Women's Forensic Mental Health Care: The Need for Gender-Based Analysis1

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Abstract

This paper critically interrogates the increasingly popular framework of Gender-based Analysis (GBA) in Canada, as it relates to psychiatry more broadly, and forensic psychiatry more specifically. Through a critical feminist and Mad Studies analysis, we argue that if GBA is to be anything more than rhetoric, it is necessary to ground policies and practices in the knowledge generated by women and service-users themselves. We further point to Mad Studies as an important field for research and an opportunity to look deeper into the 'margins within the margins.'

Keywords: Mad Studies, forensic psychiatry, Gender-Based Analysis, service-users

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1 As per the Status of Women Canada, the "plus" added to Gender-based Analysis (GBA) is meant to acknowledge that GBA goes beyond biological (sex) and socio-cultural (gender) differences as well as other identity factors, like race, ethnicity, religion, age, and mental or physical disability (Status of Women, 2016).

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Introduction

In 2015 the Government of Canada introduced a mandate through which the Ministry of the Status of Women was to ensure the sensitivity and responsiveness of all government policy, legislation and regulation to their specific impacts on women. This commitment was then articulated in the Action Plan on Gender-based Analysis (2016–2020) and the launch of the GBA+ campaign, which committed educational resources for the implementation of an intersectional gender-based analysis in federal political processes (Status of Women Canada, 2016). These governmental commitments were, further, enmeshed in a publicity campaign by Prime Minister Justin Trudeau to frame his government and leadership as actively feminist. This 'feminist' agenda became something of a slogan, as when he responded to reporters' questions with the response, 'Because it's 2015' (Chartrand, 2015).

The idea of gender-based or gender-inclusive analysis has, since, become a mainstay of so-called liberal or progressive political and policy discourse. However, at present it appears that GBA+ has failed to take hold, given that 40% of federal departments and agencies are not actually tracking the implementation of GBA+ (Wright, 2019). This should not be surprising, according to Sarah Kaplan of the Institute for Gender and the Economy at the University of Toronto. The whole programme of GBA+, Kaplan points out, was meant to 'add' women into existing policies, procedures and so on. As such, she argues, " most of the people in the departments just see this as

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an addition to their already full schedules" and this addition-based practice is "really an impoverished way to do gender-based analysis because what you should really be doing is analysis on what are the needs out there" (Wright, 2019). Rather than 'additive', then, gender analysis should be foundational, which in some cases means disrupting and transforming status quo practices.

We highlight the Canada Action Plan as a segue into a broader problem that plagues GBA in general: that is, its fundamental grounding in an 'additive' approach to gender in policy making and practice. In this paper, we take up these issues in an area where the stakes are arguably quite high—the field of psychiatry, and more specifically that of forensic psychiatry. While the need to attend to women[3] within psychiatric practice is not new (see, for example, Heilbrun et al., 2008; Braedley, 2012; Crooks et al., 2008), heightened attention to gender-based practices has generally sought to add women into existing psychiatric models and practices. Moreover, the category of 'woman' itself has frequently been conceptualized as a homogenous and singular identity, assumed to correspond with consistent and universal needs. In so much as women's mental health has been addressed, then, there is a continued failure to recognize the heterogeneity and intersectionality of women's experiences. In our work, we have observed that women within forensic mental health are routinely subject to a system of care which pivots on a masculinized model[4] of subjectivity. Where non-masculine gender is considered, it tends to be as an

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[3] In this paper, the literature we reference and the communities we have spoken to are predominantly cis-gender women. However, we wish to flag the need to conceptualize and implement GBA in a robustly intersectional fashion—attending to a diverse community of women-identifying persons (e.g. transwomen, Two-Spirit) whose bodies are furthermore classed and raced.

[4] We are drawing upon Susan Braedley's terminology, wherein masculinization is used to 'denote the ways in which some institutions, organizations, occupations, and practices are constituted as masculinized, deserving, necessary and of high value in relation to other institutions, organizations, occupations and practices—and those who rely on them—which are constituted as feminized, unnecessary, a drain on the public purse and of lower value' (2012, 72). The valuation of institutions, organizations, and occupations as masculine depends on the reproduction of norms

afterthought—added onto existing 'best practice.' And yet, women within the forensic system present with distinct backgrounds, trajectories, and needs, such that if gender is to be considered, it must be foundational.

We draw attention to the forensic population, in particular, as there is a robust and growing literature which suggests a link between inadequate mental health services for women and increasing interaction with the criminal justice system. Indeed, the incarceration of women in Canada has increased by 37% from 2007–2017; according to Canada's ombudsman for federal inmates, women comprise 'one of the fastest growing populations in the federal system' (Burke, 2017). These increases in interaction are not owing to an increase in serious violent offences amongst those with a psychiatric diagnosis, but instead are often related to administrative issues. For example, Penney et al. (2018) found that increases in forensic admissions are not reflected in an increase in serious violent crime, but instead less serious violent offence and, importantly, administrative offences (breach of conditions). Given that administrative issues account for a good deal of this increase, it is important to pay attention to how unmet social service and health needs might increase the exposure of women to criminal justice and forensic systems (Ennis et al., 2016). Women are the fastest growing population of people subjected to carceral conditions in Canada today (Burke, 2017), and while only a small proportion are subjected to forensic psychiatric institutions, a majority of women presenting in the penal system experience mental health problems (as many as two-thirds of federally sentenced women, according to a 2018 *Emerging research* report by Correctional Services Canada). As such, understanding the intersections between social policy, gender, mental health and criminalization is all the more pressing in our

associated with masculinity, such as 'independence, self-control, expertise, technological proficiency, objectivity and rational decision making' (Braedley, 2012, p. 74).

present climate. Failing this, the criminal justice system becomes the *de facto* repository for individuals in need of social and mental health services.

