify themes within the qualitative data. The interview data from Patients were analyzed separately from the interview data from Service Providers. While both the Patients and Service Providers groups have a wealth of experiential knowledge about the research topic, the Patient data was derived from community women’s direct lived experiences of incarceration, whereas Service Providers drew on their lived experiences supporting currently incarcerated women. Any differences in responses were attributed to each sample group’s distinct standpoints; the former drawing on their standpoints as women in the community, who were seemingly empowered to create change for women who are currently incarcerated, and the latter drawing on their standpoints as working within prison abolitionist organizations who want to promote change by replacing prisons and jails with community resources and interventions for

criminalized women. During the first phase of analysis, I read and reviewed each transcript and my corresponding field notes to familiarize myself with the data. In the second phase, I inductively examined the data and generated 121 preliminary codes for the Patient data, and 189 preliminary codes for the Service Provider data (Braun & Clarke, 2013; Thomas, 2006). These codes were then grouped into 51 first order codes for the Patient data, and 74 first order codes for the Service Provider data. At this point, Ms. McCorrison was involved, and we further classified the Patient data into 30 categories, and the Service Provider data into 38 second order codes. Finally, we coded the resulting data into 6 themes. This process was facilitated through the NVivo 12.6.0 software, a qualitative data analysis software produced by QSR International. In the third phase, I grouped codes into six potential themes for each dataset by identifying recurring patterns. This was accelerated through the creation of upper-level Nodes on NVivo. Ms. McCorrison and I then collaborated during the fourth phase of checking if the themes were congruent with the coded data. This process required Ms. McCorrison to read over the potential themes and corresponding codes and report back if she agreed or disagreed, and whether she would like to suggest additional codes or themes. We then discussed her thoughts and shared feedback through video conference meetings. Then in the fifth phase, Ms. McCorrison and I met through video conference to define the themes with names. It should be noted that while we aimed to apply inter-rater reliability, there were scheduling conflicts with the project timeline that hindered the level of collaboration necessary for this process. Ms. McCorrison and I thus agreed on that the level of engagement in the data analysis stage was appropriate and ethical as her commitments as a patient partner did not overwhelm her other responsibilities in her advocacy work, as well as her professional and personal life (Montreuil et al., 2019). Finally, in the sixth phase I produced this report. The process of coding highlighted similarities and

differences across the data (King, 2004), and brought forward participants' perceptions of how to improve the current mental health needs assessment protocols for women in Canadian prisons and jails.

3.6 Lessons Learned from Data Collection and Analysis

Data was collected from October to December 2020, which was during the COVID-19 pandemic; thus, phone interviews were chosen as the method of qualitative data collection due to the social distancing protocols that were in place. I was initially wary to collect data through phone interviews, due to the lack of visible social cues and the potential barrier to building rapport with research participants. I attempted to address this by asking rapport-building questions early in the interview and found this strategy advantageous. For example, among Service Provider participants, I asked why they were interested in pursuing employment with the EFS which I interpreted allowed for more vulnerable conversation. Similarly, among participants in the Patient sample, I interviewed them twice and ensured that questions in the introductory interview only focused on their strengths, interests, and brief demographics information. I interpreted the rapport I built through this strategy to be effective as several participants recruited other potential participants without any compensation or myself initiating requests for assistance with recruitment.

In line with the POR framework, Ms. McCorriston was involved in the research process. Due to scheduling limitations with her previous commitments, as well as the distance placed between us during the COVID-19 pandemic, Ms. McCorriston was moderately engaged in the research process. I found this to be beneficial as it allowed for her to decide what she could commit to, rather than exhausting her time and resources, and enriched the consequent data by drawing on her strengths. For example, during participant recruitment, Ms. McCorriston used her

social media presence to recruit participants across Canada. If I were solely responsible for participant recruitment, I would not be able to include participants from Eastern Canada as I am not very well-versed with social media platforms and would not have been able to reach that population. Additionally, Ms. McCorrison's involvement in the fourth and fifth stages of thematic analysis assured that the identified themes can be understood by the women with lived histories of incarceration and mental illness. As I do not share these same experiences, I would not be able to bring about this assurance. Ms. McCorrison has also taken the lead on the knowledge dissemination process, which I think will be beneficial as her lived experience will inform who needs to access the findings of this report.

3.7 Data Rigour

As implied in the previous discussion of the theoretical approach applied to this research, this project draws on a constructivist epistemology; that is, reality and knowledge are socially constructed, such that the standpoints of women are used as to interpret reality and uncover the underlying meanings of social events and observations (Rolin, 2009). This approach thus shaped the procedure and tools I used to answer the research question. As qualitative research has been criticized for reflecting the subjective views of researchers (e.g., Hardy et al., 2004; Malterud, 2001), I aimed to continuously reflect on my social position during the planning and data collection and analysis processes. While my identity and standpoint as a woman allowed for me to understand participants' discussions pertaining to gender, I do not have a history of mental illness and my experience with the criminal justice system is limited. Similarly, while I was inspired to undertake this area of research after reflecting on a family member's previous experiences and my close friend's current experiences within our criminal justice system, I do

not share the same lived experience as the participants who were recently released from prison or jail, or those who interact with a variety of incarcerated women on a more regular basis.

My approach to data collection included direct interactions with participants. Tewksbury (2009) proposes that our understanding qualitative approaches require “a high level of interpersonal skills, creativity, and the opportunities for accessing data may come with psychological/emotional stresses, dangers and limitations on particular researcher’s opportunities” (p. 47). Thus, when contacting prospective organizations to recruit participants, I made a conscious effort to present myself as non-threatening and build rapport with these important contacts so that key informants would feel encouraged to participate. Because of the telephone interview format, I was aware that participants were not able to visually see me and process my social cues (e.g., making eye contact, nodding) as they were speaking to me. Thus, I was conscious of my self-presentation to ensure that I could modify my behaviour based on each participant’s social cues that I could process in the moment. This included staying silent when I noticed a participant was speaking very quickly, with very little breaks in between sentences. I interpreted this as giving them the room to speak so that they would not feel like they were being interrupted during the interview. Conversely, I responded with small words of encouragement (i.e., “mhmm” and “yeah”) to participants who spoke with longer pauses, or if they would say “right?” in between thoughts, to indicate that I was following along with their dialogue. It was with these strategies that I strengthened my understanding of the research problem and ensured reliability of the data by providing the participants with a safe space to facilitate trust and honesty in their reflections.

3.8 Ethical Considerations

This study was approved on ethical grounds at the University of Saskatchewan Research Ethics Board (Beh ID #1991) on September 24, 2020. The ethical considerations that were ensured were informed consent, confidentiality, and anonymity. Each participant signed a Consent Form (see Appendices D & E), which explained the purpose of this study and described that their participation was voluntary, such that they were free to terminate their participation from the study at any time. Interviews were conducted over the phone at a designated date and time that was set by the participant. Raw data was stored in a password-protected computer. Audio recorded information was only shared with the transcriptionist in Regina, Saskatchewan who signed a confidentiality form. To protect participants' identities, their names were withheld from this final report, and were replaced with pseudonyms.

CHAPTER FOUR: RESULTS & DISCUSSIONS

4.0 Introduction

This research draws on POR and feminist standpoint theory to explore what a gender-informed mental health assessment process could be for incarcerated women at institutional intake. In this section, the research findings will be presented and discussed. Based on the review of the literature, this research proposes that a women's mental health assessment process is necessary for incarcerated women with mental illness. Results are based on 15 interviews (five Patients and ten Service Providers), and are presented by drawing on the feminist standpoint framework and applying thematic analysis to the data. First, I will justify why the Patient and Service Provider data were analyzed separately and will briefly summarize the research findings. Following this, the findings will be presented, which are organized into themes. Interview excerpts/quotes will also be incorporated to further illustrate the research findings.

4.1 Presentation of Findings

Data was informed by both Patients' reflections of their participation in prison and jail intake mental health assessments, as well as Service Providers' experiences working with incarcerated women. As these two groups have different lived experiences, the Patient data and Service Provider data were analyzed separately. Thematic analysis was applied to the data, as I interpreted the data to be rich and the participants were very conversational (i.e., data were very descriptive; participants included several personal narratives and examples when answering interview questions; most interviews were longer in duration than anticipated, with participants expressing that they were willing to continue speaking with me) during the data collection process (Saldaña, 2016). The results in this section confirm the proposition that a women's

mental health assessment process is necessary for incarcerated women with mental illness. These findings are contextualized according to what participants envision that mental health assessment process to be, and are organized into six themes: (1) safer, more comfortable environment; (2) assessment components and measurements; (3) assessment outcomes should connect patients to mental health services and programming; (4) individual conducting the assessment process; (5) culturally informed mental health assessment process; and (6) process implementation. Each of these themes are organized according to Patients' and Service Providers' responses, and will be discussed in relation to the sub-themes that were also identified in the data analysis process.

4.2 Safer, More Comfortable Environment

In their descriptions of a women's intake mental health assessment process, participants underscored the importance of the physical setting that the assessment takes place. The literature suggests that prisoners perceive the carceral environment to negatively impact their mental health status (Goomany & Dickinson, 2015) – this may likely be due to the traditional layout of prisons and jails, which are laden with brick and iron exteriors, and a lack of windows and interior decoration (Hancock & Jewkes, 2011). Participants considered these rigid environments to impede women's willingness to share their mental health history with the individual conducting the intake assessment. Based on their experiences, both Patients and Service Providers described that this process should be conducted in a safer, more comfortable environment to promote women's honest disclosure to better address women's mental health needs.

4.2.1 Patients' Suggestions

All Patients proposed that the mental health assessment process should be set in an environment which fosters women's safety and comfort. The notion of safety was conceptualized in terms of promoting feelings of vulnerability, specifically through the physical space that women are situated at the time of their assessment. Additionally, the notion of comfort was discussed in the context of permitting women to have access to materials that bring them comfort. They described the current intake assessment process to be stressful; Patient 1 explained that intake swiftly followed her arrest and detention, which she considered an instance of re-traumatization. She also discussed how her mental health assessment was done in a dental chair, which exacerbated her anxiety, as she fears dental appointments. Patient 2 explained that the strip search was followed by the provincial intake mental health assessment, and Patient 3 expressed feelings of shame and guilt during the assessment process at the same institution. Additionally, Patients 3, 5, and 6 were lost navigating to the Psychology Wing in federal facilities. As a result, they suggested that correctional systems to create a comfortable space for the assessment, as opposed to the current setup where the assessment is performed in an unassuming room. For example, Patients suggested that the assessment should be conducted in a room with a window that faces the outdoors, a painting hung up on the wall, and/or lighting candles in the room. These data indicate that incorporating music, art, and other materials could work to bring comfort to the patient during a difficult and vulnerable experience.

Additionally, Patients identified individuals whose presence during the assessment process would promote feelings of safety and comfort. This included a mental health nurse or the mental health team that would be responsible for the patient's care, as well as a third party who is not conducting the assessment, to ensure the patient is not being mistreated during the

assessment process. The literature suggests that mental health nurses are more likely to be the primary source of support for a patient's recovery (Borg & Kristiansen, 2004; Dziopa & Ahern, 2009). By including these individuals in the assessment process, Patients suggested that women would more likely feel safer to honestly disclose their symptoms, and build rapport or trust with those responsible for their care (Slemon et al., 2017).

4.2.2 Service Providers' Suggestions

Seven Service Providers proposed that the physical environment where the mental health assessment takes place should make the patient feel warm, welcome, comfortable, and safe. They suggested that the women should not feel like they are in prison, whether that would be due to the assessment being done outside of prison, or if the physical setting of the room does not resemble a prison.

The need for safety was discussed in conjunction with the provision of a confidential space for women to feel vulnerable and express themselves. Participants contended that women would feel more inclined to honestly discussing their mental health in this environment because they are more likely to feel more comfortable with sharing their emotions than incarcerated men, and their social interactions are more "communal" and "cooperative" than what the current carceral structure supports (Service Providers 5 and 7). Based on their experiences conducting intake assessments at various Western provincial correctional institutions, Service Providers 5 and 6 suggested that correctional staff members should work to support and work with each woman's needs. For example, correctional staff can contribute to promoting a safe environment by keeping their distance from the prisoner and the assessor during the assessment process; this would allow for the woman to feel safer and more comfortable with disclosing her emotions and

feelings to the assessor, without fear of judgement from authority figures. Service Provider 6 illustrated how she used her position to advocate for her clients:

“in that [assessment] process if there were any sort of flags within the conversation, what I would often do is like, remove that person from maybe like, a more public place and take them maybe off the unit or just step their mental health [assessment] away from the other people who are in that unit...just to have a more of a private conversation with the inmate.”

Although these findings share similarities with the data obtained from the Patient sample, it was unique that Service Providers’ suggested correctional staff should play a role in promoting a safer, more comfortable space for the intake mental health assessment.

4.3 Assessment Components and Measurements

This research draws on the existing literature to critique the prison and jail intake mental health assessment tools and processes, and proposes that they are overly focused on the male perspective; therefore, they are not compatible with incarcerated women. With the proposition that a women’s assessment tool would lead to improved outcomes for incarcerated women, participants’ experiential knowledge was drawn on to suggest the components of this ideal instrument.

4.3.1 Patients’ Suggestions

Based on their lived experience of incarceration, Patients’ suggestions as to the components and measurements of a women’s intake mental health assessment process was organized into two sub-themes: (1) questions about women’s concerns and needs; and (2) thorough assessments and follow-ups.

4.3.1.1 Questions about Women's Concerns & Needs

Four Patients recommended that the questions and measures included in the mental health assessment should focus on women's concerns and needs. Having sought mental health services prior to incarceration and having completed intake mental health assessments in the community, Patient 5 identified gender as a central difference between prison and community assessments:

“I think these assessments are made for males and then adjusted to fit females and that they're not actually addressing our individual needs because females and males are separate, they're different as different can be in regards to how they commit crime [...] So I think the assessments have been tailored to try to fit women but it's not, it's not designed for us so it's not addressing the issues that affect women so I don't think that it is useful at all.”

Patients also proposed that questions asked during the intake mental health assessment should not be focused exclusively on suicide; rather, follow-up questions should be prompted in response to the patient's individual answers. Specific questions should consider the how a woman's education and employment opportunities or experiences of poverty have affected her mental health status. Additionally, if she is a mother, questions should consider women's mental health in relation to their children, as incarceration may be a “traumatic separation” for her and her children (Martin et al., 2012, 502). Considered to be an experience unique to mothers, this finding supports the need for gender-sensitive considerations for incarcerated women's mental health. It is also important to note that these women may have also experienced this separation before incarceration because of poverty and consequent involvement with child protection agencies; thus, imprisonment may exacerbate the distance they already have with their children (Ibid.).

Moreover, two Patients in the sample were diagnosed with one or more learning disabilities. They described their challenges with completing the CoMHISS, the computerized

mental health assessment in the federal institutional intake process (CSC, 2007), whereby one Patient was unable to complete the assessment accurately and was subsequently disqualified from receiving correctional mental health services. They argued that computer programs disregard the human, personal component of the assessment process, and proposed that learning disabilities should be acknowledged and accommodated in a similar manner that prisoners with physical disabilities (e.g., vision impairment) are accommodated (CSC, 2018).

An additional consideration that was identified was the recognition of eating disorders in the CSC mental health and illness framework, as eating disorders disproportionately affect Canadian women (FEWO, 2014; Hudson et al., 2007; Makino et al., 2004; Smith et al., 2021). Patient 6, whose history of eating disorders was diagnosed in the community, was considered high risk for self-harm because of these symptoms. Moreover, she saw a psychiatrist in federal prison who also happened to be the same practitioner in the community who diagnosed her with an eating disorder; despite their existing patient-physician relationship, the psychiatrist could not record the eating disorder in Patient 6's medical record. Instead, her record indicated she was manipulative and a risk for self-harm. As eating disorders are more prevalent in females than males (e.g., Galmiche et al., 2019; Qian et al., 2013; Striegel-Moore et al., 2008), it is argued that the rationale for this discrepancy stems from the gendered construction of the prison mental health assessment process. Furthermore, the divergence of mental illness classifications across correctional institutions and the community results from the differing governing bodies responsible for the healthcare of prisoners. With the exception of jails in British Columbia, Alberta, and Nova Scotia, the healthcare of provincial prisoners is not managed by their respective provincial health authorities (Lam, 2017; McLeod & Martin, 2018; Murphy & Sapers, 2020); similarly, the healthcare of federal prisoners is managed by CSC (2020).

4.3.1.2 Thorough Assessments and Follow-ups

Patients suggested that a women's intake mental health assessment should allow for both incarcerated women and the assessor to take their time throughout the process to allow for a more comprehensive assessment. They proposed that women should not feel like they are answering questions for an interview, but rather, are having a conversation about their mental health. The current format of provincial mental health assessments was criticized, as they relied on quantitative answers to a short series of questions. For example, the questions asked should be more thorough, and allow for patients to elaborate on their responses. Patient 6 explained: "if they had like scenarios like I've had assessments in the past at hospitals where there's like scenarios like in this scenario how do you think you would react or can you recall a time similar to this and what you did."

Two Patients further elaborated on this process, suggesting that a comprehensive assessment would also include the opportunity for women to participate in re-assessments, so that their mental health status is subject to frequent follow-ups. Patient 3 clarified that the utility of such processes is to evaluate the efficacy of treatments and medication. By administering re-assessments and follow-ups, therapeutic continuity in the patient's mental health care is maintained, which is essential to treating mental illness (Samartzis & Talias, 2020). Patient 6 explained that currently, re-assessments are only offered to federal prisoners who are sex offenders or those who are sentenced to life imprisonment, and are focused on evaluating the prisoner's risk. She understood that while it may be difficult to determine when would be an appropriate time to conduct a re-assessment because of institutional transfers and early release, an ideal time for re-assessment could be during the midpoint of each prisoner's sentence.

4.3.2 Service Providers' Suggestions

Service Providers' suggestions for the components and measurements of a women's intake mental health assessment process was organized into three sub-themes: (1) informed by women's strengths, experiences, and needs; (2) thorough assessments and follow-ups; and (3) humanizing process.

4.3.2.1 Informed by Women's Strengths, Experiences, and Needs

Service Providers proposed that a patient-informed mental health assessment for incarcerated women should include measures that focus on women's strengths, experiences, and needs. Specifically, Service Provider 4 proposed that a "strengths-based" assessment process would validate women's responses, so that they can work with their healthcare providers to co-construct a "restorative" approach. She described this as a process that promotes women's mental health (Henderson & Jackson, 2004), arguing that the current assessment is harmful to their perceptions of themselves as prisoners and towards their overall health status.

Additionally, Service Providers identified that from their experience, women are more likely than men to be willing to talk about their backgrounds and feelings, and that this information should be used to address their mental health needs. By applying a gender analysis to the construction of the assessment process, they proposed the inclusion of three measures: i) if the prisoner has children; ii) her history of drug use; and iii) understanding her experiences of trauma. As incarcerated women are most likely to be the primary caregivers of their children (Glaze & Maruschak, 2008; Martin et al., 2012; Strauss, 2019), Service Providers witnessed how imprisonment, which separated women from their children, profoundly affected their clients' mental health. Criminal justice system involvement was described as inducing feelings of guilt

and powerlessness to provide care. Moreover, if a woman's children are involved with child protection services, she may be preoccupied with thoughts about whether her children are in care. For example, women may feel guilt and shame about their incarceration status because their role as a mother is compromised, and their emotional connections to their children are disrupted (Kennedy et al., 2020).

It was also suggested that understanding a woman's history of drug use is an important consideration in the assessment process. For example, Service Provider 1 explained that if a prisoner is experiencing withdrawal symptoms or is in active psychosis during the intake mental health assessment, that could affect the outcomes of the procedure. As substance use disorder is a stigmatized illness (Government of Canada, 2020; Yang et al., 2017; Zwick et al., 2020), the mental health assessment process was suggested to utilize accessible, non-stigmatizing language in the questions being asked, so that the prisoner could feel more comfortable discussing her mental health without fear of it being perceived as a risk and other negative consequences.

