Health & Mental Health

• HIV/AIDS was recognized as an international security issue by the United Nations Security Council in January 2000.

• In many countries of the world, including Canada, rates of HIV and HCV infection in prison populations are much higher than those found in the general population. This is result of the continued criminalization of drug users as well as lack of access to safe injection practices in the community and within prisons.

• Women represent an increasing proportion of the total number of AIDS cases reported in Canada. In 1993, women represented 7.5% of reported AIDS cases; in 2003, women represented 24.8%.

• Women represent an increasing proportion of reported HIV cases in Canada, accounting for 25.1% of positive HIV test reports in 2002. The proportion varies considerably by age and is highest among young women (15-29 years old). Aboriginal and Black women have also been identified as vulnerable populations.

• A recent study found that the number of known HIV cases in Canadian prisons has risen by 35 percent in the last five years, suggesting that HIV may be spreading in prisons.[1]

• The HIV infection rate among women in prison in 2001 was higher than among male prisoners (4.7% v. 1.7%) A 2003 study of federally sentenced women found that 19% reported engaging in injection drug use while in prison.

• In 2001, reported rates of hepatitis C infection were higher among women prisoners than among men prisoners (41.2% v. 23.2%), this may in part be due to the higher proportion of testing among women (45%) than men (26%) occasioned by more frequent healthcare visits.

• Non-sterile injection drug practices and unprotected sexual activity with a drug user were found to be the strongest risk factors for HIV infection.

• Most prisoners will eventually be released into the community, so infection rates pose a threat to public health as well as the health of those who are currently imprisoned.

• Prisoners are 20 times more likely to have been infected with Hepatitis C and 10 times more likely to be infected with HIV than the general Canadian population.

• Despite the undeniable recognition of the benefits of harm reduction initiatives, a needle exchange program has yet to be introduced to curtail the spread of infectious diseases such as Hepatitis C and HIV within and outside the penitentiary walls.[2]

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[1] *Infectious Disease Prevention and Control in Canadian Federal Penitentiaries 2000-2001*. Correctional Services of Canada.

[2] *Annual Report of the Correctional Investigator,* 2006.

• Low income Canadians, particularly women, experience greater health concerns and on average die sooner than higher income Canadians.[3]

• Low-income Canadian women are less likely to survive childbirth, more likely to experience ill health and more likely to live fewer years than wealthier women. They will also spend more of their years (particularly their senior years) in ill health.[4]

• Aboriginal women experience ill health far more often and broadly than women in general. They experience heart problems and hypertension at rates two-and-a half times the average, and diabetes at a rate five times more frequent than other women. These health statistics are understood to stem from problems of access to health services flowing from a lack of aboriginal health services, overly clinical approaches to health care, environmental degradation leading to significant dietary changes, deeper poverty and grave inadequacy in health services.[5]

• Although providing health care for over 100 years, of the CSC health care sites that provided health care to prisoners in 2006, 52 per cent of the sites failed to be accredited, 38 per cent were accredited with conditions, and only 10 per cent were fully accredited. Two key factors that prevented accreditation included the inadequacy of the existing clinical governance structure and the absence of continuing professional education and training for health care staff. Accreditation for the remaining sites has been put on hold.[6]

Mental Health

• The mental health issues faced by some federally sentenced women are considerable and tend to be different than those of their male counterparts. Many women are survivors of prior abuse, and the present effects of that abuse may impact on their mental health. More federally sentenced women have received a diagnosis of mental illness and women in federal correctional institutions have a higher rate of self-mutilation and attempted suicide than their male counterparts. In many cases women are harming themselves primarily as a means of coping with the distress caused by incarceration.

• Despite the reality that most women classified as maximum security prisoners who have a mental or cognitive disability are described by correctional authorities as not being capable of "managing" in general population, there is no significant statistical difference in the institutional adjustment of women with mental disabilities as compared to women with no mental health disability.

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[3] Canadian Association of Social Workers. (2006) *The Declining Health and Well-Being of Low Income Women in Canada.*
[4] Canadian Association of Social Workers. (2006) *The Declining Health and Well-Being of Low Income Women in Canada.*
[5] Canadian Association of Social Workers (2006) The Declining Health and Well-Being of Low Income Women in Canada.
[6] *Annual Report of the Correctional Investigator,* 2006

• Women access the mental health system more frequently, receive treatment more often, and have higher rates of hospitalization for psychiatric problems than men do.