As systemic advocates located in the Empowerment Council (EC) at the Centre for Addiction and Mental Health (CAMH), we are in a unique position to critically observe the workings of forensic mental health. The EC is a not-for-profit organization composed entirely of current and/or former service users of mental health and addictions services. The EC has a two-decade long history of advocacy, education and outreach stemming from the epistemological standpoint of service users and survivors (Rose, 2017). Our analysis for this paper draws from our advocacy and work in CAMH (Canada's largest mental health teaching hospital) as well as a long history of community advocacy and activism labour (Ross et al., 2015; Mendolia, Costa, & Chambers, 2017; Daley, Costa, & Ross, 2012).

It is from this positionality that we write this article in order to challenge government, service providers and the service users themselves working within Mad Studies and related disciplines to move beyond a quantitative approach to gender, and to mobilize and implement models and practices that support and centre the needs and voices of women in the system. As a point of entry, we ask why a broad-level governmental commitment to gender-based analysis has not led to any substantive transformation in attending to the mental health needs of women broadly, and within the forensic population more specifically. Drawing from Mad Studies theoretical work as well as feminist scholarship on gender and work, we argue that, though women have been increasingly written about in research and policy, the current rhetoric of GBA has failed to encompass the political and perspectival shift required of a robust engagement with gendered bodies. More specifically, while there is an increasing body of policy literature and academic research which focuses on the relationship between mental health and gender, the grounds upon

which gender is figured into policy decisions remain tied to hegemonic neoliberal models of medical care which are both empirically and conceptually grounded in the masculinized body. Adding women into these models precludes a serious engagement with the voices of women-identified service users in determining their needs; from the perspective of service users, services deemed necessary are often those that develop empowerment, education, and relational security, and are, as a result, non-finite and non-quantifiable in their nature.

In the following, we begin by defining and rationalizing our working definition of GBA. Following this, we provide an overview of some of the primary avenues through which the gendered experiences of mental health service users have been taken up; these contributions are necessary if we are to move beyond a purely quantitative GBA. We supplement our call to include critical feminist analyses with an insistence that the voices of service users themselves be central. We argue that there is a clear disconnect between the objectives of GBA and its practical implementation and show how this disconnect is a product of the limited, quantitative approach that has permeated policy-making and psychiatric service provision itself.

What is GBA, Why GBA

A GBA begins from the acknowledgement that the ways in which "the roles and expectations attached to being male or female also affect one's chances of completing school, providing care for others, having an adequate income, experiencing violence, and living a long, healthy life" (Clow et al., 2009, p. 1). This means that the way that we encounter the world through our bodies, our experiences, and our reactions to and interpretations of that world will vary according to our gender. Such an understanding has important implications for mental health practitioners, notably those adopting the social determinants of the health model, as gender has been clearly

demonstrated to influence the ways in which we access those social determinants of health. GBA, then, is a tool which allows practitioners and policy makers to do away with the 'one-size-fits-all' model and ask questions about how gender influences "mental illness, service utilization and delivery, outcomes, treatment interventions, and policies" (Mathias, 2015, p. 157). It seeks to uncover the factors that women are more sensitive to, *as well as* the conditions and environments which women are more often exposed to (de Vogel et al., 2016, p. 146). The latter, importantly, emphasizes the relational nature of gender in all its socio-economic, cultural, and interpersonal manifestations.

It is important to distinguish the kind of robust gender analysis that we are advocating. As Susan Braedley has argued, it is not only about asking where the women are but in what ways knowledge, practices, policies, institutions and organizations are suffused with gender and gender relations, and with what consequences for women (2012, p. 72). This necessitates an entirely different approach to bringing gender to bear on social policy. Rather than a quantitative or 'additive' approach to gender and social policy, we are arguing for gender to be *foundational* to the conceptualization and implementation of policy and practice. Additionally, a GBA will have to substantively engage with cross-cutting modalities of marginalization and oppression, as the experiences, needs, and perceptions of women will differ according to class, sexuality, racialization, ability, age, and so forth. Importantly, capturing the complexity of needs when addressing social and health policy for mental health service users will need to begin with the experiential knowledge of service users themselves and will require that scholarship in Mad Studies better engage with issues specific to incarcerated women in corrections and, further, in psychiatric forensic systems.

Critical feminist and Mad Studies engagements with mental health

To build a more substantive GBA in mental health analyses, it is necessary to draw on the robust history of feminist philosophical, sociological and political-economic theorizing around the psy-disciplines. In this section, we review three of the main strands of theorizing gender and mental health. We argue that what is clear from all these positions is the need to engage substantively with service users themselves via both experiential and academic knowledge.