Finally, Service Providers suggested that a women's mental health assessment process should be trauma-informed (i.e., an approach that recognizes trauma and demonstrates sensitivity to the needs of the patient and includes efforts to prevent further harm; Butler et al., 2011; Harris & Fallo, 2001). They asserted that a woman's individual trauma needs to be recognized in order to understand her mental health and how those experiences have influenced her involvement in the criminal justice system.

4.3.2.2 Thorough Assessments and Follow-ups

Currently, mental health screening at intake is a brief clinical process intended to identify the severity of a prisoner's mental health and illness needs (Martin, 2017). If the needs of the

prisoner are considered a priority, a comprehensive mental health assessment would then be conducted to construct a treatment plan and intervention (Ibid.). Similar to the Patient data, Service Providers critiqued the brevity of the current mental health assessment process, stating that they should be longer and more thorough. This can be attributed to the complex mental health histories that incarcerated women tend to have (Anumba et al., 2012; Miller & Mullins, 2017), and which correspondingly the current male-focused assessment process overlooks. At the provincial institution that Service Provider 5 conducted intake assessments, she noted that the questions were “really brief” at 15 minutes in duration, but were “very triggering” as questions usually include information about the prisoner’s children and family, as well as their history of substance abuse: “it can be very hard on all of the clients to be able to open up and feel safe in discussing those things.” Their conception of a women’s intake mental health assessment process would allow for the prisoner to fully express her emotions and for the assessor to listen to them.

Service Providers suggested that cultural, social, and spiritual factors should be considered in addition to the physical and mental aspects that the current assessment process focuses on to determine any explanatory factors regarding a woman’s mental health status. They referred to the bio-psycho-social-spiritual framework in understanding mental health, which explains the psychological and physiological symptoms of mental health and illness to result from an individual’s life experiences and social context to better understand the patient and her family (Campbell & Rohrbaugh, 2013; Schultz et al., 2014). Similar to the POR framework which focuses on practical outcomes, a bio-psycho-social-spiritual approach to assessment is solutions-oriented and focuses on the successes of previous treatment approaches (Schultz et al., 2014).

Service Providers further advocated for the format of the assessment to resemble a discussion, where answers such as “sometimes” would be accepted, rather than the binary yes/no checklist that is currently in place for provincial intake mental health assessments. They also noted that a long assessment could be understandably overwhelming, so the length should be dictated by the prisoner, facilitated by the assessor asking her if she has the capacity to keep moving forward with the process.

Finally, it was suggested that women’s mental health statuses should be followed up with through re-assessments. Ideas for the re-assessment schedule were varied, ranging from as often as three weeks, up to two months to ensure the prisoner continues to be safe and well. Service Providers also witnessed how certain situations among criminalized women, such as court hearings or sentencing trials, place them at risk for experiencing mental health challenges and self-harm (Caufield, 2016); thus, re-assessments were recommended to take place after those situations as well.

4.3.2.3 Humanizing Process

Six Service Providers suggested that a women’s intake mental health assessment should be a humanizing process. Their interactions with clients gave the impression that women were treated like numbers during the assessment process; as a result, they called for the consideration of prisoners as healthcare patients, whose physical needs should be addressed during the assessment process. Participants agreed that a risk assessment should be conducted at institutional arrival, but only for safety reasons. Comprehensive mental health assessments, on the other hand, should be administered on a more flexible schedule. It was noted that the intake process, whereby the mental health assessment is introduced, could take several hours. This may leave the newly admitted prisoner extremely vulnerable and uncomfortable; thus, it was

suggested that women should not be starving and changed from the clothes they came in with, as well as detoxed (i.e., not experiencing substance withdrawal) as these factors are likely to influence the patient's responses or assessor's perceptions of the patient. Service Provider 5 witnessed firsthand how the timing of the intake mental health assessments could limit the opportunities for helping the prisoner:

“you should probably not be doing that right as they walk through the doors and still have their street clothes and having eaten is a big thing for me in [province] Corrections where they wouldn't feed people until they went to their unit and the process of intake could be hours upon hours where they are starving, withdrawing from drugs and nicotine and um are not having the best days of their lives so that process is really dehumanizing.”

Service Providers also discussed how the strip search, an additional practice done at intake (CSC, 2017), was a dehumanizing procedure that likely affected the outcome of the mental health assessment that followed shortly after. Service Provider 6 reflected:

“I have had a lot of women state how difficult like, the strip search of the intake is like when they first come into us...I think that experience has been highlighted to me many, many times over the years. That, that physical part, it creates barriers for people to then turn around and say, ‘I am vulnerable. I need mental health help.’ [...] Even as a staff member, having to facilitate...or communicate to women through that strip search process...I believe [they] have a harder time sitting down and connecting with me.”

This experience could be especially reminiscent of the patient's trauma (Maeve, 2000; Hutchison, 2019), as incarcerated women have likely experienced sexual assault and abuse (Blackburn et al., 2008; Bodkin et al., 2019; Karlsson & Zielinski, 2020; Office of the Correctional Investigator, 2015). Service Providers argued that this experience leaves women feeling vulnerable, and reluctant to trust the individual conducting the mental health assessment that immediately proceeded. Considering that these dehumanizing experiences could contribute to women “rush[ing] through the questions” and not answering the assessment honestly (Service

Provider 5), they suggested that a more personable process would make the prisoner feel heard, and assurance that she is going to receive the help that she needs.

4.4 Individuals Responsible for Conducting Mental Health Assessments

The individuals responsible for conducting mental health assessments are dependent on the correctional institution. For example, as previously mentioned, federal mental health assessments are administered through a computerized program (CSC, 2012); however, in provincial settings, this assessment could be performed by a correctional staff member, or a mental health nurse (Martin et al., 2013). Based on their experiential knowledge, participants were asked to identify individuals who should be responsible for conducting the mental health assessments for incarcerated women.

4.4.1 Patients' Suggestions

Patients' responses were organized into three sub-themes: (1) prisoner should choose the gender, but most would prefer a woman; (2) training and qualifications in mental health, social work, and trauma; and (3) trustworthy and compassionate.

4.4.1.1 Prisoner should choose the gender of the assessor, but most would prefer a woman

All Patients agreed that the gender of the individual conducting the prison mental health assessment is an important consideration, and that in order to construct a women's intake mental health assessment process, the prisoner should have the opportunity to choose the gender of her assessor. However, four out of five participants expressed they would feel most comfortable with a woman. They also suggested that most women in prison would have that same preference as they may have difficulty trusting men due to having lived experience of abuse and victimization perpetrated by other men or their male romantic partners. These findings are further

contextualized by the literature which indicates that the majority of female prisoners' involvement in criminal activity was influenced by male partners (Richie & Johnson, 1996), and that the abuse which incarcerated women experience is most likely to be perpetrated by males (McDaniels-Wilson & Belknap, 2008).

Further, a female assessor may be more equipped with understanding female symptomology of mental illness. For example, Patient 5 explained that during her appointment with a female mental health professional, she was recommended to undergo an assessment for post-partum depression, which she was eventually diagnosed with: "what male doctor would have known that at nine, ten months after having my daughter that it was in fact, you know, post-partum depression." Patients proposed that if incarcerated women did not have a choice for the gender of the individual conducting the assessment, that the assessor should at least acknowledge sex and gender differences and complete gender-informed training.

4.4.1.2 Training & qualifications in mental health, social work, trauma

Patients suggested that the individual conducting the mental health assessment should have professional credentials such as psychiatry and psychology, social work, and nursing, which are competencies analogous to the professionals who conduct intake mental health assessments in community settings. By drawing on her experience of having her assessments done by correctional staff, Patient 2, proposed that a women's assessment process should be conducted by the unit staff who are responsible for overseeing the prisoner's safety and interact with her on a regular basis. This familiarity could work to promote rapport during her incarceration. Other forms of training suggested were rape crisis counselling and trauma-informed care, as criminalized women are most likely to experience these forms of victimization (e.g., Aday et al., 2014; DeHart et al., 2014; Green et al., 2005; Karlsson & Zielinski, 2020).

4.4.1.3 Trustworthy & Compassionate

Patients proposed that the assessor should demonstrate trustworthiness and compassion while conducting the mental health assessment. While the assessor should foster a professional relationship with the prisoner, they should also demonstrate some personable characteristics to build that necessary component of trust. For example, the assessor could shape the assessment as a conversation, rather than an interview, with the prisoner to build her trust. Illustrating this further, three Patients identified the mental health staff at a Western federal facility and an Eastern super jail as ideal assessors for this process. For example, Patient 5 explained that it was beneficial when correctional staff “tried to humanize” prisoners by calling them by their first names, explaining that she did not feel “just like some number” when seeking mental health care.

4.4.2 Service Providers’ Suggestions

Service Providers’ responses were organized into three sub-themes: (1) gender; (2) training in medicine, social sciences, social work, and trauma; and (3) a team of individuals.

4.4.2.1 Gender of the Assessor

When asked about the gender of the individual conducting the mental health assessment, suggestions provided by the Service Providers mirror that of the Patients. In the sample, five Service Providers considered women to be ideal. Based on her experience conducting intake assessments in a Western Canadian provincial facility, Service Provider 5 suggested: “I just think immediately when they walk in and see a female as opposed to a male there [doing the assessment], it’s almost, you almost broken down one barrier already.” The other five participants, however, proposed that the gender of the assessor should be chosen by the prisoner, as she may feel more comfortable around women or men depending on her past histories. The

similarities between the Patient and Service Provider data could likely be attributed to the Service Providers' extensive experience working with female prisoners. Their clients may have shared their histories of victimizations by men and male romantic partners, or may be aware of the existing evidence that draws the relationship between these experiences, mental illness, and criminality (e.g., DeHart, 2008; Pico-Alfonso et al., 2006; Walsh et al., 2011).

4.4.2.2 Training & qualifications in medicine, social sciences, social work, and trauma

Similar to the Patients' suggestions, Service Providers listed training and qualifications in medicine, social sciences (i.e., psychology, sociology), social work, and trauma-informed care (i.e., understanding and demonstrating sensitivity to the woman's background and social context; World Health Organization, 2004) as necessary for individuals conducting the prison mental health assessments for women. Service Providers 4, 9, and 11 explained that the benefits of the intake mental health assessment are to promote the continuum of care so that the female prisoner can access the same medication as she was prescribed in the community, and/or refer her to health services so she can access the necessary supports and medication. Additionally, they noted that an education in social work and the social sciences would advance the assessor's empathy and listening skills, so that they would be considered more personable by the female prisoner. Based on her experience working in provincial corrections, Service Provider 5 advocated for the assessor to demonstrate empathy, as corrections does not provide this training. Similarly, Service Provider 11 suggested that the assessor should be someone who is not employed by the correctional system, as they would be more likely to treat prisoners "as human beings rather than criminals."

4.4.2.3 Team of Individuals

Service Providers also suggested that multidisciplinary care team should be responsible for conducting the mental health assessment for incarcerated women. They identified EFS staff, case workers, and Indigenous Elders who work in conjunction with the correctional mental health staff to work together to contextualize the patient's background to inform their medical and therapeutic care:

“more communication between all of us would be better...when I talk to women one-by-one, and they express themselves and everything, it's easier after that for me. I would be able to talk with the health services to explain what I see or my perceptions and maybe sometimes, just to push a little bit harder for their case” (Service Provider 7).

Service Provider 7 also mentioned it would be beneficial for EFS staff involved in prison and/or jail in-reach programs to confirm that the prisoner is taking psychiatric medication, as there have been instances where prisoners have fallen asleep or were not fully participating during programming.

4.5 Assessment Outcomes Should Connect Patients to Mental Health Services and Programming

Participants understood the intake mental health assessment process to be an indicator of a prisoner's risk, which contrasts with mental health assessments done in the community to refer patients to treatments and services. Similar to community assessment outcomes, both Patients and Service Providers described that the outcomes of a women's intake mental health assessment process should connect prisoners to mental health services and programming.

4.5.1 Patients' Suggestions

Patients perceived that the criminal justice system's response to mental health and illness was to mitigate and minimize risk. This was indicated by their recollection of the emphasis on suicide and self-harm in the intake mental health assessment. The correctional system's emphasis on risk could stem from the mandate to promote the safety of the prisoner population and staff, which is informed by other governing institutions; specifically, CSC's correctional policies and practices align with guidelines set by Public Safety Canada (2020). While the intention is to promote prisoner and staff safety, the correctional focus on minimizing risk among women with mental illness may further stigmatized notions around mental health (Ghiasi et al., 2020), especially if they begin to associate their diagnoses or symptoms as indicators for recidivism or punishment.

As a mental health patient in the community, Patient 6 described her disappointment with the management of her mental health symptoms while in prison. Based on her answers to a suicide assessment at provincial intake, she was placed in an administrative segregation unit (i.e., when a remanded prisoner is physically isolated from the general prisoner population due to safety reasons; Tuttle, 2019). She noted the language that was used within the criminal justice system regarding her personality disorder, and was fearful of the consequences of her condition, as it was considered a "risk factor" rather than an illness:

"like my perception of myself from the way that CSC [does], I feel like I just had average mental health issues, um, that existed before I went to jail. [...] I just felt really boxed in... so if your risk factors are mental health or personal emotional regulation, um, that becomes, like, the forefront of everything. And if you are not coping well, maybe if you are having an episode, they see it as like, you're probably going to reoffend."

Similarly, Patient 3 perceived the care she received from the mental health team as aiming to medicate her, and restrict her activity: "I just felt like they just wanted to keep me medicated so

that I couldn't really do anything. Like, I couldn't really get in more trouble because I was a zombie." Her capacity to exert control and autonomy was further limited as she explained that the language used by several correctional psychiatrists was not comprehensible, and when she brought forward the adverse side effects to medications in follow-up appointments, her medications were switched again without confirmation of her understanding of what was being prescribed.

During her imprisonment, Patient 5 was incarcerated in two provincial and one federal institution in Eastern Canada. Her perception of the criminal justice system was that its approach to managing mental health is "100% backwards" when responding to women's symptoms of mental illness:

"when women have, um, triggered responses or other things that happen, they are disciplined so much worse than the men for something really, really petty, like an outburst and they swear at the guards because they're triggered or [it's a] trauma response or mental health, they're maxed out. They wouldn't be doing that at the male side. Males are allowed to swear, males are allowed to do what they want; we're not, we have to act ladylike" (Patient 5).

That is, a limitation in the current male-oriented correctional environment is that women's responses to trauma are neglected or misunderstood, and instead, are oftentimes met with punishment. Rather than punishing symptoms of mental illness by temporarily assigning prisoners to structured intervention units or solitary confinement due to their risk of self-harm or suicide, Patients advocated for the outcomes to connect to relevant correctional programming and referrals to counselling services to address their mental health needs. Drawing on their suggestions for re-assessments and follow-ups, they proposed that correctional staff or mental health care teams could better assess whether the prisoner received benefit from the treatment and services.

Despite the predominantly negative view that participants had of the criminal justice system, they acknowledged that it did provide some resources to manage their mental illness. Although disappointed with the lack of mental health care they received in Western provincial institutions, Patients 1 and 2 reported high satisfaction with the psychology staff in a federal prison. They noted the incorporation of music, art, and humor into the management of their mental health. Similarly, Patient 6 reported satisfaction with CSC's (2013) Structured Living Environment (SLE), a treatment option for female prisoners with complex mental health, attributing the correctional program as helpful in managing her diagnoses. She was referred to the SLE program based on the outcomes of her mental health assessment. The SLE was informed by *Creating Choices* as well as CSC's Mental Health Strategy for Women, which focus on addressing incarcerated women's needs pertaining to mental health care and community reintegration (Ibid.).

4.5.2 Service Providers' Suggestions

Three Service Providers conceptualized assessments as processes whereby the outcomes (i.e., having a mental illness) negatively impact the prisoner, and two others identified the intake mental health assessment process to be overly concerned with risk. Mental illness diagnoses were considered detrimental to women's perceptions of themselves, as they feared the outcome would impact their trial proceedings as well as their perceived parenting capacities, which would compromise the safety of their children. Additionally, Service Providers explained that their clients experienced increased surveillance by correctional staff and guards as women with mental illness are perceived to be at a higher risk for self-harm or suicide.

As previously discussed, prison mental health assessments focus on mitigating risk and do not translate to referrals for mental health services or to recommend mental health

programming (MacKenzie, 2020; MacKenzie & Amirault, 2021). Prisoners must then submit a request to see a psychiatrist or psychologist for their mental health concerns that were not identified at intake (CSC, 2012), or complete the Women Offender Correctional Programming assessment where the outcomes dictate whether the prisoner is qualified for federal programming (CSC, 2016). While these options are available, Service Provider 4 argued that such additional steps to seek care can be problematic as it “puts the onus on already very vulnerable individuals [...] and in their stressful and uh I guess crisis-driven circumstance to then...figure out how to manage their behaviours.” As they recalled various instances in which their clients experienced extremely long wait times to see a mental health professional, especially in provincial institutions, it was suggested that assessments should enhance the supports and interventions available to address women’s needs. Five Service Providers thus recommended that the outcomes of this mental health assessment should connect the prisoner to mental health services and programming towards case management. For example, Service Provider 7 explained that although receiving medication is a beneficial outcome of the intake mental health assessment, referrals to creative, non-medical interventions should also be considered. She recalled an instance where a client requested animal-assisted therapy (i.e., a structured intervention that involves interactions with a certified therapy animal and handler team; Pet Partners, as cited by Dell et al., 2019) to manage her mental health needs:

“So one time I asked, I ask a woman, ‘ok so what, what do you need? What can help you?’ And uh she answered me, ‘I just want, I just want to touch a cat.’ ‘Oh okay, you want to touch a cat, okay I think you can do it because we have those zoo therapies at the detention.’ So I worked really hard to uh to let her go in the individual session, so therapy, and take care of a cat. [...] And she felt better so I think in the, in those evaluations just what a woman needs and sometimes they don’t need medication, sometimes they just need something else.”

4.6 Components of a Culturally Informed Mental Health Assessment for Incarcerated Indigenous Women

The literature is divided as to whether a gender-informed mental health assessment is necessary (Stewart et al., 2013), or would be relevant to the Indigenous prisoner population (Gutierrez et al., 2016; Perdacher et al., 2019), as mental health is a Western concept that is incompatible with Indigenous worldviews (Health Canada and Indigenous Services Canada, 2015). By drawing on Ermine's (2007) concept of the ethical space (i.e., a framework that "can be envisioned as the safe, middle space that respects the strengths and limitations of two people, their cultures, and communities;" [M'sit No'kmaq](#) et al., 2021, p. 856), these findings represent the engagement of Western and Indigenous knowledges that could be meaningful to both. In this sample, one Patient and three Service Providers identified as Indigenous. There was one Patient who identified as Caucasian but participated in Indigenous programming while in federal prison, and one Patient who shared the perspective of her best friend who was an Indigenous woman enrolled in the same programming. These results, however, are based on the participants who identified as Indigenous.

4.6.1 Patients' Suggestions: Holistic Assessment

Patient 1 suggested that a culturally informed intake mental health assessment for her culture would mirror a medicine wheel (i.e., a wheel with four quadrants that are equally distanced from each other, to promote interconnectedness and interrelatedness; Bell, 2014), whereby the questions would emphasize on gathering holistic information about a woman's spiritual, mental, social, and physical background. She proposed that the resulting outcomes would help mental health professionals and any other staff involved in the prisoner's care to understand her lived experiences, especially her trauma, and how that affects herself and the

relationships she has with her family. Moreover, understanding these contexts allow for mental health professionals to consider her mental health and illness beyond the Western bio-medical framework (Vukic et al., 2011). Patient 1 also emphasized the need for connecting the outcomes of the assessment to cultural programming, as that is currently not being done within the carceral system.