• The Correctional Service of Canada has failed to demonstrate that it meets its statutory obligation to provide essential mental health care and reasonable access to non-essential mental health care in accordance to "professionally accepted standards." Over the last decade, the number of mentally ill prisoners has more than doubled, yet the level of mental health services within its institutions has remained the same or diminished.[7]

• For women with mental illness, poverty is often associated with increased risk of violence and abuse.

• The legacies of colonization and residential schooling have resulted in cultural discontinuity and oppression in Aboriginal communities that have been tied to high rates of depression, alcoholism, suicide, and violence against Aboriginal women. Between 1989 and 1993, Aboriginal women in Canada were more than three times as likely to commit suicide as were non-Aboriginal women.

• It has been found that mental health systems still emphasize bio- medical aspects of illness over social factors in women's lives.

• There is a need for further research to examine the under- theorized link between mental illness and addictions to help provide effective programs and services for women.

Fetal Alcohol Spectrum Disorders

• Fetal Alcohol Syndrome was first identified in 1973 in the American medical literature. Diagnosis relies upon detection of facial abnormalities, growth deficiencies and central nervous system impairment presumed due to alcohol consumption during pregnancy. The range and severity of the impact of maternal alcohol use is related to variations in the timing of alcohol use, variations in the amount of alcohol use, malnutrition, poor overall health of the mother and many other contextual matters.

• Pregnant women and mothers have been stigmatized according to this medical and social problem. The moral construction of the risks related to drinking during pregnancy individualizes the social responsibility on women, and has even been criminalized in some areas of the US.

• In Canada, the dominant approach to preventing Fetal Alcohol Spectrum Disorders has been to focus on a single determinant, alcohol use and on the impact on children's health. There must be further consideration of other situational and social risk factors that are related to FAS/E such as socioeconomic status, multiple drug use, poor water and food quality and inadequate health care.

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[7] *Annual Report of the Correctional Investigator,* 2006.

• Prevention of FAS is largely based on this assumption of individualized responsibility and focuses only on substance abstinence rather than considering a need for collective action, attempts to ameliorate social inequality, and the need for social change.

• Mothers of children with the full syndrome have been found to have co-morbid histories of serious violence and trauma, serious mental health problems, and difficult relationships in which partners often control their substance use and access to services.

• Fetal Alcohol Spectrum Disorder (FASD) was introduced to umbrella the associated diagnostics of FAS and Alcohol-Related Effects, such as Alcohol-Related Birth Defects (ARBD) and Alcohol Related Neuro Developmental Disorder (ARND). Increasing studies focusing on the social factors of FASD have debunked the element of the syndrome from the stigmatizing diagnosis. Critiques are emerging of the cultural, racial, gendered, socio - economic and classed nature of theories on FAS/E/D .

Addictions

• In a Saskatchewan study, treatment centre staff ranked lost cultural identity as the single most important factor for drug and alcohol abuse among Aboriginal people.

• The majority of prisoners suffer from a substance abuse disorder and in many cases, their substance use contributed to committing the crime that resulted in their incarceration.

• Substance use among women in prison is estimated at 80%. Women are more likely to be addicted to prescription drugs than street drugs – benzodiazepines being one of the major ones. In prisons, prescription drugs are not only considered generally acceptable, many women are actively encouraged to participate in their own chemical restraint.

• Women's addictions differ from men by the type of drugs used, their social background and the reason for use, which implies the need for gender specific substance use programs.

• Most criminalized women with substance use issues have significant histories of personal trauma and abuse, be it physical or sexual. Women frequently report substance use as a means of masking emotion in order to cope with ongoing or unresolved trauma and abuse.

• Benzodiazepines can impede cognitive functioning and side effects include depression, memory deficiency, heightened emotions, and suicidal tendencies.

• In Canada, the prescription of benzodiazepines increased by 12.8% from 1996 to 2000. Sleeping pill prescriptions have noticeably increased by 57.5%. Canadian and international studies have reported that 20 to 50% of women over the age of 60 have long term prescriptions to benzodiazepines and sleeping pills.

• In western Canada, one out of three Aboriginal women over the age of 40 has been prescribed benzodiazepines.

• Women's life experiences, such as family stress, menstruation, child birth, menopause, chronic diseases, et cetera, are too often treated as pathological and result in women being chemically restrained rather than supported in moving through the life phase.

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