The history of theorizing the relationship between gender and psychiatry emerged from the broader women's health movement in the 1970s, and more specifically, with Phyllis Chesler's *Women and madness* (2005) first published in 1972. Chesler's was a sociological approach to mental health which viewed the psy-disciplines, in general, as rooted in patriarchy. According to Chesler, the role of psychiatry was to discipline the appropriate performance of sex-roles. Thus, mental illness was read as a social construct intended to reproduce and enforce patriarchy (Chesler, 2005). As many have since argued, however, the anti-psychiatry tone of Chesler is limiting, in that it can be mobilized to deny the very real distress women experience (Allen, 1986; Busfield, 1989; Oakley, 1982). For this reason, a second body of feminist critique emerged which argued that mental illness is not a social *construct*, but a social *product.* For this school of thought, the daily social relations of sexism which unequally distribute advantage and disadvantage contribute to the real and material suffering of women and their inequitable location within the mental health system (Smart, 1976; Oakley, 1982; Usher, 2011).

For this reason, feminist theorizations of work are important in pointing to the ways in which gendered labour heightens trauma. Women have historically been overburdened with the un/underpaid labour of intergenerational reproduction (child rearing, domestic work, care for the elderly, emotional labour, education, and so forth) (LeBlanc Haley, 2017). Attending to the

burdens of socially reproductive labour can illuminate the gendered nature of psychiatric disability because a) such labour is often combined with primary labour market engagement, constituting a 'double shift' for women, b) those who choose not to or are unable to perform such labour are often read as deviant or pathological, and c) since the era of deinstitutionalization and the rise of neoliberalism, much of the 'care work' once assumed by the public sector has been offloaded into communities and private households, increasing women's burden while decreasing their access to meaningful support (Bezanson & Luxton, 2006; Braedley, 2012; LeBlanc Haley, 2017).

While not denying the reality of psychological trauma, however, an exclusive focus on structural factors alone can obfuscate the reality of mental health disabilities. Rather than an exclusive approach to psychiatric disability in women as either a sexist construct developed to discipline women, or an epiphenomenal manifestation of societal oppression, it is necessary to also examine how gender operates at varying levels of definitional practice. According to Joan Busfield, we can discern inequity in psychiatric practice by understanding the way gender frames official diagnostic definitions (i.e. anxiety, depression and eating disorders are read as distinctly 'female' maladies), symptomology (i.e. What constitutes 'irrational' behavior?), and practices of assessment (how gender bias operates in the evaluation of cases) (Busfield, 1989). When combined with a recognition of the ways in which the materiality of sexism disproportionately distributes advantage and disadvantage in society, Busfield's schematic allows for a recognition of the reality of mental illness and the impact of structural sexism on the institutional identification and treatment of illness (1989).

Of course, the burdens of gendered labour, diagnoses, assessments, and so forth are experienced heterogeneously by black, indigenous, and people of color (BIPOC) women, trans and queer women, women of different class backgrounds, and so forth. Because 'women' cannot

be homogenized and spoken of in abstraction, any robust engagement with the topic of gender and mental health must ultimately draw from the expertise and knowledge of the women themselves. It is for this reason that, alongside an argument for GBA in forensic care, it is critical to look to the insights developed in Mad Studies scholarship.

Women and Mad Studies

Women have consistently written about their experiences of the limitations of the mental health system. Alongside feminist critiques of medicine, service users themselves have long challenged the hegemonic ways psychiatry has both authoritatively defined and simultaneously erased their voices. Through Mad Studies, a maturing field that centres the voices, writing, and experiential knowledge of mental health service users/survivors, we are reminded of the long analogous history of women's writing and quests for equitable mental health care.

Earlier fictional books such as *The bell jar* (1963) by Sylvia Plath , *Women on the edge of time* (1976) by Marge Piercy, and *Yellow wallpaper (1982)* by Charlotte Perkins Gilman are well-known texts addressing the experiences of madness through women's writing. However, personal, political and Mad women's narratives found, for example, in Chamberlin's *On our own* (1977), Millet's *The loony bin trip* (1990) and Demerson's *Incorrigible* (2004) brought struggles against psychiatry out of fictitious frames and into substantive arguments (yet to be reconciled) about the need to have access to knowledge independent of the normative manner in which women have been objectified through medicine and psy-systems.

In 1991 a study by Firsten involving interviews with women about their experiences of physical and sexual abuse noted that 83 of the 85 women interviewed had experienced severe abuse in childhood and/or adulthood (46). Discussing her work at the Queen Street Mental Health

Centre (now CAMH), Firsten remarked: 'It took a few years of employment in a psychiatric institution to come to appreciate the extent to which the patients are treated as genderless' (Firsten, 1991). Accounts of women's experience with psychiatry can be found in grey literature in zines such as *Phoenix rising* (Anderson & Dunn, 1980–1990). *Madness Network News* featured Chamberlin's (1977) *Women's oppression and psychiatric oppression.* In 2002, psychiatric survivor-activist Irit Shimrat argued for the need for a safehouse for women in her report, *What women want*(2002). Feminist zine *Off our backs* also featured a special issue exploring the links between the psychiatrization of women and feminism in articles such as Katherine Hodge's (2003) "Invisible Crisis: Women and Psychiatric Oppression" and Vanessa Jackson's (2003) "In Our Own Voice: African-American Stories of Oppression, Survival and Recovery." While women organized within white dominant social justice groups, women of colour sought other spaces for political organizing, such as Toronto Women of Colour Collective and THRIVE, the Multicultural Women's Coalition against Violence and Oppression (Diamond, 2013).