4.6.2 Service Providers' Suggestions: Involve Indigenous Professionals and Draw on Cultural Knowledge

Service Providers encouraged the incorporation of ceremony and knowledge into the mental health assessment process. For example, this included cultural practices such as a smudging ceremony or allowing for patients to complete their assessments outside of prison so that their cultural needs could be better addressed. Smudging involves burning one or more sacred medicines, including tobacco, cedar, sage, and/or sweetgrass (Indigenous Inclusion Directorate, 2019). Its utility in a mental health assessment process is likely tied to its promotion of balance and reminding individuals to connect and be grounded (Ibid.).

The participants identified the need for involving Indigenous Elders (i.e., an individual who is “exceptionally wise in the ways of their culture and teachings of the Great Spirit” whom the “community looks to...for guidance and sound judgment,” Aboriginal Healing Foundation, 2005, p.4 as cited in Council on Aboriginal Initiatives, 2012), traditional Knowledge Keepers (i.e., keepers of Indigenous knowledge that has been passed down from generations, who work to “achieve balance and harmony within their communities through the practice and preservation of Indigenous knowledge and culture;” The Wîcihitowin Conference Committee, 2017, p. 8), or a cultural coordinator/liaison should be involved in some aspect of the mental health assessment for women. They noted that there might be a history of distrust on behalf of the prisoner towards

figures of authority, and so recognizing “the strength in [the] roles” of an Elder or Knowledge Keeper during the intake assessment would initiate the foundation of a therapeutic relationship for the prisoner (Service Provider 6).

It should be noted that Service Provider 11 expressed difficulty in determining what would be a “culturally appropriate” mental health assessment, as there is no direct translation for “mental health” and “mental illness” and “diagnosis” in her culture: “...I think in like, Western society, it’s so hard for that concept to be grasped. I think to like, Western society and Western medicine and ways of knowing, like, it just doesn’t – there is no overlap really. Like, it’s just so um, polar opposite” (Service Provider 11). To potentially bridge this divide, she proposed that the construction and implementation of such a process would require the guidance of Knowledge Keepers, and that the expertise of Indigenous mental health professionals could be drawn upon to conduct these assessments. Measures included in the assessment could be: how tuned in the prisoner is to her Indigenous ways of knowing; and if she has sought guidance from Knowledge Keepers. Service Provider 11 also emphasized the importance of validating women’s experiences; for example, if she is hearing voices, which in Western medicine, could be considered a symptom of mental illness such as schizophrenia (American Psychiatric Association, 2013), it would be appropriate to ask if she feels scared or comforted by the voices as in her culture, that individual would be considered “gifted.”

Further, as strengths-based approaches have more successful applications in Indigenous communities (Giovannoni, 2018; Smith, 2013), Service Provider 9 proposed that it might be useful to incorporate a strengths-based approach in understanding the prisoner’s social history, the role of colonialism and trauma, and any other underlying causes of her symptoms of mental illness:

“once we start to learn about [colonialism], we start to understand the trauma that we've experienced and we can start to like process that in a good way...we come to understand what that means and what it looks like. There's just a lot of anger and a lot of feelings that make us you know, appear to have that like really disordered, um or so-called disordered behaviour.”

4.7 Implementation of the Patient-informed Mental Health Assessment Process for Incarcerated Women

4.7.1 Patients' Suggestions for Implementation

Patients' perspectives regarding implementation were organized into two sub-themes: (1) incorporate women's experiences; and (2) advocacy and public pressure.

4.7.1.1 Incorporate Women's Experiences

All Patients held negative views towards the criminal justice system, and some expressed pessimism about how a women's intake mental health assessment process could be brought forward and utilized within the institution. Despite her initial skepticism, however, Patient 1 expressed that this process should incorporate the perspectives of women with lived experience of incarceration:

“[this] assessment isn't going to come from guards, it's not going to come from parole officers, and it's not going to come from anybody but the women that have to live there. That is their home, everybody else leaves and they come back; we don't. That is our home so listen to what we have to say. [...] It's our mental health, it's not theirs.”

She expressed her frustration that such lived experience is not incorporated into these decisions, and so a plausible solution would be for women to work with someone whose voice will be heard at an institutional level and is willing to advocate for them: “yeah, we have voices but...they won't listen to us, so we need that voice that they are going to listen to. [...] if you don't have that voice that is going to advocate for you on your behalf that CSC is going to listen to, it's all up in smoke.”

Similarly, Patient 5 suggested that the process of implementing a gender-informed mental health assessment process would require the inclusion of incarcerated women's voices to design a women's assessment tool that is administered by female staff. She expressed her frustration that the CoMHISS was not constructed based on a female sample, and was not piloted on the female prisoner population before it was implemented (Stewart, 2009). Drawing on her difficulties with the CoMHISS, she also noted that such a process should take into consideration that prisoners are not medicated at intake, and so a more humanizing assessment process would make help identify more accurate service recommendations for managing prisoners' mental health.

4.7.1.2 Advocacy and Public Pressure

Four Patients discussed how advocacy groups and public pressure can assist with implementation. They identified resources such as the Office of the Correctional Investigator, court-ordered implementation, and the assignment of internal bodies within corrections to oversee and implement changes. Additionally, Patients identified how public pressure and connections with advocacy groups can be useful for such projects. Patient 6, however, cautioned that a strengths-based approach (i.e., advancement through utilizing an individual's strengths or community's resources and assets; Saleeby, 1992) to advocacy work would be more beneficial than approaches that are in opposition with the institution of corrections: "so like advocates and like advocate agencies that want change are usually complaining about the problems in the jail instead of like complementing what could make it better."

4.7.2 Service Providers' Suggestions for Implementation

Service providers' ideas regarding the implementation of a patient-informed mental health assessment process for incarcerated women were organized into 2 sub-themes: (1) hire and train supportive correctional staff members; and (2) community resources.

4.7.2.1 Hire & Train Supportive Correctional Staff Members

Service Providers discussed how the current structures that exist in corrections can allow for policy change and subsequent implementation. Specifically, they suggested that changes in resource allocation whereby mental health staff and addictions counsellors, social workers, cultural coordinators, and correctional staff are hired and/or provided additional training resources to better support incarcerated women. For example, it was described that in some provincial facilities, such as Alouette Correctional Centre for Women in British Columbia, and The Pas Correctional Centre in Manitoba, correctional staff conduct the intake mental health assessment in its entirety or partially (i.e., Suicide Assessment Form). As such, these roles may be transformed to promote trusting, therapeutic relationships between prisoners and staff. Drawing on her lived experience of incarceration and mental illness nearly two decades prior, Service Provider 3 highlighted the importance of trust and building relationships with correctional staff during the assessment process:

“...when you are an inmate, to have trust there is something big. [...] if you cannot trust the person, you are not going to give that person any information or nothing. So trust for me, an assessment, the first assessment is to gain the trust of that other person who is going to be willing to talk with you and give you something to be able to work with.”

4.7.2.2 Community Resources

Service Providers explained that various community resources could be drawn on for implementation. They proposed that such assessments should be done outside of the carceral

setting, arguing that the institutional environment hinders women from fully expressing themselves which can detriment the mental health services that they receive: “just somewhere that there is an opportunity to not feel like a prisoner, I think makes such a significant difference” (Service Provider 9). In this group, two participants argued that such assessments should be done before the woman is incarcerated, so that she can have the opportunity to collaborate with psychologists and social workers to manage her mental health conditions. For example, Service Provider 9 suggested that CSC’s (2019) policy on community corrections and specifically regarding escorted temporary absences, whereby a prisoner is granted permission to leave the institution if accompanied by at least one staff escort, could be amended to include mental health assessments as a medical reason. Understanding that this might not be entirely practical, Service Provider 7 suggested that at the very least, mental health assessments should be done in a separate building from the institution, so that the woman can feel comfortable in fully expressing herself.

CHAPTER FIVE: DISCUSSION & CONCLUSION

5.0 Introduction

This research critiques the prominence of the male experience in the construction and delivery of the mental health assessment process at institutional intake. By drawing on the POR paradigm and feminist standpoint theory, women's lived experiences were used to explore what a gender-informed intake mental health assessment process could be for incarcerated women. In this section, the key findings of this study are first introduced. Following this, the implications of these findings are summarized. Finally, I will discuss the research limitations and suggest future directions in this area.

5.1 Summary and Discussion of Findings

By critiquing the current intake mental health assessment process, the findings of this research focused on suggesting practical, gender-informed changes within correctional systems to benefit currently incarcerated women with mental illness. This research draws on inspiration from the existing feminist literature, such as Dr. Ruth Elwood Martin, whose research focuses on working within the system and engaging incarcerated women to address their healthcare needs, as well as the POR paradigm to suggest practical applications to the current healthcare system (i.e., correctional health care). The objective of this qualitative research was to bring forward recommendations to improve the current mental health assessment procedures for incarcerated women, as informed by the lived experiences of 15 participants who are former prisoners and current EFS staff members from various chapters. The need for this process is a consequence of the overarching problem that Canadian prisons and jails have not incorporated women's experiences in assessing their mental health, but rather, have focused on the male experience. To

identify the components of a mental health assessment process for incarcerated women, the five participants in the Patient group reflected on their lived experiences during the correctional intake process, and the remaining ten Service Providers drew on their experiential knowledge in working with female prisoners. The Patient group consisted of recently released women, and the Service Provider group consisted of two former correctional staff members who have previously conducted provincial intake assessments and processes, as well as one woman with incarceration experience from several years ago.

5.1.1 Assessment Environment

The first finding in this research is that a safer, more comfortable environment is necessary for the intake mental health assessment process. It should be noted that this finding was unexpected; as the sole interviewer in the data collection process, I did not anticipate these participants to organically speak to the importance of the setting of the mental health assessment at institutional intake. Drawing on the literature, the notion of safety could be considered as incompatible with, or contradictory to the prison and jail environment, in light of the concerning incidents of self-harm and suicide among federally and provincially incarcerated women (e.g., Corabian et al., 2013; Gordon, 2010; Office of the Correctional Investigator, 2014), the disproportionate punitive responses towards women's symptoms of mental illness (Vaswani & Paul, 2019), how incarceration could induce traumatic histories (CSC, 2017), and the overall reality that prisons and jails are "dangerous" environments (Jewkes et al., 2019, p. 13). These suggestions were thus interpreted to address the need to promote increased levels of safety and comfort among women, as they may be especially vulnerable during institutional intake. For example, if she had just experienced the strip search prior to the mental health assessment, she may be reminded of a previous sexual trauma (Miller & Najavits, 2012; Veysey, 2010); or, in

consideration of the assessment outcomes which link symptoms of suicidality with institutional segregation (i.e., in federal corrections, this would be in Structured Intervention Units wherein a prisoner is confined to a cell for a maximum of 20 hours, and is entitled to two hours of “meaningful human contact;” CSC, 2019; in provincial corrections, this confines the prisoner in a cell for 23 hours a day and may have no human interaction; Canadian Association for Elizabeth Fry Societies et al., 2016), she may be reluctant to fully disclose honest answers to the questions she is being asked. Moreover, a woman’s feelings of safety, or lack thereof, may impact the outcomes of the programming and services that she participates in (Benedict, 2014). The participants thus advocated for a setting that mirrors a mental health setting in the community, whereby the patient and practitioner are comfortably speaking in confidence and in turn, a more accurate diagnosis can result.

To facilitate women prisoner’s honest disclosure during the assessment, Patients suggested that this setting can be promoted through paintings or windows in the room, and Service Providers proposed this could be facilitated by gender- and trauma-informed correctional or mental health staff conducting the mental health assessment. The importance of art and creativity has been proposed by Gusask (2007) as beneficial in prison settings as it allows prisoners to express themselves without feeling vulnerable, and serves as an emotional release. Artistic expression, such as painting or drawing on symbols that hold personal meaning to the patient, have been proposed by Oster and Crone (2004) to be less threatening, facilitate discussion, and promote therapeutic engagement in the assessment process. This could facilitate empowerment among these marginalized groups, and moreover, foster trust between them and authority figures (Coemans et al., 2015). In a participatory action research study, Maeve (2000) examined the role of poetry as a form of healing for incarcerated women with mental health and

substance use problems. Similarly, Hongo and colleagues (2015) found that creative projects helped incarcerated women who were reluctant to seek mental health care cope with trauma. Drawing on Jaggar's standpoint literature on criminalized women's disproportionate experiences of trauma and marginalization, this finding accounts for Patients' descriptions of experiencing trauma, anxiety, shame, and guilt during institutional intake, as well as feeling lost and confused while navigating the new environment. They identified that mental health nurses and staff responsible for their care to promote feelings of safety and comfort during this process. In contrast to the emphasis on objectivity within the current intake mental health assessment tools, Patients also suggested that women should have access to materials that can bring them comfort during the mental health assessment, including incorporating art or hanging paintings on the walls of the room in which the assessment would be done.

Similarly, Service Providers suggested that the mental health assessment should be conducted in an environment that does not resemble a prison or correctional setting. This can be accounted for by feminist literature, which emphasizes that the architecture of prisons and jail facilities "tend to be organized on the basis of the needs and requirements of male prisoners...rather than designed from scratch from a women-centred perspective" (Fair, 2009, p. 3). Jewkes and colleagues (2019) associate this with "long corridors, right-angled pathways with poor sightlines, metal staircases, hard surfaces, bars on windows, clanging doors, jangling keys, [and] a performative, macho officer culture" (p. 2). Relatedly, a comparative study across Dutch remand centres finds that a more physically open environment and layout of a correctional centre can facilitate supportive relationships between correctional officers and prisoners, as it provides more opportunities for interactions (Beijersbergen et al., 2016). It then follows that the hard exteriors of correctional environments could deter women from feeling secure about their

participation in the intake mental health assessment. Drawing on their lived experience, former correctional officers who now work within EFS understood that correctional staff have the capacity to promote a safer, more comfortable environment by isolating the woman from other staff when they show symptoms of distress to allow for confidentiality during the assessment process. They described women to be more social (i.e., respond positively to others during interactions) than men, and would therefore more likely to be willing to share their mental health status and current emotional state, if these conditions were met.

5.1.2 Assessment Components & Measures

This research addresses a gap in the literature by identifying an intake mental health assessment process for incarcerated women, which is based on women's lived experiences. By drawing on their respective standpoints of women in the community and service providers for currently incarcerated women, participants advocated for the construction of a women's mental health assessment tool, as the current protocols have been based on all-male samples and/or have not been validated on women prior to implementation. Through our (Ms. McCorriston's and myself) analysis of the data, it was evident that the participants argued that a women's mental health assessment tool should start with women's standpoints, or experiences. In doing so, and in line with Comack's (1996) contention that a woman's individual context and history should be acknowledged, this tool would thus consider women's concerns and needs, including their family and children, as well as their experiences of poverty to account for their mental health status. Similar to Smith's (1978) position that women's standpoints tend to be overlooked by medical experts in the diagnostic criteria, Patients also called for CSC's recognition of psychiatric diagnoses that disproportionately affect women, specifically, eating disorders, rather than attribute these symptoms to self-harm. Additionally, as two women identified as having learning

disabilities, they suggested that the ideal women's mental health assessment tool would not be facilitated through a computer or include human assistance to promote accurate outcomes.

A gender-informed assessment tool should incorporate women's experiences and factors that they considered to be appropriate indicators for their mental health status, including children and family, poverty, and trauma. Moreover, the overall process would entail that women have their mental health status re-assessed to evaluate the recommended treatment and services. Similar to the Patient data, Service Providers suggested that an intake mental health assessment process for incarcerated women would incorporate women's experiences and needs, as well as draw on a strengths-based approach to work towards a treatment plan. This includes considering the woman's social background, including her family, history of substance use, and experiences of trauma. This proposed assessment process would thus contextualize the woman's lived experiences and trauma, and how that contributed to her involvement in the criminal justice system.

Findings further highlight the need for a trauma-informed mental health assessment process. This aligns with Leschied's (2011) review of correctional mental health assessment tools, whereby the tools found to be sensitive to women contain items about their trauma experiences. According to Harner and Burgess (2011), a trauma-informed assessment process would help clinicians "know and understand the signs and symptoms of childhood and adult trauma and victimization and their aftermath to know how to assess a patient's trauma history" (472). Trauma can be defined as a woman's past experiences of physical, sexual, or emotional abuse. As previously discussed, prison and jail environments subject prisoners to strip searches, confinement, potential violence, and discipline from authority figures – all of which can be triggering and exacerbate trauma responses and related symptoms (Miller & Najavits, 2012).

Additionally, a woman's imprisonment and consequent separation from her children can also be a form of emotional trauma (DeHart, 2008). In their recognition of their clients' trauma histories and how prison and jail environments may cause instances of re-traumatization, many participants shared the sentiment that while a trauma-informed mental health assessment process would be ideal for incarcerated women, it would be challenging to implement within these systems. This is largely in part to the traditionally masculine environment of corrections, which discourages displays of emotional vulnerability (Crawley, 2006; Miller & Najavits, 2012), which is inherent in sharing traumatic experiences, or on the receiving end of understanding a woman's trauma. Due to the punitive foundation of the criminal justice system, the literature debates whether trauma-informed care and practices are feasible within prison; however, as the literature is also consistent that trauma plays a "vital and often unrecognized role in the evolution of a woman's physical and mental health problems" (Covington & Bloom, 2006, p. 14), it follows that trauma-informed practices are essential within corrections. Thus, these findings that call for a trauma-informed mental health assessment for incarcerated women shares sentiments with Dell and Poole's (2015) propositions that while prisons and jails are "seldom mandated to treat trauma," they are "in a key position to prevent re-traumatization and to offer universal trauma-informed support" (p. 170).

Unique from the Patient data, Service Providers proposed for the assessment to be a humanizing process. While the Patients did not specifically identify as feeling dehumanized during their mental health assessments, their anecdotes of feeling trauma, shame, and substance withdrawal added context to why a humanizing assessment process is necessary for incarcerated women. This process was discussed in conjunction with when the assessment(s) is/are administered when the woman is fed and not starving, changed out of her street clothes, and is

not experiencing substance withdrawal, as the prison and jail intake processes could last several hours. The Standing Senate Committee on Human Rights (2021) recommends that promoting a “human rights culture” in correctional environments would entail that a “zero-tolerance policy” for prisoner abuse or maltreatment is mandated (p. 23). Drawing on their experience in conducting assessments or working with their clients, they explained that a more humanizing approach would allow for a more accurate assessment. Specifically, by allowing for some time after the woman has settled into the institution, it may promote her to interpret this process as personable and feel assured that she will be receiving the necessary supports for rehabilitation and treatment.

In consideration of the literature which documents incarcerated women’s social backgrounds to include histories of trauma, abuse, and victimization (e.g., Covington & Bloom, 2006; DeHart, 2008; Harner & Burgess, 2011), the notion of trauma-informed care was discussed in conjunction with the need for cultural safety (i.e., respecting a woman’s values and beliefs, and integrating them into the care she receives; Scott et al., 2014), training, and humility to better understand the prisoner’s background and social context. Similarly, participants’ justifications were based on the evidence that finds criminalized women to be more often victims of trauma and abuse (Comack, 2018; Covington & Bloom, 2006; DeHart et al., 2014; Green et al., 2016; Maeve, 2000), and consequently, adjusting to the prison environment could trigger their symptoms of mental illness (Severson, 2019). Thus, this approach was reasoned to result in further benefiting women, rather than applying a blanket assessment that was constructed on an all-male sample. This also includes understanding the woman’s social history, including experiences of intergenerational traumas if she identifies as Indigenous, and requires the

practitioner to exercise critical self-reflection so that they can model culturally safe and trauma-informed clinical behaviours (Menzies, 2010; Scott et al., 2014).

Finally, Patients and Service Providers further illustrated that a women's mental health assessment tool should be thorough, incorporating a woman's spiritual, cultural, and social background. They suggested that the assessment format should allow for women to express their symptoms and responses in more detail or allow the woman to respond with the answer "sometimes," rather than following a binary yes/no format that is typical to the current assessment protocol. By allowing for more time and facilitating thorough conversations in the process, this draws on the feminist epistemology that challenges the positivist approach to assessment. Additionally, they called for the opportunity for patients' mental health status and treatment plans to be followed up with on a regular or scheduled basis. Thus, if a woman is referred to a treatment program, her records would include this information.