The Canadian Women's Health Network (CWHN) also called into question the exclusion of women in the early Mental Health Commission's report *Out of the shadow at last*. In response to an obvious lack of planning for gender, in 2006, a Working Group submitted "a formal written response to the Senate, entitled, 'Women, Mental Health and Mental Illness and Addiction in Canada: An Overview,' highlighting the importance of sex- and gender-based analysis (SGBA) for any accurate and comprehensive understanding of mental health issues in Canada" (2007). The CWHN knew that given previous attempts with reports such as the Canadian Mental Health Association's *Women and mental health in Canada: Strategies for change* (1987), and the Working Group on Women's Health's *Working together for women's mental health: A framework for the development of policies and programs* (1993), the obvious oversight was deliberate.

In the latter years, much of the organizing for GBA has continued primarily through academics and/or not-for-profit mental health agencies looking to improve various tenets of women's subjugation and exclusion from social and economic capital. The trajectory of critical scholarship on women's mental health experiences vacillates between feminist and Mad Studies scholarship, but we signal for deeper exploration and empirical research at psychiatric sites given that even within these spaces of exclusion the experiences and stories of forensic women remain marginalized. Our contribution here is modest: we wish to use our observations within the EC to draw attention to the need for greater scholarship and activism around gender and forensic psychiatry, given so much still remains to be done. Indeed, there is very little scholarship on forensic mental health services in Canada in general, let alone scholarship which is informed by gendered- and service-user-informed insights.

Forensic mental health and gender in Canada: An overview

In Canada, forensic institutions service individuals who have been found unfit to stand trial or not criminally responsible for reasons of mental disorder (NCRMD). This system is intended to 'manage' the safety of individuals and the public in circumstances where criminal intent at the time of the offence cannot be determined. Because Canadian law distinguishes those found NCRMD as in need of 'treatment' as opposed to 'punishment,' the sentence is one which is open-ended and left to the discretion of Review Boards, ultimately resting on the extent to which an individual can be 'cured.' Individuals under the Review Board must be reassessed on a yearly basis, at minimum (Department of Justice, 2015).

The state of research on forensic institutions in Ontario, and Canada more broadly, is limited. Data is thin, though there are three studies that examine in whole, or part, the national

profile of individuals passing under the authority of the Review Board (Department of Justice, 2015; Nicholls et al., 2009; Penney et al., 2018). While data can be limited in its use, at the very least it begins to point us in useful directions. Service users are not the sum of their diagnoses, but their life histories. Data can begin to capture important elements of this, such as education, income bracket, ethnic, religious or racial background, and so forth. Of course, without more substantive qualitative information about the life histories of individuals, these data can leave us with only a partial picture of the different service and treatment needs of the population.

It is often remarked that a lack of GBA in forensic psychiatry reflects a pragmatic decision—women make up a very small percentage of Canada's total forensic population (Nicholls et al., 2009). And to be sure, this is true: a study assessing Review Board data from all provinces between the program's implementation in 1992 and the date of the study, 2004, found that 16% of the national population of those with NCRMD dispositions was women (Latimer, 2006). A second study, published in 2015 and drawing from 2005 Review Board Data in Ontario, British Columbia, and Quebec, found that women comprised 28.9%, 11.8%, and 59.3% of the total NCRMD population, respectively (Nicholls et al., 2015). Furthermore, as part of the former study, above, it was found that, overall, between 2000 and 2005, 15.6% of the NCRMD population was women (Crocker et al., 2015a). Women, by any of these measures, do indeed make up a small percentage of the NCRMD population in Canada. However, we should be mindful that provincial data seem to vary (specifically, the rate of women under Review Boards in Quebec), and it appears that there may be provincially variable increases in the presence of women in forensic psychiatry since the implementation of Review Boards in 1992. More recently, a 2018 study by Penney et al. examining forensic psychiatric demographics in Ontario confirms many of the above observations, notably

the assertion that women in the forensic system present with unique needs that "would benefit from gender-sensitive treatment programming" (2018, p. 7).

While the data we have on women's representation in the forensic system in Canada is limited, broader qualitative analyses have been conducted which suggest a likelihood of increased interactions between women and the forensic system. Specifically, this literature links the era of deinstitutionalization with a lack of adequate access to social services, especially mental health services. The result has been that many individuals with mental health service needs have increasingly come to rely on family and community supports, which are inadequate in the provision of care. Simultaneously, a focus on curative over therapeutic services for those labelled with a mental health disability has meant that a specific subset of services, often deemed particularly necessary for women, has been defunded due to its ongoing, non-objective, or qualitative nature (Braedley, 2012). The result has been a transition from ambulatory to acute care as a focus of mental health provision, which has tended to increase the rate of interaction between individuals with addictions or mental health disability and the criminal justice system. Indeed, a recent CBC investigation found that, across Canada, 70% of people who died at the hands of police suffered from mental health issues (Nicholson & Marcoux, 2018). While such encounters may be exceptional, they speak to the ways in which unmet mental health needs bring about interactions with law enforcement. It is no surprise, then, that the forensic system has increasingly become the repository for individuals with unmet service needs.

As part of a five-part series on T*he National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder*, Nicholls et al. examined whether gender-specific psychiatric services were necessary in Canada's forensic health system. Part of this evaluation was rooted in an examination of the gendered differences in patients' socio-

demographic, criminological and mental health profiles. The findings pointed to some crucial gendered differences in the forensic population of Canada. Specifically, the study identified differences in social integration and functioning, diagnoses, and average time spent 'in the system,' suggesting that women will present with very different immediate and long-term needs with regard to services, care and intervention (Nicholls et al., 2009).[5] While this information helps answer the question 'where are the women,' it is important to recall that the location of women will often be the product of gendered distinctions in defining and sorting 'disorder' (Busfield, 1989). Thus, it is still necessary to question how gendered social policy, institutions, and environmental/social relations precipitate or prolong engagement with forensic mental health services, as well as how such gendered relations function as prohibitive barriers to the adequate provision of services *for women*. In general, much of the forensic literature remains grounded within a framework of inquiry predicated on a quantitative assessment of tendencies to violence, recidivism, and prospects for 'cure' (see, for example, Chambers et al., 2009; Nicholls et al., 2009; de Vogel et al., 2016).

A substantive GBA approach to forensic mental health services

Addressing the above limitations of GBA in practice requires intensive, qualitative research exploring the sociological interaction between gender, mental health, and the social determinants of health. Importantly, this exploration will require engagement from Mad Studies scholarship and continued engagement in non-academic community spaces. It must include recognition of the fact that, for example, women are far more likely to have histories of victimization, including sexual, physical and psychological abuse. Thus, research shows that women with histories of abuse and

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5 Penney et al. (2018) confirm these findings.

victimization may well find the clinical environment triggering in itself; that is to say, these women who have historically had their autonomy constrained by their abuser(s), as well as societal relations and institutions, may well be triggered into hostility or personal acts of self-destruction because the "oppressive physical and procedural security controls and strict routines" (Parkes & Freshwater, 2015) replicate the very loss of autonomy that has been so traumatizing in the past. Behaviours such as harm against others and self may present in response to the perception or reality of threat or danger as a means of reasserting personal control; thus, while we may know in quantitative terms how often or likely women are to be processed as violent offenders, the sources and circumstances of such violence need to be contextualized. Understanding how gender influences interpretations of situations as dangerous and threatening is necessary to implement practices that do the least damage, and which refrain from recreating trauma in vulnerable and abused populations (Parkes & Freshwater, 2015). And yet, current research has found that women are subjected to punitive measures such as room restriction at higher rates than men, across Ontario facilities, suggesting that the interaction between histories of abuse, loss of control, and mental illness have not been adequately incorporated into intervention protocols on forensic units (Mathias, 2015). In our observation of female forensic clients, we heard that room restriction was often used as a means of mediating conflict with other (often male) clients, and was rarely followed up by discussion, such that there was no space to process and manage the trauma experienced through such punitive measures. Rather, it appears that trauma and victimization, from this vantage, were normalized and regularized.

Relational security, rather than physical security (such as room restriction), should receive far greater emphasis in forensic settings (Long et al., 2008, p. 305). Relational security relies on the cultivation of therapeutic relationships which do not strip service users of their autonomy, but

instead build up their capacities and esteem through empowerment-based therapeutic models (Heilbrun et al., 2008). Indeed, this has been noted as necessary for forensic service users' recovery more broadly, in a burgeoning forensic mental health literature that draws on consumer/survivor work (Livingston, 2018; Simpson & Penney, 2011). Given the centrality of empowerment as a therapeutic tool for women, focus needs to shift from 'curative' models of recovery which focus on individual 'deficiency,' to capacity building which locates individual capacities and decision making within a wider web of material, psychic and institutional barriers (gendered, racialized, ableist and classed biases) (Chunn & Menzies, 1990). However, at present, the very premises of forensic mental health create significant barriers to the realization of these goals; forensic psychiatry relies on an individualized model of 'recovery' within the institution, thereby limiting the extent to which societal and relational factors can be addressed.

Through years of advocacy work, workshops and informal discussions, the EC observed women articulate a desire for more therapy, trauma-informed care, and skills development. Women are clear in articulating these needs and connecting them to personal goals. As always, alleviating distress is tied to socio-economic and interpersonal autonomy and security; goals that are best achieved not through medicalization and institutionalization, but through empowerment. If mental health services are to move beyond a mere 'additive' approach to gender and encompass these ideas of relational security and empowerment as crucial to recovery, the medical model of health as *the* foundational framework needs to be abandoned. As Braedley (2012) has argued, the medical model is inherently a masculinized model of care, which has been further exacerbated following deinstitutionalization, and under neoliberalism. Emphasis on 'cure,' evidenced by a quantifiable reduction of symptoms, clear paths of treatment with stable outcomes, and finite expenditure are all characteristic of a 'masculinized' model of psychiatric care

(Braedley, 2012). Such a model obfuscates the need, and reduces the spaces and opportunities for a focus on the qualitative (read, feminized) aspects of care (comfort, satisfaction, access, support, culture, etc.), which, as we have noted, are critical in the provision of services for women (though it should be noted that, while the urgency of these techniques for women is magnified by certain characteristics of gendered social relations, they are also important for male-identified service users).