5.1.3 Gender and Training of Assessors

Smith's (1978) feminist standpoint literature on women and mental illness proposes that the individual conducting the mental health assessment is in a privileged position, as their reports can validate or invalidate a patient's diagnosis, which can dictate the services and treatments they receive. Correspondingly, the promotion and maintenance of the therapeutic alliance between the patient and clinician is essential. In comparison to community mental health settings, Martin (2017) suggests that diagnostic error is more prevalent in correctional settings, which could be due to the limited therapeutic alliance between the patient and clinician, with the patient not responding honestly during the assessment process. Similarly, participants described how not being honest was a common response exhibited by themselves or their clients during the assessment process. To address this, both Patients and Service Providers identified gender and

training/qualifications in mental health and social work, gender- and trauma-informed training, and rape crisis counselling as important competencies for the individuals conducting the intake mental health assessment for women in prisons and jails.

Gender was discussed in relation to the need for the prisoner to feel safe and trust the assessor, as incarcerated women are most likely to have experienced victimization and trauma perpetrated by men, including sexual abuse or assault (McDaniels-Wilson & Belknap, 2008; Richie & Johnsen, 1996). Additionally, a female assessor may be more likely to recognize women's symptoms of mental illness, as illustrated by Patient 5's experience in receiving her post-partum depression diagnosis. The majority of participants stated that female assessors would be preferable by female patients, but ideally, each patient should have her say in who conducts the assessment. Considering that these women may experience the strip search just prior to the intake mental health assessment, they would most likely feel comfortable discussing their mental health concerns with another female, or at the very least, have their voice heard by who they would feel most comfortable having that conversation with.

While it would be ideal that the prisoner can choose the gender of the individual conducting the mental health assessment, most participants suggested that a woman would be preferred. Dysvik and Sommerseth (2010) explain that female mental health practitioners may be more likely to demonstrate a "natural quality for caring" (p. 80) and have strengths in interpreting emotions, which could account for these women's descriptions of feeling more comfortable having their mental health assessed by other women. In consideration of the need for honest communication during the mental health assessment, Calhoun and colleagues (2010) propose that an all-women environment would provide the safety and comfort that are necessary for incarcerated women to disclose personal information.

Patients recognized trust and compassion as ideal qualities for the individual conducting the mental health assessment during institutional intake. As previously discussed, the intake process can leave women feeling extremely vulnerable and can invoke re-traumatization. In line with their discussions on their own and other incarcerated women's lived experiences, they recommended that an individual who demonstrates compassion could promote feelings of comfort and could facilitate the female prisoner's willingness to share her past history and current mental health status. The World Health Organization (2004) has similarly promoted the need for mental health care workers to demonstrate sensitivity towards women, as well as integrate their knowledge of the evidence that women are more likely to be victims of abuse and how those experiences have shaped their mental health status. Thus, it would further benefit the assessment process if the assessor has earned credentials in mental health and/or social work and demonstrated trust and compassion.

Finally, in addition to the assessor's gender and training competencies, Service Providers suggested that a multidisciplinary team of individuals should be conducting the mental health assessment for women at intake. This team would consist of correctional mental health team members, case workers, EFS staff, and Indigenous Elders, and should incorporate shared decision-making and communication to work together towards women's care and programming recommendations. Drawing on standpoint feminist theory, this research considers the correctional mental health framework as incompatible with the female prisoner population, because of its emphasis on the male perspective in the intake assessment process. Thus, a limitation in this process may be that a single assessor's understanding of a woman's mental health status could be enhanced by collaborating within a multidisciplinary team. Multidisciplinary mental health care teams challenge the traditional paradigm of medical

paternalism by promoting shared decision-making, sharing goals and values, contributing to a shared team culture, and drawing on the strengths of other disciplines in the team (Schultz et al., 2014). In Carlson's (2000) review of the literature, she proposes that multidisciplinary care teams "enable a clearer view...and sharpen the accuracy of the diagnosis" among women, in comparison to traditional models of care (p. 80). While this framework has its challenges, such as inconsistent applications and that the practical guidelines are still in development (Haines et al., 2018; Woody et al., 2018), this collaborative approach has been found to promoting improved patient outcomes, especially among women (Carlson, 2000), based on effective discussion about treatment options and plans (Felker et al., 2004).

5.1.4 Outcomes Connect Patients to Mental Health Services & Programming

The data relating to the outcomes of the intake mental health assessment process were substantial, and were thus considered a high priority. In their discussions of the ideal outcomes, both Patients and Service Providers called for less punitive responses to women's symptoms of mental illness by correctional systems. These women called for the outcomes of the intake mental health assessments to be connected with referrals to correctional mental health services and programming. They critiqued how access to services such as counselling and psychiatry fall on the onus of the woman, and are associated with long wait times, which could discourage her from seeking these necessary services herself. Certain services available in Canadian prisons and jails, however, have been found to be especially therapeutic for the Patients in this study, and so drawing a connection to these services and programs was identified as necessary.

Participants argued that an outcome of a women's mental health assessment process would be that women's symptoms of mental illness are not met with excessive medication, nor punishment. Kilty (2012) has highlighted the predominance of medicating incarcerated women

with mental illness, arguing that this trend reinforces medical paternalism and delegitimizes women's agency – not only due to the sedative effects, but also in providing their informed consent regarding treatment. This in itself can be reminiscent of a woman's trauma history if, for example, she is a victim of sexual assault. Similarly, Felton and colleagues (2018) found that the dominance of risk management in mental health care can influence service providers' decision-making processes and consequently limits patients' autonomy if their symptoms are defined as "risky." Moreover, by medicating the prisoner population to the point where they feel like "zombies," the likelihood of women behaving in ways that promote risk to prisoner and staff safety would be reduced (Kilty, 2012).

Findings consider that the current assessment framework responds to mental illness and specifically suicide, through a stigmatized lens (e.g., Ackerson, 2003; Corrigan & Miller, 2004; Lacey et al., 2015; Nicholson et al., 1998), and that the broader correctional system identifies mental illness as a risk factor (Appelbaum et al., 2001; Dvoskin & Spiders, 2004; Standing Senate Committee on Human Rights, 2021). Coupled with a long and oppressive history between women and psychiatric diagnoses, reinforcing this stigma could negatively affect prisoners' self-image and perceptions of their mental illness diagnoses. Altogether, this places incarcerated women in a vulnerable position as they are more likely to present with symptoms of mental illness at institutional intake. Furthermore, prisons and jails may be reminiscent of trauma experiences (Adams, 1983; O'Keefe & Schnell, 2007); thus, the outcomes of gender-informed mental health assessment process should recognize a woman's trauma response and the difficulty she experiences adjusting to the prison environment (Bloom et al., 2003; Houser et al., 2012; Severson, 2019), rather than respond to her symptoms of mental illness with punishment (Fedock & Covington, in press).

5.1.5 Culturally Informed Assessment

The Truth and Reconciliation Commission of Canada (2015) calls for the actionable change towards reducing the overrepresentation of Indigenous prisoners by 2025. The unfortunate reality is that while these trends continue to grow, racialized and Indigenous prisoners are more likely to receive punishment for their symptoms of mental illness. Thus, an implication of a culturally informed mental health assessment process could be that women's symptoms are considered as legitimate symptoms, and appropriate measures are taken towards promoting their mental health and wellness (Standing Senate Committee on Human Rights, 2021).

Although most of the participants in this study identified as Caucasian, they demonstrated their allyship by voicing their support for Indigenous-specific assessments, due to their own experiences interacting or working with female prisoners who are Indigenous. The participants who identified as Indigenous suggested that a culturally informed mental health assessment process should be holistic and strengths-based. Typically, assessments focus on a woman's risk factors (Martin et al., 2018), i.e., traits that can correlate with re-offending or potential harm (Shepherd & Willis-Esqueda, 2018); however, this framework is incompatible with Indigenous worldviews, which are focused on recognizing her strengths (Snowshoe et al., 2015; Webster & Deng, 2015).

Additionally, the Western concept of "mental health" was considered as incompatible with Indigenous culture. The literature explains that this is because mental health can be used to explain a patient's health status and symptoms, whereas the mental aspect of an Indigenous individual's wellness is interconnected with their spiritual, emotional, and physical wellness, and thus their health status is "expressed through a balance of spirit, heart, mind, and body"

(McConnery & Dumont, 2010 as cited in Fiedeldey-Van Dijk et al., 2016). By applying Ermine's (2007) notion of the ethical space through engaging the strengths of both Western and Indigenous conceptions of mental health and wellness, it was suggested that this disconnect could possibly be bridged by drawing on the knowledge of Elders and Knowledge Keepers or having them involved in the assessment process. Conversely, however, the engagement of Indigenous leaders and experts may reveal the incompatibility of a mental health assessment tool and process for this population.

In consideration of these differences, Fiedeldey-Van Dijk and colleagues (2016) developed the Native Wellness Assessment, which is a culturally informed holistic assessment tool that evaluates wellness for Indigenous individuals. Similar to participants' suggestions, this tool draws on the Medicine Wheel in relation to wellness, to evaluate a person's spiritual, emotional, mental, and physical well-being (Ibid.). Whereas the scope of this study is to examine what a mental health assessment process should be for incarcerated women, guided by the suggestions by Service Provider 11 and the literature, it is understood that a framework which provides a more comprehensive view of the Indigenous woman (i.e., rather than simply focusing on one aspect of her wellness) may then be culturally informed.

5.1.6 Implementation

Drawing on the overlap between feminist theories and POR which calls for practical and actionable change based on this research, the final finding pertains to participants' suggestions as to how a women's mental health assessment should be implemented in Canadian prisons and provincial jails. That is, by applying Hawkesworth's (1999) proposition to recognize the plurality of standpoints, bringing forward various experiences allowed for insightful and meaningful ways to improve this process for incarcerated women. Specifically, they noted that the process of

implementing a mental health assessment process designed for women at correctional intake should incorporate women's experiences in developing the tool, as well as drawing on public advocacy and community resources. These recommendations are supported in a review of the literature by Heilbrun and colleagues (2012), who found that the use of community supports as an alternative for incarceration have shown positive effects in managing an individual's mental illness. Their findings suggest that public safety is not compromised, community mental health supports are more cost-efficient than jails and prisons, and patients' needs are better met in the community.

Participants' suggestions also drew on the relationships between the incarcerated woman and the staff member responsible for her assessment, and the importance of that individual's role in providing a safer and more comfortable environment, asking the necessary questions and providing trauma-informed care, attending to the woman's social cues and nonverbal responses, and in making appropriate recommendations for programming and services. By examining and considering a prisoner's individual context, including her lived experience and history of abuse and trauma, their diagnoses and consequent behaviour would be better understood in the construction of a treatment plan (DeHart et al., 2014). These suggestions further align with the recommendations set forth in the *Creating Choices* report (1990), which promotes a mandate for correctional guards to "respond to their pain and to support, motivate, and reinforce the growth of self-esteem and judgement" among incarcerated women as during times of crises, correctional staff may be the only available sources of support (p. 66).

POR represents a "culture shift" in research (Aubin et al., 2019, p. 861) which mirrors the standpoint feminist framework that calls for a similar shift in social science research, to be generated from women's standpoints and have social impacts. This also provides context as to

how some participants met their suggestions for implementation with skepticism as to whether a women's mental health assessment process could feasibly be implemented in Canadian federal and provincial corrections. Interestingly, while the participants' suggestions as to what would constitute a women's mental health assessment for prisons and jails were based on the "ideal," I considered their recommendations for implementation as practical. For example, Patient 6's critique of advocacy groups that "complain...about the problems in the jail instead of like complementing what could make it better" was interpreted as working with the system to facilitate changes and necessary improvements for incarcerated women. Similarly, participants identified the current structures that exist in corrections could allow for this, including facilitating supportive and trustful relationships between incarcerated women and correctional staff, and amending federal policies on escorted temporary absences for these assessments to be done in the community. Overall, the strengths of these women were highlighted as they provided critical, insightful, and solutions-oriented suggestions for implementation.

5.2 Implications

The findings of this research suggest that incarcerated women would find benefits in a gender-informed mental health assessment process during institutional intake. Moreover, implementation of a women's mental health assessment process would rely on community resources in conjunction with the systems and resources already in place within the Canadian criminal justice system. Thus, the first recommendation would be for CSC and each provincial correctional body to develop and/or incorporate mental health assessment tools based on all-female samples into the intake assessment process. For federal corrections, it could be that the CoMHISS then incorporates the gender-informed assessment tool for female prisoners at intake, in lieu of the male-constructed DHS. Additionally, the measures in the tool should draw on

women's experiences, including how instances of trauma, substance use, poverty, or separation from children/family affects her mental health status during intake.

Similar to the recommendations put forward in *Creating Choices*, a POR approach to this topic could ensure that the health concerns of women in prisons and jails to be treated “like patients, not offenders” (CSC & Canadian Association of Elizabeth Fry Societies, 1990, p. 34). Correspondingly, the setting in which the intake assessment takes place should promote women's feelings of safety and comfort so that they can feel comfortable discussing their mental health status with correctional staff. This could be facilitated through the physical layout of the room that the assessment is being conducted in, or through interactions with trauma- and gender-informed correctional staff members, mental health professionals, social workers, and/or EFS staff responsible for conducting the assessment.

With regards to a culturally informed intake mental health assessment process for Indigenous women who are incarcerated, findings suggest this should be holistic, involve Indigenous professionals, incorporate cultural knowledge, and draw on a strengths-based approach. Additionally, these findings should be used to guide future research inquiries.

Finally, this research supports the need to connect the outcomes of the intake mental health assessment to women's mental health services and programming. This may require follow-up assessments after the intake process, whereby the mental health status of the prisoner is documented and revisited on a regular basis to assess whether the intervention benefits her, or if another approach should be referred.

5.3 Research Limitations & Future Directions

This study is not without limitations. First, while the COVID-19 pandemic allowed for expanding on the research study sample and include participants across Canada and various EFS chapters, the social distancing measures in place limited patient partner engagement. The original, pre-pandemic plan was to partner with EFS Saskatchewan to recruit two patient partners with lived experience of incarceration and mental illness to guide the research. It was also intended that these patient partners would recruit key informants as participants and would co-conduct the interviews alongside myself. The interviews were designed to be in-person, whereby the first interview with each participant would serve to build rapport between us, and incorporate art to facilitate discussion and positive engagement (Coemans et al., 2015; Oster & Crone, 2004). Due to the pandemic social distancing measures that were in place at the time of data collection, I changed the data collection method to conducting phone interviews between the participant and myself. Additionally, I could not recruit the intended two patient partners because the EFS Saskatchewan office was closed and were not directly working with clients during the initial months of the pandemic. While there was one EFS Saskatchewan staff member who agreed to serve as the project advisor, she ended her employment with this chapter prior to data collection and before the project received approval from the University of Saskatchewan's Behavioural Research Ethics Board. The pandemic also added delays to the ethics board operations, which impacted the research design. Specifically, while it would have been ideal to enhance collaboration and patient engagement by inviting Ms. McCorrison to co-conduct the interviews alongside myself, our paths did not cross until towards the end of data collection (i.e., during the last three interviews); hence, she was not onboarded as a patient partner before then. If the research timeline was not already significantly delayed at that point, I would have felt

comfortable taking the necessary time to file an ethics amendment (including updating the participant recruitment documents), and provide additional interview/data collection training, including assisting Ms. McCorriston with obtaining her TCPS-2 Course on Research Ethics certification. If it were not for these time and distancing restrictions, I anticipate that there would be further patient engagement in the data collection process.

Data collection was also considered to be hindered by the pandemic, as the Patient sample was considered difficult to recruit. By drawing on phone interviews for data collection to respect the social distancing guidelines, the participant pool was limited to women who were comfortable with speaking on the phone. For example, there was one potential participant who contacted me indicating her interest in participating in the study, but explained that talking on the phone was extremely anxiety-inducing for her. Fortunately, by having Ms. McCorriston join the research team towards the end of data collection, she was able to recruit the final two participants of the Patient sample.

Additionally, I considered it a challenging experience to teach qualitative data analysis through a distance, and it was also Ms. McCorriston's first time conducting thematic analysis. She explained that while she read through the data and identified codes and resulting themes, she was not as engaged in the Service Provider data as much as she was the Patient data. I also experienced the loss of my great uncle and youngest cousin in the Winter and Spring of 2021, and these instances called for additional time spent with my family and some distance from my research to cope with my grief. In an in-person environment, Ms. McCorriston and I could have conducted qualitative analysis alongside each other in real time, which entails thorough discussion about the data; however, in the interest of time and these conflicts, we agreed it would

be most efficient to analyze data separately. Thus, we met through video conferencing and phone calls to discuss the codes and identify the resulting themes.

It should also be noted that the changing of patient partners during prior to the data collection process may be a limitation. The first patient partner for this research was an E. Fry Saskatchewan staff member who helped with the project planning and identifying the research questions. From the time that she resigned from her position with EFS in July 2020, this project did not draw on the advice of a patient partner until December 2020. During this time, I was in the process of obtaining a Certificate of Approval from the Behavioural Research Ethics Board and then conducting data collection. Thus, I was not able to share my interview notes with Ms. McCorrison immediately after each interview, or have her listen to the interview audio recordings or read the interview transcripts as soon as they were prepared by the transcriptionist. This could have further limited Ms. McCorrison's engagement with the data.

An additional limitation is that the experiences of incarcerated women with mental illness are not fully represented in this sample. For example, the women in the Patient sample are younger than 50 years old, which is the average age that Canadian women experience menopause (Stuenkel et al., 2015; Velez et al., 2019). The literature indicates that a woman's mental health status can be affected by menopause (Freeman et al., 2004; Szeliga et al., 2021), and that incarcerated women who are experiencing the transition into (Jaffe et al., 2021), or have already experienced menopause (Aday & Farney, 2014; Knittel et al., 2017), encounter unique barriers to accessing healthcare. It is therefore suggested that future research in the area of gender-informed mental health assessments should consider the role of menopause among incarcerated women's mental health needs and status.

Finally, the findings of this research pertaining to this area were limited to one Indigenous Patient and three Service Providers. While the Executive Directors of each EFS chapter who participated in this research were involved in identifying key informants for the Service Provider sample, the Patient sample was established through purposive, snowball sampling. This sample was thus not representative of the current population of women in Canadian prisons and jails. In consideration of the mixed literature on the necessity and benefits of a culturally informed mental health assessment, as well as the limited findings of the current research, it is recommended that future areas of inquiry should examine the components for a culturally informed mental wellness assessment process for incarcerated Indigenous women. Drawing on the data presented, a POR approach to this suggested research direction should incorporate Indigenous Knowledge Keepers in the participant pool or as patient partners, in addition to a larger sample of Indigenous women with lived experience of incarceration and mental illness.

5.3.1 Knowledge Translation

The process of knowledge translation (KT), or the dissemination of findings, is an important component to POR as this approach emphasizes the practical applications of research (Canadian Institutes for Health Research, 2019). This process began in May 2021, and is anticipated to end in December 2021. The first KT product I created was a digital storytelling video that highlighted the relationship that was built between myself and Ms. McCorrison. While I aimed to engage Ms. McCorrison and patients throughout the KT process, I created this video myself and with the assistance of Ms. McCorrison's daughter, as a surprise appreciation gift. The digital story shared my perspective of how easy I found it was to build an efficient working and personal relationship with Ms. McCorrison, despite collaborating on this project

through a distance, and without the opportunity to have met in-person due to the COVID-19 restrictions that were in place at the time of the study.

In May 2021, Ms. McCorrison and I co-hosted a meeting with the Patients who participated in data collection to share the results of our research and gather insight as to how we should disseminate these findings. While all of the Patients were invited, three were in attendance. At the meeting, I shared the study results, and provided them with the space to openly discuss their thoughts. This led to an in-depth discussion of Patients' standpoints and experiences. They agreed that they were respectfully characterized in the research, and there was consensus about the actionable tasks for dissemination. They suggested that the study findings should be shared in a video, which highlights the strengths of these women, and their meaningful contributions in sharing their lived experience to facilitate change in the prison and jail mental health assessment processes. The Patients emphasized that this video should be used to empower and inspire other women with lived experience of incarceration and mental illness.