Research also demonstrates that the differences amongst male- and female-identified forensic populations pertain not only to on-site care, but to the preparation for, provision of, and access to services in the post-discharge stage. The leading cause of recidivism for women is not re-offense, but violation of discharge conditions; chief among these are a loss of housing (Penney et al., 2018, p. 370). While there is a dearth of long-term research on the different needs and outcomes of women and men in supportive, supported or independent housing following discharge, the little research that does exist strongly supports the idea that women have very distinct needs and vulnerabilities when accessing housing (Centre for Addiction and Mental Health, 2014; Kidd et al., 2013). At present, forensic units and their partnerships with community housing have generally failed to systematically build in a gendered analysis when constructing, financing, and administering housing. Inappropriate or unsafe living conditions will impact a woman's ability to maintain satisfactory housing, influencing rates of recidivism. Here, once more, histories of violence and victimization will come into play. Co-ed living facilities may pose real and perceived threats to women, a lack of community supports may increase the risks posed to women for housing unit takeovers, and neighborhoods and/or housing units embedded in marginalized or high-risk populations may present with increased exposure to law enforcement, again triggering feelings of a loss of autonomy and re-victimization. While the capacity of forensic

health institutions to influence these broader, community factors is limited, what scope there is for intervention is important and can be productively leveraged if a gender-based analysis were to be more seriously adopted (Elizabeth Fry, 2014; Salem et al., 2015; Suttor, 2016).

Despite increasing rhetoric from Canadian federal and provincial institutions of the need for GBA, the picture of women's service provision, specifically as it relates to forensic mental health, continues to operate according to a limited, quantitative approach. Thus, despite the physical presence of women's-only forensic spaces (sparse as they may be), they continue to operate in an institutional and policy environment in which acute and medicalized services receive funding, while ambulatory care is increasingly defunded and relegated to the private sector. Thus, for example, from 2007 to2008, Braedley found that "money was being invested in high tech, surgically-oriented hospitals where cure results could be easily counted, while budgets were being squeezed in the ambulatory care environment where care results were more difficult to assess" (2012, p. 74). Given the recognition in the literature that women who find themselves in the forensic system present with complex histories of trauma and violence, face significant socio-economic disadvantage, and require therapies addressing intimate and parental relationships, care cannot be framed as acute, nor can it be practiced in isolation from wider community services and institutional relations.

The institutional segmentation of care reflects further marginalization of women's needs, potentially contributing to a self-perpetuating cycle of unmet needs, criminalization, and forensic involvement. Under the current masculinized models of care, services that are not amenable to scientific calculus have been increasingly privatized and shifted out of hospitals. The disconnect between private and public prevents a smooth transition from the forensic system into the community, a situation that will contribute to recidivism and increasing interaction with

emergency and criminal justice services (see, for example, Braedley, 2012; Penney et al., 2018). Because the needs of women are decidedly long-term, and because the forensic system is presently modeled on a reduction of symptomology as indicative of 'cure,' it is even more crucial that transitions to the community are accompanied by long-term care plans which integrate institutional and community supports and services to support long-term empowerment and quality of life.

Where do we go from here?

Based on the preceding discussion, we have argued that moving forward requires both a political and perspectival shift for GBA to demonstrate any meaningful change in policy and practices impacting women. Several immediate changes to forensic psychiatric practices could contribute to the beginnings of a robust gender engagement, such as changes to physical environment, clinical relations, staff relations, and programming. As we have already noted, 'treatment' in forensic institutions typically amounts to the medicalized reduction of symptomology. However, if we acknowledge that women's mental health and interactions with the criminal justice system are bound up with often violent and oppressive gendered social relations and inequitable access to social services and material resources, then it becomes necessary to provide services such as trauma-informed care, education, and long-term care planning and objectives. This shift in clinical approaches would, in turn, reorient the balance of power between clinician and client, making clients active in their own treatment. In general, with staff relations, it is necessary to ensure that staff are trained in alternative conflict resolution practices. Seclusion, room restriction and the use of restraints will all serve to re-victimize women and create an environment of insecurity and hostility. Conflict resolution practices should be accompanied by the establishment and education of a clear anti-harassment policy, so as to head off potentially traumatizing conflict.

Mad Studies, as we have argued, also has a role in leading and pushing these arguments by undertaking a process to better understand the contextual and administrative processes involved in incarcerating women within the corrections and mental health forensic system. If GBA is nothing more than lip service that works to "feminize" psy-disciplines in order to punish and mobilize more sophisticated forms of surveillance and coercion, then GBA becomes nothing less than co-opted discourse and another form of institutional discipline. For any of this to move forward, better links need to happen across multiple sites of discrimination, and there also needs to be a reinvigoration of politicized women's and gender health movements that does not dematerialize political agendas and actively works to push to enact previous report recommendations for services and care that are available and valued by their recipients.

References

Allen, H. (1986). Psychiatry and the feminine. In P. Miller & N. Rose. (Eds.), *The power of psychiatry* (pp. 85-99). Cambridge, England: Polity.

Anderson, A., & Dunn, J. (Eds.) (1980–1990). *Phoenix rising: The voice of the psychiatrized.* Toronto, Canada: On Our Own.

Bezanson, L., & Luxton, M. (Eds.) (2006). *Social reproduction: Feminist political economy challenges neoliberalism.* Montreal, Canada: McGill-Queen's University Press.