In June 2021, Ms. McCorrison and I co-presented our research through a virtual keynote at the 2021 Canadian Sociological Association. This provided a unique opportunity to share and defend our research with an academic audience, and, moreover, her role as a co-presenter was considered incredibly empowering by Ms. McCorrison. Our presentation received an overwhelming amount of positive feedback, and were extremely inspired from the conversations that were facilitated through us sharing our findings.

A future direction for this specific project is the production and dissemination of the video suggested by Patients, which is the final KT product. I will be responsible for creating the video, and Ms. McCorrison and Dr. Acoose will advise the most appropriate channels to share

this work. The final product will also be shared with all of the participants, including the EFS chapters involved in this research.

REFERENCES

- Ackerson, B. J. (2003). Coping with the dual demands of severe mental illness and parenting: the parents' perspective. *Families in Society, 84*(1), 109-118.
- Adams, K. (1983). Former mental patients in a prison and parole system: A study of socially disruptive behavior. *Criminal Justice Behavior, 10*(3), 358-384
- Aday, R. H., Dye, M. H., & Kaiser, A. K. (2014). Examining the traumatic effects of sexual victimization on the health of incarcerated women. *Women & Criminal Justice, 24*(4), 341-361.
- Aday, R. & Farney, L. (2014). Malign neglect: Assessing older women's health care experiences in prison. *Journal of Bioethical Inquiry, 11*(3), 359-372.
- Afifi, M. (2007). Gender differences in mental health. *Singapore Medical Journal, 48*(5), 385-391.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Anumba, N., Dematteo, D., & Heilbrun, K. (2012). Social functioning, victimization, and mental health among female offenders. *Criminal Justice and Behavior, 39*(9), 1204-1218.
- Appelbaum K. L., Hickey J. M., & Packer, I. (2001). The role of correctional officers in multidisciplinary mental health care in prisons. *Psychiatric Services, 52*(10), 1343-1347. doi:10.1176/appi.ps.52.10.1343. 90.

- Archambault, K., Stewart, L., Wilton, G., & Cousineau, C. (2010). *Initial results of the Computerized Mental Health Intake Screening System (CoMHIS) for Federally Sentenced Women*. Research Report R-230. Correctional Service of Canada.
- Aubin, D., Hebert, M., & Eurich, D. (2019). The importance of measuring the impact of patient-oriented research. *CMAJ*, *191*(31), E860-E864.
- Bartlett, A., & Hollins, S. (2018). Challenges and mental health needs of women in prison. *The British Journal of Psychiatry*, *212*(3), 134-136. doi:10.1192/bjp.2017.42
- Becker, H. (1998). Chapter 3: Sampling. *Tricks of the trade*. University of Chicago Press.
- Beijersbergen, K. A., Dirkzwager, A. J., van der Laan, P. H., & Nieuwbeerta, P. (2016). A social building? Prison architecture and staff–prisoner relationships. *Crime & Delinquency*, *62*(7), 843-874.
- Bell, A., Trevethan, S., & Allegri, N. (2004, June). A needs assessment of federal Aboriginal women offenders. <https://www.csc-scc.gc.ca/research/r156-eng.shtml>
- Bell, N. (2014). Teaching by the medicine wheel. *Education Canada*, *54*(3), 14-16.
- Benedict, A. (2014). Using trauma-informed practices to enhance safety and security in women’s correctional facilities. <https://www.ojp.gov/ncjrs/virtual-library/abstracts/using-trauma-informed-practices-enhance-safety-and-security-womens>
- Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. Commonwealth Fund, Quality of Care

for Underserved Populations.

Blackburn, A. G., Mullings, J. L., & Marquart, J. W. (2008). Sexual assault in prison and beyond: Toward an understanding of lifetime sexual assault among incarcerated women. *The Prison Journal*, 88(3), 351-377.

Bloom, S. W. (2005). The relevance of medical sociology to psychiatry: A historical view. *The Journal of Nervous and Mental Disease*, 193(2), 77-84.

Bill, L. (1998). The victimization and revictimization of female offenders: Prison administrators should be aware of ways in which security procedures perpetuate feelings of powerlessness among incarcerated women. *Corrections Today*, 60, 106-113.

Bodkin, C., Pivnick, L., Bondy, S. J., Ziegler, C., Martin, R. E., Jernigan, C., & Kouyoumdjian, F. (2019). History of childhood abuse in populations incarcerated in Canada: A systematic review and meta-analysis. *American Journal of Public Health*, 109, e1–e11.

Borg, M. & Kristiansen, K. (2004). Recovery-orientated professionals: Helping Relationships in mental health services. *Journal of Mental Health*, 13, 493–505.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. doi:10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London, UK: Sage.

Brennan, S. (2014). Canada's Mother-Child Program: Examining its emergence, usage and current state. *Canadian Graduate Journal of Sociology and Criminology*, 3(1), 11.

- 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). Jones and Bartlett.
- Brooks, A. (2007). Feminist standpoint epistemology: Building knowledge and empowerment through women's lived experience. In S. Hesse-Biber & P. Leavy (Eds.), *Feminist research practice: A primer* (pp.83-110). Sage.
- Bumiller, K. (2013). Incarceration, welfare state, and the labor market nexus: The increasing significance of gender in the prison system. In B. Carlton & M Segrave (Eds.), *Women exiting prison: Critical essays on gender in the prison system* (pp. 13-33). Routledge.
- Busfield, J. (2000). Introduction: Rethinking the sociology of mental health. *Sociology of Health & Illness*, 22, 543-558. doi: 10.1111/1467-9566.00219
- Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry*, 31(3), 197–212.
- Cabeldue, M., Blackburn, A., & Mullings, J. (2018). Mental health among incarcerated women: An examination of factors impacting depression and PTSD symptomology. *Women & Criminal Justice*, 29(1), 1-21. doi: 10.1080/08974454.2018.1433099
- Calhoun, S., Messina, N., Cartier, J., & Torres, S. (2010). Implementing gender-responsive treatment for women in prison: Client and staff perspectives. *Federal Probation*, 74(3), 27-33.

- Campbell, W. H., & Rohrbaugh, R. M. (2013). *The biopsychosocial formulation manual: A guide for mental health professionals*. New York, NY: Routledge.
- Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*(3), 181-184.
- Canadian Association of Elizabeth Fry Societies, Centre for Indigenous Governance - Ryerson University, & Canadian Feminist Alliance for International Action. (2016). *Reply to Issues 2, 3, 16 & 18: Indigenous women and women in detention*. Report to the Committee on the Elimination of Discrimination against Women on the Occasion of the Committee's Eighth and Ninth Periodic Review of Canada.
- https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/CAN/INT_CEDAW_NGO_CAN_25420_E.pdf
- Canadian Association of Elizabeth Fry Societies. (2020). *Defending prisoners' rights*.
- <https://www.caefs.ca/defending-prisoners>
- Canadian Institutes of Health Research. (2019, May 27). *Strategy for Patient-Oriented Research – Patient engagement*. <https://cihr-irsc.gc.ca/e/45851.html>
- Canadian Institutes of Health Research. (2021, March 15). *Strategy for patient-oriented research*. <https://cihr-irsc.gc.ca/e/41204.html>
- Cale, E. M. & Lilienfeld, S. O. (2002). Sex differences in psychopathy and antisocial personality disorder: A review and integration. *Clinical Psychology Today, 22*, 1179-1207.

- Carlson, K. J. (2000). Multidisciplinary women's health care and quality of care. *Women's Health Issues, 10*(5), 219–225. doi:10.1016/s1049-3867(00)00052-9
- Casey, R. C. (2018). Hard time: A content analysis of incarcerated women's personal accounts. *Affilia, 33*(1), 126-138. doi:10.1177/0886109917718233
- Caulfield, L. (2010). Rethinking the assessment of female offenders. *The Howard Journal of Criminal Justice, 49*(4), 315-327.
- Caulfield, L.S. (2016) Counterintuitive findings from a qualitative study of mental health in English women's prisons. *International Journal of Prisoner Health, 12*(4), 216- 229.
- Chesney-Lind, M. (1989). Girls' crime and woman's place: Toward a feminist model of female delinquency. *Crime & Delinquency, 35*(1), 5-29. doi:10.1177/0011128789035001002
- Coemans, S., Wang, Q., Leysen, J., & Hannes, K. (2015). The use of arts-based methods in community-based research with vulnerable populations: Protocol for a scoping review. *International Journal of Educational Research, 71*, 33-39.
doi:10.1016/j.ijer.2015.02.008
- Cohen, A. K. (1955). *Delinquent boys*. Routledge & Kegan Paul.
- Cohen, J. W. (2015). Criminal justice as a male enterprise. In T. L. Freiburger & C. D. Marcum (Eds.), *Women in the criminal justice system: Tracking the journey of females and crime* (pp.31-47). Routledge.
- Comack, E. (1996). *Women in trouble*. Fernwood Publishing.

- Comack, E. (2018). *Coming back to jail: Women, trauma, and criminalization*. Fernwood Publishing.
- Corabian, G., Appell, R., & Wormith, J. S. (2013). *Female offenders and self-harm: An overview of prevalence and evidence-based approaches*. Centre for Forensic Behavioural Science and Justice Studies, University of Saskatchewan. https://cfbsjs.usask.ca/documents/research/research_papers/ReviewOfSelfHarmInWomenOffenders.pdf
- Correctional Service of Canada. (2010). *Aboriginal national custody tables*. Ottawa, ON, Canada: Correctional Service of Canada.
- Correctional Service of Canada. (2012). *Mental health strategy for corrections in Canada: A federal-provincial territorial partnership*. <https://www.csc-scc.gc.ca/health/092/MH-strategy-eng.pdf>
- Correctional Service of Canada. (2012, February 23). *Review of mental health screening at intake*. <https://www.csc-scc.gc.ca/005/007/005007-2514-eng.shtml>
- Correctional Service of Canada (2013, December 6). *Structured Living Environment*. <https://www.csc-scc.gc.ca/publications/fsw/sleop/structured-living-eng.shtml>
- Correctional Service of Canada. (2015, March 5). *Towards a continuum of care: Correctional Service Canada Mental Health Strategy*. <https://www.csc-scc.gc.ca/text/pblct/health/tcc-eng.shtml>
- Correctional Service of Canada. (2016, March 9). *Assessment of women offender correctional programs*. <https://www.csc-scc.gc.ca/research/005008-err-14-09-eng.shtml>

- Correctional Service of Canada. (2017, November 30). *Gender responsive corrections for women in Canada: The road to successful reintegration*. <https://www.csc-scc.gc.ca/women/002002-0005-en.shtml#t10>
- Correctional Service of Canada. (2017, December 14). *Searching of offenders*. <https://www.csc-scc.gc.ca/politiques-et-lois/566-7-cd-eng.shtml>
- Correctional Service of Canada. (2018, March 1). *National correctional program referral guidelines*. <https://www.csc-scc.gc.ca/acts-and-regulations/726-2-gl-eng.shtml>
- Correctional Service of Canada. (2019, September). *Indigenous federal admissions and releases: 2013-14 to 2018-19*. <https://www.csc-scc.gc.ca/research/rib-19-12-en.shtml>
- Correctional Service of Canada. (2019, September 11). *Types of release*. <https://www.csc-scc.gc.ca/parole/002007-0002-en.shtml>
- Correctional Service of Canada. (2019, November 30). *Commissioner's Directive 711 Structured Intervention Units*. <https://www.csc-scc.gc.ca/acts-and-regulations/711-cd-en.shtml#t1>
- Correctional Service of Canada. (2020, April 3). *Health services*. <https://www.csc-scc.gc.ca/health/index-eng.shtml>
- Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health, 13*(6), 537-548.
- Council on Aboriginal Initiatives. (2012). *Elder protocol & guidelines*. University of Alberta.
- Covington, S. (2003). A woman's journey home: Challenges for female offenders. In J. Travis & M. Waul (Eds.), *Prisoners once removed: The impact of incarceration and re-entry on*

- children, families, and communities* (pp. 67–103). The Urban Institute.
- Covington, S. S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs, 40*(sup5), 377-385
- Covington, S. S., & Bloom, B. E. (2006). Gender responsive treatment and services in correctional settings. *Women and Therapy, 29*(3/4), 9-33.
- Crawley, E. (2006) *Doing prison work: The public and private lives of prison officers*. Willan.
- DeHart, D. D. (2008). Pathways to prison: Impact of victimization in the lives of incarcerated women. *Violence Against Women, 14*(12), 1362-1381.
- DeHart, D., Lynch, S., Belknap, J., Dass-Brailsford, P., & Green, B. (2014). Life history models of female offending: The roles of serious mental illness and trauma in women's pathways to jail. *Psychology of Women Quarterly, 38*(1), 138-151.
- Dell, C., Chalmers, D., Stobbe, M., Rohr, B., & Husband, A. (2019). Animal-assisted therapy in a Canadian psychiatric prison. *International Journal of Prisoner Health, 15*(3). doi:10.1108/ijph-04-2018-0020
- Dell, C. & Fillmore, C. (2007). Substance use as self-harm: Perspectives of criminalized women. in N. Poole and L. Greaves (Eds.), *Highs & lows: Canadian perspectives on women's substance use* (pp.187-190). Centre for Addiction and Mental Health.
- Dell, C. A., & Kilty, J. M. (2013). The creation of the expected Aboriginal woman drug offender in Canada: Exploring relations between victimization, punishment, and cultural identity. *International Review of Victimology, 19*(1), 51-68.

Dell, C. A., & Poole, N. (2015). Taking a PAWS to reflect on how the work of a therapy dog supports a trauma-informed approach to prisoner health. *Journal of Forensic*

Nursing, 11(3), 167-173.

Demers, J. (2014, September). *Warehousing prisoners in Saskatchewan: A public health*

approach. [https://www.policyalternatives.ca/sites/default/files/uploads/publications/](https://www.policyalternatives.ca/sites/default/files/uploads/publications/Saskatchewan%20Office/2014/10/warehousing_prisoners_in_saskatchewan.pdf)

[Saskatchewan%20Office/2014/10/warehousing_prisoners_in_saskatchewan.pdf](https://www.policyalternatives.ca/sites/default/files/uploads/publications/Saskatchewan%20Office/2014/10/warehousing_prisoners_in_saskatchewan.pdf)

Department of Justice. (2019, April 12). *Spotlight on Gladue: Challenges, experiences, and*

possibilities in Canada's criminal justice system. [https://www.justice.gc.ca/eng/rp-](https://www.justice.gc.ca/eng/rp-pr/jr/gladue/p2.html)

[pr/jr/gladue/p2.html](https://www.justice.gc.ca/eng/rp-pr/jr/gladue/p2.html)

Derkzen, D., Booth, L., Taylor, K., & McConnell, A. (2013). Mental health needs of federal

female offenders. *Psychological Services*, 10(1), 24-36. doi: 10.1037/a0029653

Derkzen, D., Barker, J., McMillan, K., & Stewart, L. (2017). *Rates of current mental disorders*

among women offenders in custody in CSC. Correctional Service of Canada.

<https://www.csc-scc.gc.ca/research/err-16-23-eng.shtml>

Derkzen, D., Wardrop, K., & Wanamaker, K. (2019). *Women offender assessment: Can gender-*

informed variables improve risk prediction? (Research Report R-413).

Correctional Service of Canada.

Derogatis, L. R. (1993). *BSI Brief Symptom Inventory: Administration, scoring, and procedures*

manual (4th ed.). National Computer Systems.

- Doucet, S. A., Letourneau, N. L., & Stoppard, J. M. (2010). Contemporary paradigms for research related to women's mental health. *Health Care for Women International*, 31(4), 296-312. doi:10.1080/07399330903518509
- Drapalski, A. L., Youman, K., Stuewig, J., & Tangney, J. (2009). Gender differences in jail inmates' symptoms of mental illness, treatment history and treatment seeking. *Criminal Behaviour and Mental Health*, 19(3), 193-206. doi:10.1002/cbm.733
- Dugosh, K. L., Festinger, D. S., Croft, J. R., & Marlowe, D. B. (2010). Measuring coercion to participate in research within a doubly vulnerable population: Initial development of the coercion assessment scale. *Journal of Empirical Research on Human Research Ethics*, 5(1), 93-102.
- Dvoskin, J. A., Spiers, E. M. (2004). On the role of correctional officers in prison mental health. *Psychiatric Quarterly*, 75(1), 41-59. doi:10.1023/B:PSAQ.0000007560.09475.a0.
- Dysvik, E., & Sommerseth, R. (2010). A man could never do what women can do: Mental health care and the significance of gender. *Patient Preference and Adherence*, 4, 77-86.
<https://doi.org/10.2147/ppa.s9103>
- Dziopa, F., & Ahern, K. J. (2009). What makes a quality therapeutic relationship in psychiatric/mental health nursing: A review of the research literature. *Internet Journal of Advanced Nursing Practice*, 10(1), 7-7.
- Ermine, W. (2007). The ethical space of engagement. *Indigenous Law Journal*, 6(1), 193-203.
- Fair, H. (2009). International review of women's prisons. *Prison Service Journal*, 184(3), 3-8.
- Fedock, G. & Covington, S. "Strengths-Based Approaches to the Treatment of Female

- Offenders.” *The Wiley Handbook of Offender Desistance from Aggression and Crime: Theory, Research, and Evidence-Based Practice*. Edited by C. Langton and J. Worling. United Kingdom: John Wiley & Sons, in press.
- Felker, B. L., Barnes, R. F., Greenberg, D. M., Chaney, E. F., Shores, M. M., Gillespie-Gateley, L., Buike, K., & Morton, C. E. (2004). Preliminary outcomes from an integrated mental health primary care team. *Psychiatric Services*, 55(4), 442-444.
- Felton, A., Repper, J., & Avis, M. (2018). Therapeutic relationships, risk, and mental health practice. *International Journal of Mental Health Nursing*, 27(3), 1137-1148.
- FEWO. (2014). *Eating disorders among girls and women in Canada: Report of the Standing Committee on the status of women*. House of Commons Canada
- Ford, J., Trestman, R. L., Osher, F., Scott, J. E., Steadman, H. J., & Robbins, P. C. (2007). *Mental health screens for corrections*. Washington, DC: U.S. Department of Justice.
- Fiedeldej-Van Dijk, C., Rowan, M., Dell, C., Mushquash, C., Hopkins, C., Fornssler, B., Hall, L., Mykota, D., Farag, M., & Shea, B. (2017). Honoring Indigenous culture-as-intervention: Development and validity of the Native Wellness Assessment. *Journal of Ethnicity in Substance Abuse*, 16(2), 181-218.
- Fitzgerald, P. & Dinan, T. G. (2010). Biological sex differences relevant to mental health. In Kohen, D. (Ed.), *Oxford textbook of women and mental health* (pp.30-42). New York, NY: Oxford University Press.
- Fitzgibbon, W. & Green, R. (2006). Mentally disordered offenders: Challenges in using the OASys risk assessment tool. *Journal of Community Justice*, 4, 35-46.

- Freeman, E. W., Sammel, M. D., Liu, L., Gracia, C. R., Nelson, D. B., & Hollander, L. (2004). Hormones and menopausal status as predictors of depression in women in transition to menopause. *Archives of General Psychiatry*, *61*(1), 62-70.
- Friedman, S. H., Tamburello, A. C., Kaempf, A., & Hall, R. C. (2019). Prescribing for Women in Corrections. *The Journal of the American Academy of Psychiatry and the Law*, *47*(4), 476-485.
- Frisch, N., Atherton, P., Doyle-Waters, M. M., MacLeod, M. L., Mallidou, A., Sheane, V., Ward, J., & Woodley, J. (2020). Patient-oriented research competencies in health (PORCH) for researchers, patients, healthcare providers, and decision-makers: results of a scoping review. *Research Involvement and Engagement*, *6*(1), 1-14.
- Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000–2018 period: a systematic literature review. *The American Journal of Clinical Nutrition*, *109*(5), 1402-1413.
- Gagné, S., Vasiliadis, H., & Prévaille, M. (2014). Gender differences in general and specialty outpatient mental health service use for depression. *BMC Psychiatry*, *14*, 135-145.
- Ghiasi, N., Azhar, Y., & Singh, J. (2020). Psychiatric illness and criminality. In *StatPearls*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK537064/>
- Giovannoni, M. (2018). *All my relations: Patient oriented research for reconciliation and empowerment of indigenous women's experiences with cervical screening*. [Master's thesis, University of British Columbia]. University of British Columbia Open Collections.
- Glaze, L. E., & Maruschak, L. M. (2008). *Parents in prison and their minor children (NCJ*

- 222984). Bureau of Justice Statistics. <https://bjs.ojp.gov/content/pub/pdf/pptmc.pdf>
- Goormany, A., & Dickinson, T. (2015). The influence of prison climate on the mental health of adult prisoners: a literature review. *Journal of Psychiatric and Mental Health Nursing*, 22(6), 413-422.
- Gordon, A. (2010, December). *Self-injury incidents in Correctional Service of Canada institutions over a thirty-month period*. <https://www.csc-scc.gc.ca/research/005008-0233-01-eng.shtml>
- Government of Canada. (2020, March 10). *Stigma around substance use*. <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/stigma.html>
- Green, B. L., Miranda, J., Daroowalla, A., & Siddique, J. (2005). Trauma exposure, mental health functioning, and program needs of women in jail. *Crime & Delinquency*, 51(1), 133-151.
- Green, B. L., Dass-Brailsford, P., Hurtado de Mendoza, A., Mete, M., Lynch, S. M., DeHart, D. D., & Belknap, J. (2016). Trauma experiences and mental health among incarcerated women. *Psychological Trauma: Theory, Research, Practice, and Policy*, 8(4), 455–463. <https://doi.org/10.1037/tra0000113>
- Guba, E. (1990). The alternative paradigm dialogue. In E. Guba (ed.) *The Paradigm Dialogue*. Sage.
- Guba, E. G. & Lincoln, Y. (2004). Competing paradigms in qualitative research: Theories and

- issues. In Hesse-Biber, S. N. & Leavy, P. (Eds.), *Approaches to Qualitative Research: A Reader on Theory and Practice* (pp.17-39). New York, NY: Oxford.
- Gutierrez, L., Helmus, L., & Hanson, R. (2016). What we know and don't know about risk assessment with offenders of Indigenous heritage. *Journal of Threat Assessment and Management*, 3(2), 97-106. doi:10.1037/tam0000064
- Haines, A., Perkins, E., Evans, E. A., & McCabe, R. (2018). Multidisciplinary team functioning and decision making within forensic mental health. *Mental health review (Brighton, England)*, 23(3), 185–196. <https://doi.org/10.1108/MHRJ-01-2018-0001>
- Hancock, P., & Jewkes, Y. (2011). Architectures of incarceration: The spatial pains of imprisonment. *Punishment & Society*, 13(5), 611-629.
- Harding, S. (2004). *The feminist standpoint theory reader: Intellectual and political controversies*. Routledge.
- Hardy, C., Harley, B., & Phillips, N. (2004). Discourse analysis and content analysis: Two solitudes. *Qualitative Methods*, 2(1), 19-22.
- Hardyman, P. & van Voorhis, P. (2004). Developing gender-specific classification systems for women offenders. U.S. Department of Justice, National Institute of Corrections.
- Harner, H., & Burgess, A. W. (2011). Using a Trauma-Informed Framework to Care for Incarcerated Women. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 40(4), 469–476. doi:10.1111/j.1552-6909.2011.01259.x
- Hatton, D. & Fisher, A. (2011). Using participatory methods to examine policy and women

- prisoners' health. *Policy, Politics, & Nursing Practice*, 12(2), 119-125.
- Hawkesworth, M. (1999). Analyzing backlash: Feminist standpoint theory as analytical tool. *Women's Studies International Forum*, 22, 135-155.
- doi:10.1016/S0277-5395(99)00003-5
- Head, D. (2017). *Evaluation of CSC's health services* (File #394-2-96). Ottawa, ON: Correctional Service of Canada.
- Health Canada and Indigenous Services Canada. (2015). *First Nations Mental Wellness Continuum Framework*. Ottawa, ON: Health Canada.
- Heidensohn, F. (1968). The deviance of women: A critique and an enquiry. *The British Journal of Sociology*, 19, 160-175.
- Heilbrun, K., DeMatteo, D., Yasuhara, K., Brooks-Holliday, S., Shah, S., King, C., ... Laduke, C. (2012). *Community-Based Alternatives for Justice-Involved Individuals with Severe Mental Illness*. *Criminal Justice and Behavior*, 39(4), 351-419.
- doi:10.1177/0093854811432421
- Henderson, A., & Jackson, M. (2004). Restorative health: Lessening the impact of previous abuse and violence in the lives of vulnerable girls. *Health Care for Women International*, 25(9), 794-812.
- Hill, E. (1998). Gender-informed archaeology: the priority of definition, the use of analogy, and the multivariate approach. *Journal of Archaeological Method and Theory*, 5(1), 99-128.

Holdcroft, A. (2007). Gender bias in research: How does it affect evidence based medicine?

Journal of the Royal Society of Medicine, 100(1), 2-3. doi:10.1258/jrsm.100.1.2

Holtfreter, K., Reisig, M. D., & Morash, M. (2004). Poverty, state capital, and recidivism among women offenders. *Criminology & Public Policy*, 3, 185-208.

Houser, K. A., Belenko, S., & Brennan, P. K. (2012). *The Effects of Mental Health and Substance Abuse Disorders on Institutional Misconduct Among Female Inmates*. *Justice Quarterly*, 29(6), 799–828. doi:10.1080/07418825.2011.641026

Howard, L. M., Ehrlich, A. M., Gamlen, F., & Oram, S. (2017). Gender-neutral mental health research is sex and gender biased. *The Lancet Psychiatry*, 4(1), 9-11. doi:10.1016/S2215-0366(16)30261-9

Hudson, J. I., Hiripi, E., Pope Jr, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, 61(3), 348-358.

Hume, L. (2015). *A gender-specific substance abuse program for federally-sentenced women*.

Retrieved from <https://www.csc-scc.gc.ca/research/forum/Vol16No1/v16-a14-eng.shtml>

Hutchison, J. (2019). “It’s sexual assault. It’s barbaric”: Strip searching in women’s prisons as state-inflicted sexual assault. *Affilia*, 088610991987827, 1-17.

doi:10.1177/0886109919878274

Indigenous Inclusion Directorate. (2019). *Smudging protocol and guidelines*. Government of Manitoba, Minister of Education and Training.

Jaffe, E., Palmquist, A., & Knittel, A. K. (2021). Experiences of menopause during incarceration.

Menopause, 28(7), 829-832. doi: [10.1097/gme.0000000000001762](https://doi.org/10.1097/gme.0000000000001762)

Jaggar, A. (2004). Feminist politics and epistemology: The standpoint of women. In S. G.

Harding (Ed.), *The feminist standpoint theory reader: Intellectual and political controversies* (pp.55-66). Routledge.

Jewkes, Y., Jordan, M., Wright, S., & Bendelow, G. (2019). Designing 'healthy' prisons for women: Incorporating trauma-informed care and practice (TICP) into prison planning and design. *International Journal of Environmental Research and Public Health*, 16(20), 3818. <https://doi.org/10.3390/ijerph16203818>

Jina, R., & Thomas, L. S. (2013). Health consequences of sexual violence against women. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 27(1), 15-26.

Johnson, J. E., Schonbrun, Y. C., Peabody, M. E., Shefner, R. T., Fernandes, K. M., Rosen, R. K., & Zlotnick, C. (2014). Provider experiences with prison care and aftercare for women with co-occurring mental health and substance use disorders: Treatment, resource, and systems integration challenges. *Journal of Behavioural Health Services & Research*, 42(4), 417-436. doi: 10.1007/s11414-014-9397-8

Jones, R., Patel, K., & Simpson, A. (2019). Assessment of need for inpatient treatment for mental disorder among female prisoners: A cross-sectional study of provincially detained women in Ontario. *BMC Psychiatry*, 19(98), 1-8. doi: 10.1186/s12888-019-2083-x

Kapoor, R., Dike, C., Burns, C., Carvalho, V., & Griffith, E. (2013). Cultural competence in

- correctional mental health. *International Journal of Law and Psychiatry*, 36, 273-280.
- Karlsson, M. E., & Zielinski, M. J. (2020). Sexual victimization and mental illness prevalence rates among incarcerated women: A literature review. *Trauma, Violence, & Abuse*, 21(2), 326-349.
- Kennedy, S. C., Mennicke, A. M., & Allen, C. (2020). 'I took care of my kids': Mothering while incarcerated. *Health & Justice*, 8(1), 12. <https://doi.org/10.1186/s40352-020-00109-3>
- Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E., Howes, M. J., Jin, R., Secnik, K., Spencer, T., Ustun, T. B., & Walters, E. E. (2005). The World Health Organization Adult ADHD Self-Report Scale (ASRS): A short screening scale for use in the general population. *Psychological Medicine*, 35(2), 245-56. doi: 10.1017/s0033291704002892.
- Kimerling, R., Allen, M. C., & Duncan, L. E. (2018). Chromosomes to social contexts: sex and gender differences in PTSD. *Current Psychiatry Reports*, 20(12), 114.
- King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research* (pp. 257–270). Sage.
- Kjelsberg, E., Hartvig, P., Bowitz, H., Kuisma, I., Norbech, P., Rustad, A., Seem, M., & Vik, T. (2006). Mental health consultations in a prison population: A descriptive study. *BMC Psychiatry*, 6(27), 1-9. doi:10.1186/1471-244X-6-27

- Knittel, A., Ti, A., Schear, S., & Comfort, M. (2017). Evidence-based recommendations to improve reproductive healthcare for incarcerated women. *International Journal of Prisoner Health*, 13(3/4), 200-206. doi:10.1108/IJPH-07-2016-0031
- Kouyoumdijan, F., Schuler, A., Matheson, F. I., & Hwang, S. P. (2016). Health status of prisoners in Canada. *Canadian Family Physician*, 62(3), 215-222.
- Lacey, M., Paolini, S., Hanlon, M. C., Melville, J., Galletly, C., & Campbell, L. E. (2015). Parents with serious mental illness: Differences in internalised and externalised mental illness stigma and gender stigma between mothers and fathers. *Psychiatry Research*, 225(3), 723-733.
- Lam, R. (2017, March 3). *B.C. Health Ministry to take responsibility for inmate health care*. The Globe and Mail. <https://www.theglobeandmail.com/news/national/bc-health-ministry-to-take-responsibility-for-inmate-health-care/article34207554/>
- LaPrairie, C. (1996). *Examining Aboriginal corrections in Canada*. Public Safety Canada. <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/xmng-brgnl-crrctns/xmng-brgnl-crrctns-eng.pdf>
- LaPrairie, C. (2002). Aboriginal over-representation in the criminal justice system: A tale of nine cities. *Canadian Journal of Criminology*, 44(181).
- Lawson, H. (2020). *Decriminalizing race: The case for investing in community and social support for imprisoned racialized women in Canada*. Canadian Centre for Policy

Alternatives.

<https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2020/09/Decriminalizing%20Race.pdf>

Leschied, A. W. (2011). *The treatment of incarcerated mentally disordered women offenders: A synthesis of current research*. Public Safety Canada.

<https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/2011-03-tmdw/index-en.aspx>

Li, S. H., & Graham, B. M. (2017). Why are women so vulnerable to anxiety, trauma-related and stress-related disorders? The potential role of sex hormones. *The Lancet Psychiatry*, 4(1), 73-82.

Lincoln, Y. & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lindqvist, A., Sendén, M. G., & Renström, E. A. (2020). What is gender, anyway: A review of the options for operationalising gender. *Psychology & Sexuality*, 1-13.

<https://doi.org/10.1080/19419899.2020.1729844>

Linzer M., Spitzer R., Kroenke K., Williams, J. B., Hahn, S., Broady, D., & deGruy, F. (1996).

Gender, quality of life, and mental disorders in primary care: Results from the PRIME-MD 1000 study. *American Journal of Medicine*, 101(5), 526-33.

Lombroso, C. & Ferrero, G. (1958). *Female Offender*. Philosophical Press.

Lynch, S. M., DeHart, D. D., Belknap, J., & Green, B. L. (2013). Women's pathways to jail: Examining mental health, trauma, and substance use. *BJA Policy Brief*, NCJ241045.

- Maeve, M. K. (2000). Speaking unavoidable truths: Understanding early childhood sexual and physical violence among women in prison. *Issues in Mental Health Nursing* 21(5), 473-498.
- MacKenzie, C., & Amirault, J. (2021). From Incarceration to Reintegration: Using the Human Services Model to Manage Canadian Prisoner Mental Health. *Journal of Correctional Health Care*, 27(1), 66-70.
- MacKenzie, K. (2020). *Mental health, violence, and Corrections Canada: A critical discourse analysis of 2 reports published by CS on mental health in federal corrections*. [Master's thesis, McMaster University] MacSphere: McMaster University Libraries Institutional Repositories.
- Makino, M., Tsuboi, K., & Dennerstein, L. (2004). Prevalence of eating disorders: a comparison of Western and non-Western countries. *Medscape General Medicine*, 6(3).
- Mallidou, A., Frisch, N., Doyle-Waters, M., MacLeod, M., Ward, J., & Atherton, P. (2018). Patient-oriented research competencies in health (PORCH) for patients, healthcare providers, decision-makers and researchers: Protocol of a scoping review. *Systematic Reviews*, 7(101), 1-10. doi: 10.1186/s13643-018-0762-1
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358(9280), 483-488.
- Marecek, J. & Gavey, N. (2013). DSM-5 and beyond: A critical feminist engagement with psychodiagnosis. *Feminism & Psychology*, 23(1), 3-9. doi: 10.1177/0959353512467962
- Martin, M. (2017). *Detection and treatment of mental illness among prison inmates: A validation*

- of mental health screening at intake to Correctional Service of Canada.* [Doctoral dissertation, University of Ottawa]. uO Research.
- Martin, M. S., Colman, I., Simpson, A. I., & McKenzie, K. (2013). Mental health screening tools in correctional institutions: a systematic review. *BMC Psychiatry, 13*(1), 1-10.
- Martin, M. S., Crocker, A. G., Potter, B. K., Wells, G. A., Grace, R. M., & Colman, I. (2018). Mental health screening and differences in access to care among prisoners. *The Canadian Journal of Psychiatry, 63*(10), 692-700.
- Martin, R. E., Buxton, J. A. Smith, M., & Hislop, G. (2012). The scope of the problem: The health of incarcerated women in BC. *BC Medical Journal, 54*(10), 502-508.
- Martin, R. E., Murphy, K., Chan, R., Ramsden, V. R., Granger-Brown, A., Macaulay, A. C., Kahlon, R., Ogilvie, G., & Hislop, T. G. (2009). Primary health care: Applying the principles within a community-based participatory health research project that began in a Canadian women's prison. *Global Health Promotion, 16*(4), 43-53.
- doi:10.1177/1757975909348114
- McDaniels-Wilson, C., & Belknap, J. (2008). The extensive sexual violation and sexual abuse histories of incarcerated women. *Violence Against Women, 14*(10), 1090-1127.
- McDermott, B. E. (2013). Coercion in research: Are prisoners the only vulnerable population? *The Journal of the American Academy of Psychiatry and the Law, 41*, 8-13.
- McLeod, K. E., & Martin, R. E. (2018). Health in correctional facilities is health in our communities. *CMAJ, 190*(10), E274-E275.
- Menzies, P. (2010). Intergenerational trauma from a mental health perspective. *Native Social*

Work Journal, 7, 63-85.

Miller, N. A. & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology*, 3(10), 17246. doi: 10.3402/ejpt.v3i0.17246

Mills, J. F., & Kroner, D. G. (2004). A new instrument to screen for depression, hopelessness and suicide in offenders. *Psychological Services*, 1, 83-91.

Mills, J. F. & Kroner, D. G. (2005). Screening for suicide risk factors in prison inmates: Evaluating the efficiency of the Depression, Hopelessness, and Suicide Screening From (DHS). *Legal and Criminal Psychology*, 10, 1-12.

Monchalin, L. (2016) "The Failed Foreign System of Criminal Justice and the Problem with Canada." In David Long and Olive Dickason (Eds.), *Visions of the Heart: Issues Involving Aboriginal Peoples in Canada* (pp.351-373). Oxford University Press.

Montreuil, M., Martineau, J. T., & Racine, E. (2019). Exploring ethical issues related to patient engagement in healthcare: Patient, clinician and researcher's perspectives. *Journal of bioethical inquiry*, 16(2), 237-248.

[M'sit No'kmaq](#), Marshall, A., Beazley, K. F., Hum, J., Joudry, S., Papadopoulos, A., Pictou, S.,

Rabesca, J., Young, L., & Zurba, M. (2021). "Awakening the sleeping giant": Re-Indigenization principles for transforming biodiversity conversation in Canada and beyond. *FACETS*, 6, 839-869. doi:10.1139/facets-2020-0083

Murphy, Y. & Sapers, H. (2020). Prison health as public health in Ontario corrections. *Journal of Community Safety and Well-Being*, 5(1), 19-25. <https://doi.org/10.35502/jcswb.122>

Naples, D. (2007). Feminist methodology and its discontents. In Outhwaite, W. & Turner, S. (Eds.), *The SAGE handbook of social science methodology* (pp.547-564). Thousand Oaks, CA: Sage.

Nicholls, T. L., Lee, Z., Corrado, R. R., & Olgoff, J. (2004). Women inmates' mental health needs: Evidence of the Validity of the Jail Screening Assessment Tool (JSAT). *International Journal of Forensic Mental Health*, 3(2), 167-184.

doi:10.1080/14999013.2004.10471205

Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998). Focus on women: Mothers with mental illness: I. The competing demands of parenting and living with mental illness. *Psychiatric Services*, 49(5), 635-642.

Office of the Correctional Investigator. (2014, September 10). *A three year review of federal inmate suicides*. <https://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf>

Office of the Correctional Investigator. (2015, June 26). *Annual report of the Office of the Correctional Investigator 2014-2015*.

<https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20142015-eng.aspx#s10>

Office of the Correctional Investigator. (2018, June 29). *Office of the Correctional Investigator Annual Report 2017-18*.

<https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20172018-eng.aspx>

Office of the Correctional Investigator. (2020, January 21). *Indigenous people in federal custody*

surpasses 30%: Correctional Investigatory issues statement and challenge.

<https://www.oci-bec.gc.ca/cnt/comm/press/press20200121-eng.aspx>

O'Keefe, M. L., & Schnell, M. J. (2007). Offenders with mental illness in the correctional system. *Journal of Offender Rehabilitation, 45*(1/2), 81-104.

O'Leary, C. M. (1998). Counteridentification or counterhegemony? Transforming feminist standpoint theory. *Women & Politics, 18*(3), 45-72. doi:10.1300/j014v18n03_04

Oram, S., Khalifeh, H., & Howard, L. M. (2017). Violence against women and mental health. *The Lancet Psychiatry, 4*(2), 159-170.

Oster, G. D., & Crone, P. G. (2004). *Using drawings in assessment and therapy: A guide for mental health professionals*. Psychology Press.

Palinkas, L. A., Horwitz, S. M., Chamberlain, P., Hurlburt, M. S., & Landsverk, J. (2011).

Mixed-methods designs in mental health services research: A review. *Psychiatric services, 62*(3), 255-263.

Parsons, T. (1951). *The Social System*. The Free Press.

Parsons, T. (1954). *Essays in Sociological Theory* (2nd ed.). The Free Press.

Parsons, T. (1967). *Structure of Social Action*. The Free Press.

Parsons, T. & Bales, R. (1955). *Family, Socialization and Interaction Process*. The Free Press.