Braedley, S. (2012). The masculinization effect: Neoliberalism, the medical paradigm and Ontario's health care policy. *Canadian Woman Studies/Les Cahiers de la Femme*, *29*(3), 71-83.

Burke, D. (2017, October 11). Number of women in federal prisons is up, and advocates think they know why. *CBC News.* Retrieved from https://www.cbc.ca/news/canada/nova-scotia/women-prisons-crime-nova-institution-overcrowding-1.4347197

Busfield, J. (1989). Sexism and psychiatry. *Sociology, 23*(3), 343-364.

Brown, G.P., Barker, J., McMillan, K., Norman, R., Derkzen, D., Stewart, L.A., & Wardrop, K. (2018). *Prevalence of mental disorder among federally sentenced women offenders: In-custody and intake samples (Research Report R-420).* Ottawa, Ontario: Correctional Service of Canada.

Canadian Mental Health Association. (1987). *Women and mental health in Canada: Strategies for change.* Retrieved from http://www.cwhn.ca/sites/default/files/PDF/CMHArecommendations.pdf

Canadian Women's Health Network. (2007). *Women, mental health and mental illness and addiction in Canada: An overview.* Retrieved from http://www.cwhn.ca/en/node/28610

Centre for Addiction and Mental Health. (2014). *Housing policy framework.* Toronto, Canada: Retrieved from https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/housingpolicyframework_final2014-pdf.pdf

Chamberlin, J. (1977). *On our own: Patient-controlled alternatives to the mental health system*. New York, NY: McGraw-Hill.

Chamberlin, J. (1977). "Women's oppression and psychiatric oppression." *Madness Network News*, *4*(2), 8-10.

Chambers, J., Yiend, J., Barrett, B., Burns, T., Doll, H., Fazel, S., … Fitzpatrick, R. (2009). Outcome measures used in forensic mental health research: A structured review. *Criminal Behaviour and Mental Health*, *19*(1), 9-27.

Chartrand, F. (2018, March 22). Trudeau's 'Because it's 2015' retort draws international attention. *The Globe and Mail.* Retrieved from https://www.theglobeandmail.com/news/politics/trudeaus-because-its-2015-retort-draws-international-cheers/article27119856/

Chesler P. (2005). *Women and madness: Revised and updated*. New York, NY: St. Martin's Griffin.

Chunn, D. E., & Menzies, R. J. (1990). Gender, madness and crime: The reproduction of patriarchal and class relations in a psychiatric court clinic. *The Journal of Human Justice*, *1*(2), 33-54.

Clow, B., Pederson, A., Haworth-Brockman, M., & Bernier, J. I. (2009). *Rising to the challenge: Sex- and gender-ased analysis for health planning policy and research in Canada*. Halifax, Canada: Atlantic Centre of Excellence for Women's Health.

Crocker, A. G., Nicholls, T. L., Seto, M. C., Cote, G., Charette, Y., & Caulet, M. (2015a). The National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder Part 1: Context and Methods. *Canadian Journal of Psychiatry*, *60*(3), 98-105.

Crocker, A. G., Nicholls, T. L., Seto, M. C., Cote, G., Charette, Y., & Caulet, M. (2015b). The National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder Part 2: The People Behind the Label. *Canadian Journal of Psychiatry*, *60*(3), 106-116.

Crooks, V., Chouinard, V., & Wilton, R. D. (2008). Understanding, embracing, rejecting: Women's negotiations of disability constructions and categorizations after becoming chronically ill. *Social Science & Medicine*, *67*, 1837-1846.

Daley, A., Costa, L., & Ross, L. (2012). (W)righting women: Constructions of gender, sexuality & disorder through psychiatric documentation practices. Culture, *Health and Sexuality: An International Journal for Research, Intervention and Care*, *14*(8), 955-969.

Demerson, V. (2004). *Incorrigible*. Waterloo, Canada: Wilfrid Laurier University Press.

Department of Justice, Canada. (2015). *The review board systems in Canada: An overview of results from the mentally disordered accused data collection study*. Retrieved from http://www.justice.gc.ca/eng/rp-pr/csj-sjc/jsp-sjp/rr06_1/p1.html

de Vogel, W., Stam, J., Bouman, Y. H. A., Ter Horst, P., & Lancel. M. (2016). Violent women: A   multicenter study into gender differences in forensic psychiatric patients. *The Journal of   Forensic Psychiatry and Psychology*, *27*(2), 145-168.

Diamond, S. (2013). What makes us a community? Reflections on building solidarity in anti-sanist praxis. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies*. Toronto, Canada: Canadian Scholars' Press, 64–78.

Elizabeth Fry Society. (2014). *Housing needs assessment: Facilitating access to housing for criminalized women in Toronto*. Toronto, Canada: SN Management.

Ennis, A., McLeod, P., Watt, M. C., Campbell, M. A., & Quackenbush, N. A. (2016). The role of gender in mental health court admission and completion. *Canadian Journal of Criminology and Criminal Justices*, *58*(1), 1-30.

Firsten, T. (1991). Violence in the lives of women on psych wards. *Canadian Women's Studies, 11*(4), 45-48.

Gilman, C. P. (1980). *The Charlotte Perkins Gilman reader: The yellow wallpaper, and other fiction*. New York, NY: Pantheon Books.