Perdacher, E., Kavanagh, D., & Sheffield, J. (2019). Well-being and mental health interventions for Indigenous people in prison: Systematic review. *BJPsych Open*, 5(6), e95.

<https://doi.org/10.1192/bjo.2019.80>

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health*, 15(5), 599-611.

Pollack, S. (2009). “You can't have it both ways”: Punishment and treatment of imprisoned women. *Journal of Progressive Human Services*, 20(2), 112–128.

Pollack, S. (2019). Transformative praxis with incarcerated women: Collaboration, leadership, and voice. *Affilia: Journal of Women and Social Work*, 35(3), 1-14,
[doi:10.1177/0886109919886133](https://doi.org/10.1177/0886109919886133)

Popper, K. (1963). Science as falsification. *Conjectures and Refutations*, 1, 33-39.

Public Safety Canada. (2012). *Marginalized: The Aboriginal women's experience in federal corrections*. <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/mrgnlzd/mrgnlzd-eng.pdf>

Public Safety Canada. (2015, November 7). *Mental health action plan for federal offenders*.
<https://www.publicsafety.gc.ca/cnt/cntrng-crm/crrctns/mntl-hlth-ctn-pln-en.aspx>

Public Safety Canada. (2020, December 1). *Corrections and criminal justice policy*.
<https://www.publicsafety.gc.ca/cnt/cntrng-crm/crrctns/crrctns-plc-en.aspx>

- Qian, J., Hu, Q., Wan, Y., Li, T., Wu, M., Ren, Z., & Yu, D. (2013). Prevalence of eating disorders in the general population: a systematic review. *Shanghai Archives of Psychiatry*, 25(4), 212.
- Ragin, C. (2000). *Fuzzy-set social science*. University of Chicago Press.
- Richie, B. E. (2001). Challenges incarcerated women face as they return to their communities: Findings from life history interviews. *Crime & Delinquency*, 47(3), 368-389.
- Richie, B. E., & Johnsen, C. (1996). Abuse histories among newly incarcerated women in a New York City jail. *Journal of the American Medical Women's Association (1972)*, 51(3), 111-4.
- Riecher-Rössler, A. (2017a). Sex and gender differences in mental disorders. *The Lancet Psychiatry*, 4(1), 8-9.
- Riecher-Rössler, A. (2017b). Oestrogens, prolactin, hypothalamic-pituitary-gonadal axis, and schizophrenic psychoses. *The Lancet Psychiatry*, 4(1), 63-72.
- Robertson, K., & Murachver, T. (2007). Correlates of partner violence for incarcerated women and men. *Journal of Interpersonal Violence*, 22, 639-655.
- Rogers, A., & Pilgrim, D. (2011). Medical sociology and its relationship to other disciplines: The case of mental health and the ambivalent relationship between sociology and psychiatry. In *Handbook of the sociology of health, illness, and healing* (pp. 21-37). Springer.
- Rogstad, J. E. & Rogers, R. (2008). Gender differences in contributions of emotions to psychopathy and antisocial personality disorder. *Clinical Psychology Review*, 28,

1472-1484.

Rolin, K. (2009). Standpoint theory as a methodology for the study of power relations.

Hypatia, 24(4), 218-226.

Rowland, P., McMillan, S., McGillicuddy, P., & Richards, J. (2017). What is “the patient perspective” in patient engagement programs? Implicit logics and parallels to feminist theories. *Health*, 21(1), 76-92.

Rumboldt, J. (2019). An Analysis of the Over-Representation of Aboriginal Offenders in the Canadian Correctional System. *Footnotes*, 8.

Saldaña, J. (2016). *The coding manual for qualitative researchers (3rd ed.)*. Sage Publications Ltd.

Saleebey, D. (1992). *The strengths perspective in social work practice*. Longman.

Salisbury, E. J., & Van Voorhis, P. (2009). Gendered pathways: A quantitative investigation of women probationers' paths to incarceration. *Criminal justice and behavior*, 36(6), 541-566.

Samartzis, L., & Talias, M. A. (2019). Assessing and Improving the Quality in Mental Health Services. *International Journal of Environmental Research and Public Health*, 17(1), 249. <https://doi.org/10.3390/ijerph17010249>

Savage, L. (2019, January 10). *Female offenders in Canada, 2017*. Statistics Canada.

<https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00001-eng.htm>

Schultz, C., Walker, R., Bessarab, D., McMillan, F., MacLeod, J., & Marriott, R. (2014).

Interdisciplinary care to enhance mental health and social and emotional wellbeing. In P.

- Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 221-242). Australian Government Department of the Prime Minister and Cabinet.
- Scott, K., Bourassa, C., Dignan, T., Lavalee, B., Frechette, D., & Tomascik, P. (2014). *Examining 'cultural safety': Indigenous health values and principles as interpreted through the CanMEDS framework*. Royal College of Physicians and Surgeons of Canada.
- Sein Myint, N., Kunavikitul, W., & Stark, A. (2021). A contemporary understanding of organizational climate in healthcare setting: A concept analysis. *Nusing Forum*, 56(1), 172-180.
- Severson, R. E. (2019). Gender differences in mental health, institutional misconduct, and disciplinary segregation. *Criminal Justice and Behavior*, 46(12), 1719–1737. <https://doi.org/10.1177/0093854819869039>
- Shaywitz D. A., Martin, J. B., & Ausiello, D. A. (2000). Patient-oriented research: principles and new approaches to training. *The American Journal of Medicine*, 109(2), 136–40.
- Shepherd, S. M., & Willis-Esqueda, C. (2018). Indigenous perspectives on violence risk assessment: A thematic analysis. *Punishment & Society*, 20(5), 599-627.
- Slemon, A., Jenkins, E., & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24(4), e12199. <https://doi.org/10.1111/nin.12199>
- Snowshoe, A., Crooks, C. V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a cultural connectedness scale for First Nations youth. *Psychological Assessment*, 27 (1), 249–159. doi:10.1037/a0037867

Stoppard, J. M. (2000). *Understanding Depression: Feminist Social Constructionist Approaches*.
Routledge.

Strandh, M., Hammarström, A., Nilsson, K., Nordenmark, M., & Russel, H. (2013).

Unemployment, gender and mental health: the role of the gender regime. *Sociology of Health & Illness*, 35(5), 649-665

Strauss, M. (2019). "This messed up system was not designed for you": Women, freed from prison and organizing their rights. *New Labour Forum*, 29(1), 93-97. doi:

<https://doi.org/10.1177%2F1095796019891156>

Simon, V. (2005). Wanted: Women in clinical trials. *Science*, 308(5728), 1517.

Simpson, A., McMaster, J., & Cohen, S. (2013). Challenges for Canada in meeting the needs of persons with serious mental illness in prison. *Journal of the American Academy of Psychiatry and the Law*, 41(501), 1-9.

Smith, A. J., Farstad, S. M., & von Ranson, K. M. (2021). Self-reported eating disorder psychopathology prevalence in community-based female and male Albertans: Gender and age group comparisons. *International Journal of Eating Disorders*, 54(3), 438-444.

Smith, C. & Borland, J. (1999). Minor psychiatric disturbance in women serving a prison sentence: The use of the General Health Questionnaire in the estimation of the prevalence of non-psychotic disturbance in women prisoners. *Legal and Criminological Psychology*,

4, 273-284.

Smith, D. (1978). K is mentally ill: The anatomy of a factual account. *Sociology*, 12(27), 32-33.

doi:10.1177/003803857801200103

Smith, D. (1990). *The conceptual practices of power: A feminist sociology of knowledge*.

Northeastern University Press.

Smith, L. T. (2013). *Decolonizing methodologies: Research and Indigenous peoples*. Zed Books Ltd.

SPOR Evidence Alliance. (2019). *Patient partner appreciation policy and protocol*. SPOR Evidence Alliance.

Sprague, J. & Zimmerman, M. (2004). Overcoming dualisms: A feminist agenda for sociological methodology. In Hesse-Biber, S. N. & Leavy, P. (Eds.), *Approaches to qualitative research: A reader on theory and practice* (pp.39-61). New York, NY: Oxford.

Stewart, L. A., Archambault, K., & Wilton, G. (2013). Results of the Computerized Mental Health Screening System for Female Offenders. *Socialomics*, 2(2), 1-5.

doi:10.4172/2167-0358.1000103

Stewart, L. A., Harris, A., Wilton, G., Archambault, K.Y. Cousineau, C., Varrette, S., & Power, J. (2009). *R-218 An Initial Report on the Results of the Pilot of the Computerized Mental Health Intake Screening System (CoMHISS)*. Correctional Service of Canada.

Striegel-Moore, R. H., Rosselli, F., Perrin, N., DeBar, L., Wilson, G. T., May, A., & Kraemer, H.

- C. (2009). Gender difference in the prevalence of eating disorder symptoms. *International Journal of Eating Disorders*, 42(5), 471-474.
- Stuenkel, C. A., Davis, S. R., Gompel, A., Lumsden, M. A., Murad, M. H., Pinkerton, J. V., & Santen, R. J. (2015). Treatment of symptoms of the menopause: an endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, 100(11), 3975-4011.
- Sunderji, N., Angl, E. N., Polaha, J., & Gao, C. (2019). Why and how to use patient-oriented research to promote translational research. *Families, Systems, & Health*, 37(1), 1-9.
<http://dx.doi.org/10.1037/fsh0000405>
- Szeliga, A., Stefanowski, B., Meczekalski, B., Snopek, M., Kostrzak, A., Smolarczyk, R., Bala, G., Duszewska, A., Smolarczyk, K., & Maciejewska-Jeske, M. (2021). Menopause in women with schizophrenia, schizoaffective disorder and bipolar disorder. *Maturitas*, 152, 57-62. <https://doi.org/10.1016/j.maturitas.2021.07.003>
- Taylor, J. Y., Williams, R., & Eliason, M. J. (2002). Invisible, underserved, and diverse: The health of women in prison. *International Journal of Global Health*, 2(1), 28-42.
- The Standing Senate Committee on Human Rights. (2021, June). *Human rights of federally-sentenced persons*. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data.

American Journal of Evaluation, 27(2), 237-246.

Tewksbury, R. (2009). Qualitative versus quantitative methods: Understanding why qualitative methods are superior for criminology and criminal justice. *Journal of Theoretical and Philosophical Criminology* 1(1), 38-58

Truth and Reconciliation of Canada. (2015). *Honoring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Ottawa: Truth and Reconciliation Commission of Canada.

Tuttle, M. (2019, March 4). *Administrative segregation and the Charter or Rights and Freedoms*. ABlawg: The University of Calgary Faculty of Law Blog.
http://ablawg.ca/wpcontent/uploads/2019/03/Blog_MT_Administrative_Segregation_and_the_Charter.pdf

van den Bergh, B. J., Gatherer, A., Fraser, A., & Moller, L. (2011). Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bulletin of the World Health Organization*, 89, 689-694.

Van Den Tillaart, S., Kurtz, D., & Cash, P. (2009). Powerlessness, marginalized identity, and silencing of health concerns: Voiced realities of women living with a mental health diagnosis. *International Journal of Mental Health Nursing*, 18, 153-163. doi: 10.1111/j.1447-0349.2009.00599.x

- Vaswani, N., & Paul, S. (2019). 'It's Knowing the Right Things to Say and Do': Challenges and Opportunities for Trauma-informed Practice in the Prison Context. *The Howard Journal of Crime and Justice*, 58(4), 513-534
- Velez, M. P., Rosendaal, N., Alvarado, B., Da Câmara, S., Belanger, E., & Pirkle, C. (2019). Age at natural menopause and physical function in older women from Albania, Brazil, Colombia and Canada: A life-course perspective. *Maturitas*, 122, 22-30.
- Veysey, B. M. (2010). Mental health issues of incarcerated women. In B. L. Levin & M. A. Baker (Eds.), *A public health perspective of women's mental health*. pp. 245-260. Springer
- Vukic, A., Gregory, D., Martin-Misener, R., & Etowa, J. (2011). Aboriginal and Western conceptions of mental health and illness. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 9(1), 65-86.
- Walsh, K., DiLillo, D., & Scalora, M. J. (2011). The cumulative impact of sexual revictimization on emotion regulation difficulties: An examination of female inmates. *Violence Against Women*, 17(8), 1103-1118.
- 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. D., & Deng, X. C. (2015). Paths from trauma to intrapersonal strength: Worldview, posttraumatic growth, and wisdom. *Journal of Loss and Trauma*, 20(3), 253-266.
- 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.
- Wittchen, H. U. (2010). Women-specific mental disorders in DSM-V: Are we failing again? *Archives of Women's Mental Health, 13*(1), 51-55.
- 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.
- Woody, C. A., Baxter, A. J., Harris, M. G., Siskind, D. J., & Whiteford, H. A. (2018). Identifying characteristics and practices of multidisciplinary team reviews for patients with severe mental illness: a systematic review. *Australasian Psychiatry, 26*(3), 267–275. doi:10.1177/1039856217751783
- Wilton, G., Stewart, L. A., & Power, J. (2015). *Agreement among three mental health screening measures*. Correctional Service of Canada.
- World Health Organization. (2000). *Women's mental health: An evidence based review*.
https://apps.who.int/iris/bitstream/handle/10665/66539/WHO_MSD_MDP_00.1.pdf
- World Health Organization. (2002, June). *Gender and mental health*.
https://www.who.int/gender/other_health/genderMH.pdf
- World Health Organization. (2004). *Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and*

the University of Melbourne. World Health Organization.

World Health Organization (2008). *Report of the proceedings on gender and mental health.*

World Health Organization.

Wright, N., & Owen, S. (2001). Feminist conceptualizations of women's madness: A review of

the literature. *Journal of Advanced Nursing*, 36(1), 143-150. doi:10.1046/j.1365-

2648.2001.01951.x

Wynn, R., Høiseth, M. H., & Pettersen, G. (2012). Psychopathy in women: Theoretical and

clinical perspectives. *International Journal of Women's Health*, 4, 257-263.

doi:10.2147/ijwh.s25518

Yang, L. H., Wong, L. Y., Grivel, M. M., & Hasin, D. S. (2017). Stigma and substance use

disorders: an international phenomenon. *Current Opinion in Psychiatry*, 30(5), 378–388.

<https://doi.org/10.1097/YCO.0000000000000351>

Zwick, J., Appleseth, H. & Arndt, S. (2020). Stigma: How it affects the substance use disorder

patient. *Substance Abuse Treatment, Prevention, and Policy*, 15(50), 1-4.

<https://doi.org/10.1186/s13011-020-00288-0>

APPENDIX A: LETTER OF INFORMATION FOR PATIENTS

Letter of Information

“A patient-oriented approach towards gender-informed processes for mental health assessment for incarcerated women”

This is a research project being carried out by Maria Cruz and Dr. Colleen Dell from the Department of Sociology at the University of Saskatchewan in Saskatoon.

What is this study about?

This project would like to find out how the prison mental illness assessment could be improved, based on the experiences of women who have been in prison. Specifically, the research questions are:

- 1) How do women in the community view “assessment”?
- 2) What, if any, changes would women in the community like to see in the assessment procedures for mental illness?
- 3) How would have women in the community wanted to be assessed while they were in prison?

The findings of this study could be used to better address women’s mental health needs by making suggestions to the current psychiatric assessments used in Canadian prisons. Women in prison are more likely to be diagnosed with a mental illness than male prisoners. However, the current assessment procedures used have been based on research with all-male samples.

Moreover, by listening to women’s lived experiences, we hope to empower our participants.

Who are you recruiting?

We ask that our sample consists of individuals who meet all of the following criteria:

- identify as women in both biology (sex) and gender (i.e., does not include two-spirit or gender fluid individuals)
- previously incarcerated in a Canadian (federal or provincial) prison and have been living in the general community for at least 3 months
- received a mental illness diagnosis while in prison, or had a prior diagnosis verified while in prison

What would I be participating in?

You will be participating in two interviews for 15-60 minutes each in duration. The first interview will be general introductions, and the second will consist of questions that ask for your views on the current mental health assessment processes used in prison. Due to the current social distancing measures, the interviews will be conducted over the phone. Should these measures be lifted, then interviews will be held in person at the Arts Building (Room 1023 – 9 Campus Drive, Saskatoon) at the University of Saskatchewan.

Is my participation voluntary?

Yes. You are encouraged to answer all questions as honestly as possible, but are under no obligation to reply to any question you do not wish to answer. You may also withdraw at any time. If you choose to withdraw, you may ask that part or all of the data that you have supplied

be destroyed and not included in the results of the study. To withdraw after your participation, you would simply need to contact Maria Cruz and let her know you no longer wish to participate in the study. She will then destroy any data collected from you.

What will happen to my responses?

Your participation in this research project is completely confidential. All identifying information will be replaced with pseudonyms or codes. Digitally recorded interviews will be destroyed after five years, and each participant given a pseudonym by the researchers. Transcript files with pseudonyms will be saved to a memory stick and stored in a locked filing cabinet that only the research team can access. As per the Behavioural Research Ethics Board policies at the University of Saskatchewan, information will be stored for 5 years after the project is complete, or until you withdraw. After this period, or after withdrawal, your data will be destroyed.

Confidentiality:

While every effort will be made to ensure your confidentiality is guaranteed, due to the small number of participants, confidentiality cannot be guaranteed; however, all information presented in public forums will be anonymized through the use of pseudonyms. This includes your identifying information. Any information provided will only be accessible in its complete form to the researchers. Data may be published in professional journals, presented at academic conferences, and included in thesis work but the data will never be published in full. Every effort will be made to avoid including identifying information.

Will I be compensated for my participation? Yes. Each participant will receive an honorarium of \$50.00.

What if I have concerns?

Any questions about study participation may be directed to the Research Coordinators, Maria Cruz (mtc785@mail.usask.ca) or Dr. Colleen Dell (colleen.dell@usask.ca). Any ethical concerns about the study may be directed to the Behavioural Research Ethics Board at ethics.office@usask.ca or (306) 966-2975. Out of town participants may call toll free 1 (888) 966-2975.

Again, thank you. Your interest in participating in this research study is greatly appreciated.

This study has been granted clearance according to the recommended principles of Canadian ethics guidelines, and Behavioural Research Ethics Board policies at the University of Saskatchewan.

APPENDIX B: LETTER OF INFORMATION FOR SERVICE PROVIDERS

Letter of Information

“A patient-oriented approach towards gender-informed processes for mental health assessment for incarcerated women”

This is a research project being carried out by Maria Cruz and Dr. Colleen Dell from the Department of Sociology at the University of Saskatchewan in Saskatoon.

What is this study about?

This project would like to find out how the prison mental illness assessment could be improved, based on the experiences of women who have been in prison. To enrich our data, we would like to also include the experiences of staff members from various chapters of the Elizabeth Fry Society, as they may have extensive knowledge about this topic due to the nature of their work. Specifically, the research questions are:

- 1) How do women in the community view “assessment”?
- 2) What, if any, changes would women in the community like to see in the assessment procedures for mental illness?
- 3) How would have women in the community wanted to be assessed while they were in prison?

The findings of this study could be used to better address women’s mental health needs by making suggestions to the current psychiatric assessments used in Canadian prisons. Women in prison are more likely to be diagnosed with a mental illness than male prisoners. However, the

current assessment procedures used have been based on research with all-male samples. Moreover, by listening to women's lived experiences, we hope to empower our participants.

What would I be participating in?

You will be participating in one phone interview, which will be approximately 45-60 minutes in duration. The interview will consist of questions that ask for your views on the current mental health assessment processes used in prison.

Is my participation voluntary?

Yes. You are encouraged to answer all questions as honestly as possible, but are under no obligation to reply to any question you do not wish to answer. You may also withdraw at any time. If you choose to withdraw, you may ask that part or all of the data that you have supplied be destroyed and not included in the results of the study. To withdraw after your participation, you would simply need to contact Maria Cruz and let her know you no longer wish to participate in the study. She will then destroy any data collected from you.

What will happen to my responses?

Your participation in this research project is completely confidential. All identifying information will be replaced with pseudonyms or codes. Digitally recorded interviews will be stored for five years, and each participant given a pseudonym by the researchers. Transcript files with pseudonyms will be saved to a memory stick and stored in a locked filing cabinet that only the research team can access. As per the Behavioural Research Ethics Board policies at the

University of Saskatchewan, information will be stored for 5 years after the project is complete, or until you withdraw. After this period, or after withdrawal, your data will be destroyed.

Confidentiality:

While every effort will be made to ensure your confidentiality is guaranteed, due to the small number of participants, confidentiality cannot be guaranteed; however, all information presented in public forums will be anonymized through the use of pseudonyms. This includes your identifying information, as well as the organization that you represent. Any information provided will only be accessible in its complete form to the researchers. Data may be published in professional journals, presented at academic conferences, and included in thesis work but the data will never be published in full. Every effort will be made to avoid including identifying information.

Will I be compensated for my participation? Yes. Each participant will receive an honorarium of \$50.00.

What if I have concerns?

Any questions about study participation may be directed to the Research Coordinators, Maria Cruz (mtc785@mail.usask.ca) or Dr. Colleen Dell (colleen.dell@usask.ca). Any ethical concerns about the study may be directed to the Behavioural Research Ethics Board at ethics.office@usask.ca or (306) 966-2975. Out of town participants may call toll free 1 (888) 966-2975.

Again, thank you. Your interest in participating in this research study is greatly appreciated.

This study has been granted clearance according to the recommended principles of Canadian ethics guidelines, and Behavioural Research Ethics Board policies at the University of Saskatchewan.

APPENDIX C: RECRUITMENT POSTER



PARTICIPANTS NEEDED

for a Community-based Research Study on Prison Psychiatric Assessments

Community women with a mental illness/psychiatric diagnosis are invited to participate in a research study with the Department of Sociology at the University of Saskatchewan.

The purpose of this study is to:

- **Understand** prison mental health assessments from a **woman's experience**
- Use women's experiences to **improve prison mental health assessments**
- **Empower women in the community** by validating their experiences and voices

This study will be administered through **2 telephone interviews**. The first phone call will be a 15-minute conversation which will discuss background information, hobbies, and interests. The second phone call may be 45-60 minutes, and will draw more on experiences of assessment.

Each participant will receive an honorarium for their participation.



This research has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board (BEH-1991).

To find out more about this study and your eligibility as a participant, please contact:

Maria Cruz, Masters Student in Sociology

mtc785@mail.usask.ca

APPENDIX D: CONSENT FORM FOR PATIENTS



UNIVERSITY OF
SASKATCHEWAN

✦ **Department of Sociology**

Room 1019 - 9 Campus Drive Saskatoon SK S7N 5A5 Canada

Telephone: (306) 966-6947 Facsimile: (306) 966-6950

Email: sociology@usask.ca

Contact Information:

Colleen Dell, PhD. (Principal Investigator)

Department of Sociology

Room 1109 - 9 Campus Drive

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colleen.dell@usask.ca

Maria Cruz (Student Researcher)

Department of Sociology

Room 1019 - 9 Campus Drive

Saskatoon, SK S7N 5A5 Canada

mtc785@mail.usask.ca

Consent Form

Purpose and Procedure: The aim of this study is to include the voices of women with lived experience of incarceration to suggest how prison mental health assessments can be improved. In this study, participants will participate in two interviews with the student researcher, Maria Cruz. The first interview should take 10-15 minutes as it serves as an introduction to the study. The second interview will be approximately 45-60 minutes and draw on your perspectives about the mental health assessments used in prison. Due to the current social distancing measures, the interviews will be conducted over the phone. Should these measures be lifted, then interviews will be held in person at the Arts Building (Room 1023 – 9 Campus Drive, Saskatoon) at the University of Saskatchewan. The interview questions will give you the opportunity to explain what you think would be a sufficient prison mental health assessment for women, and how you think this process can be carried out.

Potential Benefits & Risks: We understand that some questions might bring up feelings of distress. Should this occur, the following are emotional and mental health support services specific for women with lived experience of incarceration:

Elizabeth Fry Society of Canada

190 Bronson Ave., Ottawa, Ontario K1R 6H4

(613) 238-2422

1 (800) 637-4606

admin@caefs.ca



• Department of Sociology

Room 1019 - 9 Campus Drive Saskatoon SK S7N 5A5 Canada
Telephone: (306) 966-6947 Facsimile: (306) 966-6950
Email: sociology@usask.ca

Elizabeth Fry Society of Saskatchewan
1120 20th St W Suite 205, Saskatoon, SK S7M 0Y8
(306) 934-4606
reception@elizabethfrysask.org

Additionally, the following are 24-hour emotional and mental health support services:

HealthLine
811

Saskatchewan Mental Health Services
(306) 665-7777

While the goal of this research project is to empower women who have been in prison, and make recommendations for the prison assessment processes, there is no guarantee that you will personally benefit from your involvement. However, each participant will be compensated with a \$50 honorarium. We hope that participants can appreciate the anticipated positive outcomes that can result from conducting this study. In the case that you choose to withdraw during the data collection process, you will still be compensated with the full value of the honorarium.

Storage of Data: Your participation in this research project is completely confidential. This consent form will be stored separately from interview data. All identifying information will be replaced with pseudonyms or codes. The phone interview will be recorded using a digital recorder that has a secure digital card with removable storage. As per the guidelines outlined by the Behavioural Research Ethics Board at the University of Saskatchewan, digitally recorded interviews will be kept for the full 5-year post-publication retention period. After this period, or after withdrawal, your data will be destroyed. All digital files, including recordings and documents of the interview, will be deleted from all storage locations. Only the principal investigator and members of the research team will have access to this information. The principal investigator, Dr. Colleen Dell, will be responsible for the long-term storage of this data.

You will have the opportunity to review and revise the transcript of your interview. A digital copy of your transcripts will be sent to the email address that you provided. Any revisions must be sent to the student researcher two weeks from the date that the transcript is received. If no revisions are received within this two-week period, then the transcript will be analyzed in its present form.



Department of Sociology
Room 1019 - 9 Campus Drive Saskatoon SK S7N 5A5 Canada
Telephone: (306) 966-6947 Facsimile: (306) 966-6950
Email: sociology@usask.ca

Confidentiality: While every effort will be made to ensure confidentiality during the interview process, due to the small number of participants, confidentiality cannot be guaranteed; however, all information presented in public forums will be anonymized through the use of pseudonyms. The researchers will use a master list that contains identifying information to keep track of the dates of the scheduled interviews, contact information to send the digital transcripts, and whether the honorarium was received. This master list will be stored separately from the data and will be deleted immediately after the data collection process is complete. Any information provided will only be accessible in its complete form to the researchers. The audio recordings of your interviews will be transcribed by a transcriptionist who will sign a confidentiality agreement. Data will be available in its de-identified form to the project advisory committee, which includes women with lived experience of incarceration and mental illness and a member of the Elizabeth Fry Society of Saskatchewan. Data may be published in professional journals, presented at academic conferences, and included in academic work, but they will only appear in excerpted form. Every effort will be made to avoid explicitly identifying information of the informant who supplied it.

Right to Withdraw: Your participation is voluntary, and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. You can request for the audio recording device to be turned off at any time without giving a reason. You are under no obligation to reply to any question you do not wish to answer. Your decision to participate, or to not participate will not affect your access to social services, healthcare, education, employment, or how you will be treated. The deadline for withdrawing your data is one month after your participation in this study.

Questions: This research project has been approved by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office at ethics.office@usask.ca or (306) 966-2975. Out of town participants may call toll free at (888) 966-2975.

Debriefing: Once you have finished the study, you will be provided with the research team's contact information. If you would like to request a copy of the final results, please contact the researchers at the email addresses provided.

Project Funding: This research is funded by the Social Sciences and Humanities Research Council and the Centre for Forensic Behavioural Science and Justice Studies at the University of Saskatchewan.



Department of Sociology

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Email: sociology@usask.ca

Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

I consent to having interviews audio recorded.

If you do not consent to having your interview audio recorded, then the student researcher will take notes during the interview.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Oral Consent: I read and explained this consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

Name of Participant

Researcher's Signature

Date

APPENDIX E: CONSENT FORM FOR SERVICE PROVIDERS



Department of Sociology

Room 1019 - 9 Campus Drive Saskatoon SK S7N 5A5 Canada

Telephone: (306) 966-6947 Facsimile: (306) 966-6950

Email: sociology@usask.ca

Contact Information:

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colleen.dell@usask.ca

Maria Cruz (Student Researcher)

Department of Sociology

Room 1019 - 9 Campus Drive

Saskatoon, SK S7N 5A5 Canada

mtc785@mail.usask.ca

Consent Form

Purpose and Procedure: The aim of this study is to include both the voices of women with lived experience of incarceration and staff members from various chapters of the Elizabeth Fry Society to suggest how prison mental health assessments can be improved. In this study, participants will participate in a 45-60 minute phone interview with the student researcher, Maria Cruz. The interview questions will give you the opportunity to explain what you think would be a sufficient prison mental health assessment for women, and how you think this process can be carried out.

Potential Benefits & Risks: There are no known risks to your participation. While the goal of this research project is to empower women who have been in prison and make recommendations for the prison assessment processes, there is no guarantee that you will personally benefit from your involvement. However, each participant will be awarded with a \$50 honorarium. We hope that participants can appreciate the anticipated positive outcomes that can result from being involved with this study. In the case that you choose to withdraw during the data collection process, you will still be compensated with the full value of the honorarium.

Storage of Data: Your participation in this research project is completely confidential. This consent form will be stored separately from interview data. All identifying information will be replaced with pseudonyms or codes. The phone interview will be recorded using a digital recorder that has a secure digital card with removable storage. As per the guidelines outlined by the Behavioural Research Ethics Board at the University of Saskatchewan, digitally recorded interviews will be kept for the full 5-year post-publication retention period. After this period, or

after withdrawal, your data will be destroyed. All digital files, including recordings and documents of the interview, will be deleted from all storage locations. Only the principal investigator and members of the research team will have access to this information. The principal investigator, Dr. Colleen Dell, will be responsible for the long-term storage of this data.

You will have the opportunity to review and revise the transcript of your interview. A digital copy of your transcripts will be sent to the email address that you provided. Any revisions must be sent to the student researcher two weeks from the date that the transcript is received. If no revisions are received within this two-week period, then the transcript will be analyzed in its present form.

Confidentiality: While every effort will be made to ensure confidentiality during the interview process, due to the small number of participants, confidentiality cannot be guaranteed; however, all information presented in public forums will be anonymized through the use of pseudonyms. The researchers will use a master list that contains identifying information to keep track of the dates of the scheduled interviews, contact information to send the digital transcripts, and whether the honorarium was received. This master list will be stored separately from the data and will be deleted immediately after the data collection process is complete. Any information provided will only be accessible in its complete form to the researchers. The audio recording of your interview will be transcribed by a transcriptionist who will sign a confidentiality agreement. Data will be available in its de-identified form to the project advisory committee, which includes women with lived experience of incarceration and mental illness and a member of the Elizabeth Fry Society of Saskatchewan. Data may be published in professional journals, presented at academic conferences, and included in academic work, but they will only appear in excerpted form. Every effort will be made to avoid explicitly identifying information of the informant who supplied it.

Right to Withdraw: Your participation is voluntary, and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. You can request for the audio recording device to be turned off at any time without giving a reason. You are under no obligation to reply to any question you do not wish to answer. Your decision to participate, or to not participate will not affect your access to social services, healthcare, education, employment, or how you will be treated. The deadline for withdrawing your data is one month after your participation in this study.

Questions: This research project has been approved by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that



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committee through the Research Ethics Office at ethics.office@usask.ca or (306) 966-2975. Out of town participants may call toll free at (888) 966-2975.

Debriefing: Once you have finished the study, you will be provided with the research team’s contact information. If you would like to request a copy of the final results, please contact the researchers at the email addresses provided.

Project Funding: This research is funded by the Social Sciences and Humanities Research Council and the Centre for Forensic Behavioural Science and Justice Studies at the University of Saskatchewan.

Signed Consent: Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

I consent to having interviews audio recorded.

If you do not consent to having your interview audio recorded, then the student researcher will take notes during the interview.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Oral Consent: I read and explained this consent form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.

Name of Participant

Researcher’s Signature

Date

APPENDIX F: INTERVIEW GUIDE FOR PATIENT INTERVIEWS

Patient Interview 1

Hello, I'm _____.

Thank you very much for agreeing to take part in this interview today. As a person who is willing to share your knowledge and experience as a mental health patient in prison, your perspectives are invaluable to our research, and I encourage you to share as detailed responses to the questions as you wish to. I also want to let you know that I will be reading from this script to ensure consistency across interviews.

In the interview I'm going to ask you questions that give you the opportunity to describe your experience having undergone a mental health assessment in prison, your opinions about the current mental health assessments used in prison, and how you think these assessment processes can be improved for women in prison. I assure you that all of the information you provide will be stored and analyzed in accordance with the Behavioural Research Ethics Board requirements at the University of Saskatchewan. Information that personally identifies you will never be associated with the data, and data will only be published anonymously.

Before I begin the interview, I want to take a moment to remind you that your participation in this interview today is completely voluntary. If at any point during the interview you would prefer to no longer take part in the process you are welcome to end the call. Information collected from individuals who choose to withdraw is not analyzed and will be destroyed at the

first available opportunity. Also, if there are particular questions that you would prefer not to answer for any reason I understand. You are under no obligation to provide any information that you would prefer not to.

[Even though I have to read from this script, I just wanted to emphasize that there are no trick questions in this interview. The point isn't to coerce you or draw specific answers from you.]

Finally, may I please have your permission to digital record our interview today for the purpose of transcription at a later point? The digital audio recording will never be used as a means to identify you with any comments made today.

Receive or fail to receive participant permission to tape record interview.

First, I would like for you to tell me a little bit about yourself.

- 1) What is your age?
- 2) Where did you grow up?
- 3) What are your hobbies?
- 4) Are you in school or do you work?
 - a. What are you studying/where are you working?
 - b. How long have you been doing that for?
- 5) Do you have any children or nieces/nephews?
- 6) What is your gender identity?
- 7) What is your ethnicity or cultural background?
- 8) How long ago were you released from prison?

Great, thank you. For the next interview, I'd like to talk a bit more about the mental health and illness assessment processes that were used while you were in prison. In preparation for our next call, is there anything else you would like to talk about or let me know during this time?

Patient Interview 2

Hi again,

Similar to last time, you are encouraged to describe in detail your experiences and perspectives about the mental health assessments used in prison, but are under no obligation to answer questions you are not comfortable with. If at any point during the interview you would prefer to no longer take part in the process you are welcome to end the call. I assure you that all of the information that you do provide will be stored and analyzed in accordance with the Behavioural Research Ethics Board requirements at the University of Saskatchewan. Any information collected from individuals who choose to withdraw is not analyzed and will be destroyed at the first available opportunity.

May I ask for your permission to digitally record this interview for the purpose of transcription at a later point?

Great, thank you.

- 1) For the first question, I'd like to know if you will be drawing from your experience in federal or provincial prisons, or experiences in both settings?
 - a. How long was your prison sentence(s)?
- 2) The focus of this study is the prison mental health assessment process. First may I ask what does the word "assessment" mean to you?
- 3) What was the intake assessment process(es) like?

- a. What records did they share with you (about what was written about you)?
- 4) What elements of mental health or illness were discussed during the assessment process(es)?
- 5) What programs were available in prison to manage your diagnosis?

Thank you. For this study, my aim is to give women the opportunity to voice their opinions about mental health assessments and validate their experiences. The next set of questions focus on your perspectives about how to improve these procedures.

- 9) What elements of the mental health assessment process did you find to be helpful?
 - a. Why did you find these elements to be helpful?
- 10) What elements did you not find to be helpful?
 - a. Why did you not find these to be helpful?
- 11) Based on your experience in a [federal and/or provincial] prison setting, what do you think a mental illness assessment process for incarcerated women would look like?
 - a. What measures do you think would be relevant to women that are not already included?
 - b. Who do you think should be conducting the assessment?
 - i. Does the gender of the assessor matter?
 - ii. What training should they have?
 - iii. How should these assessments be administered?
 - 1. How many people should be present in the room?
 - 2. How long should they take?
 - c. How do you think this could be implemented?

Great, thank you. Now in taking this altogether, I'd like to explore how this assessment process affected you.

12) How did this process of assessment affect your perceptions of the criminal justice system?

13) How did this process of assessment or your resulting mental illness diagnosis affect your perception of yourself as a former patient in the prison system or as a woman in the community?

Finally, I would like to know if you would like to add anything else that was not covered in the interview?

Thank you so much for your time today. Your insights are very helpful to our research.

APPENDIX G: INTERVIEW GUIDE FOR SERVICE PROVIDER INTERVIEWS

Hello, I'm _____.

Thank you very much for agreeing to take part in this interview today about your experience as a staff member with the Elizabeth Fry Society of [chapter]. As a person who is willing to share your knowledge about prison mental health and psychiatric assessments and/or who has worked with women in prison and in the community, your perspectives are invaluable to our research, and I encourage you to share as detailed responses to the questions as you wish to. I also want to let you know that I will be reading from this script to ensure consistency across interviews.

In the interview I'm going to ask you questions that give you the opportunity to describe your work experience, your opinions about the current mental health and illness assessments used in prison, and how you think these assessment processes can be improved for women in prison. I assure you that all of the information you provide will be stored and analyzed in accordance with the Behavioural Research Ethics Board requirements at the University of Saskatchewan.

Information that personally identifies you will never be associated with the data, and data will only be published anonymously.

Before I begin the interview, I want to take a moment to remind you that your participation in this interview today is completely voluntary. If at any point during the interview you would prefer to no longer take part in the process you are welcome to end the call. Information collected from individuals who choose to withdraw is not analyzed and will be destroyed at the first available opportunity. Also, if there are particular questions that you would prefer not to

answer for any reason I understand. You are under no obligation to provide any information that you would prefer not to.

[Even though I have to read from this script, I just wanted to emphasize that there are no trick questions in this interview. The point isn't to coerce you or draw specific answers from you.]

Finally, may I please have your permission to digital record our interview today for the purpose of transcription at a later point? The digital audio recording will never be used as a means to identify you with any comments made today.

Receive or fail to receive participant permission to tape record interview.

First, I would like to gather some basic demographics information:

- 1) What is your age?
- 2) What is your gender identity?
- 3) What is your ethnicity?
- 4) How long have you worked with the Elizabeth Fry Society of [chapter name]?
- 5) What is your experience working with women in the community?
- 6) What is your experience working with women in prison?
 - a. Federal or provincial prisons?
- 7) Why were you interested in pursuing this line of work?

Thank you. That helps provide some background information. Now I would like to gather your thoughts about the focus of this study, the prison mental health assessment process.

- 8) First, may I ask what does the word “assessment” mean to you?
- 9) Based on your experience and knowledge, what is the prison intake assessment process like?
- 10) Based on your experience and knowledge, what is the mental health assessment process like?
- 11) Have you received any feedback from the women that you’ve worked with about the assessment process?
 - a. How the process of assessment or being diagnosed with a mental illness has affected their self-image or identity?
 - b. How the process of assessment or being diagnosed with a mental illness has affected their perceptions of the criminal justice system?

Now that I have a better understanding of these assessments, I would like to give you the opportunity to discuss your opinions about these processes.

- 12) Based on your experience and knowledge, what elements of the mental health assessment process do you think are helpful?
 - a. Why do you think these are helpful?
- 13) Based on your experience and knowledge, what elements of the mental health assessment process do you think are not helpful?
 - a. Why do you think these are not helpful?

14) Based on your experience and knowledge, what would a mental illness assessment look like for women in a prison setting?

- a. What measures do you think would be relevant that are not already included?
- b. Who do you think should be conducting the assessment?
 - i. Does gender matter?
 - ii. What training should they have?
 - iii. How should these assessments be administered?
 1. How many people should be present in the room?
 2. How long should they take?
 - iv. How do you think this could be implemented?

Finally, I would like to know if you would like to add anything else that was not covered in the interview?

Thank you so much for your time today. Your insights are very helpful to our research.