Government of Ontario. (2016, November 1). Mental health unit for female adult inmates. Retrieved from: https://news.ontario.ca/mcscs/en/2016/11/ontario-to-open-first-dedicated-mental-health-unit-for-female-adult-inmates.html

Grobe, J. (1996). *Beyond bedlam: Contemporary women psychiatric survivors speak out*. Third Side Press.

Hamilton-McCharles, J. (2015, March 11). $3.7 Million for Female Forensic Program. *North Bay Nugget.* Retrieved from http://www.nugget.ca/2015/03/11/37-million-for-female-forensic-program.

Heilbrun, K., DeMatteo, D., & Fretz, R. (2008). How "specific" are gender-specific rehabilitation needs? An empirical analysis. *Criminal Justice and Behavior*, *35*(11), 1382-1397.

Hodges, K. (2003). The invisible crisis: Women and psychiatric oppression. *Off Our Backs 33*(7/8), 12-15.

Jackson, V. (2003). In our own voice: African-American stories of oppression, survival and recovery. *Off Our Backs, 33* (7/8), 19-21.

Kidd, S. A., Gursharan, V., Krupa, T., Burnham, D., Hemingway, D., Margolin, I., Patterson, M., & Zabkiewicz, D. (2013). The role of gender in housing for individuals with severe mental illness: A qualitative study of the Canadian service context. *BMJ Open*, *3*(6). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3669714/

Leblanc Haley, T. (2017). Intimate constraints: A feminist political economy of biological reproduction and parenting in high support housing in Ontario. *Palgrave Communications*, *3*(50), 1-12.

Livingston, J. D. (2018). What does success look like in the forensic mental health system? Perspectives of service users and service providers. *International Journal of Offender Therapy and Comparative Criminology*, *62*(1), 208-228.

Long. C. G., Fulton, B., & Hollin, C. R. (2008). The development of a 'best practice' service for women in a medium-secure psychiatric setting: Treatment components and evaluation. *Clinical Psychology and Psychotherapy*, *15*(5), 304-319.

Malik, L. (2006). Still in the Shadows: Kirby Report Turns a Blind Eye to Women. *Canadian Women's Health Network*, 9(1/2).

Mathias, K. (2015). *Gender-based analysis of criminogenic risk and clinical need among Ontario forensic patients* [Unpublished dissertation]. University of Waterloo, Canada.

Mendolia, S., Costa, L., & Chambers, J. (2017). *Safewards: Including service user voices.* Toronto, Canada: The Empowerment Council: A Voice for the Clients of the Centre for Addiction and Mental Health.

Menzies, R. J., Chunn, D. E., & Webster, C. D. (1992). Female follies: The forensic psychiatric assessment of women defendants. *International Journal of Law and Psychiatry*, *14*, 179-193.

Millet, K. (1990). *The looney bin trip.* New York, NY: Simon and Schuster.

Munro, L., Costa, L., Daley, A., & Ross, L. (draft paper). *"Helping" spaces as sites of discrimination: Understanding sexual health service access for women with psychiatric disabilities.*

Nicholls, T., Crocker, G., Seto, M. C., Wilson, C. M., Charette, Y., & Cote, G. (2015). The National Trajectory Project of Individuals Found Not Criminally Responsible on Account of Mental Disorder. Part 5: How essential are gender-specific forensic psychiatric services? *Canadian Journal of Psychiatry*, *60*(3), 135-145.

Nicholls, T., Brink, J., Greaves, C., Lussier, P., & Verdun-Jones, S. (2009). Forensic psychiatric inpatients and aggression: An exploration of incidence, prevalence, severity, and interventions by gender. *International Journal of Law and Psychiatry*, *32*, 23-30.

Nicholson, K., & Marcoux, J. (2018). Most Canadians killed in police encounters since 2000 had mental health or substance abuse issues. *CBC Investigates*. Retrieved from http://www.cbc.ca/news/investigates/most-canadians-killed-in-police-encounters-since-2000-had-mental-health-or-substance-abuse-issues-1.4602916

Oakley, A. (1982). *Subject women*. London, England: Martin Robertson.

Office of the Correctional Investigator. (2015). *Annual report of the office of the correctional investigator.* Ottawa, Canada. Retrieved from https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20152016-eng.aspx

Parkes, J., & Freshwater, D. (2015). Meeting the needs of women in secure mental health: A conceptual framework for nurses. *Journal of Research in Nursing*, *20*(6), 465-478.

Penney, S. R., Seto, M. C., Crocker, A. G., Nicholls, T. L., Gimbos, T., Darby, P. L., & Simpson, A. I. F. (2018). Changing characteristics of forensic psychiatric patients in Ontario: A population-based study from 1987 to 2012. *Social Psychiatry and Psychiatric Epidemiology*, *54*(5), 1-12.

Piercy, M. (1976). *Women on the edge of time*. New York, NY: Alfred A. Knopf.

Plath, S. (1963). *The bell jar*. East Sussex, UK: William Heinemann.

Reaume, G. (2009). *Remembrance of patients past: Patient life at the Toronto Hospital for the Insane, 1870–1940.* Toronto, Canada: University of Toronto Press.

Rose, D. (2017). Service user/survivor-led research in mental health: Epistemological possibilities. *Disability & Society, 32*(6), 773-789.

Ross, L. E., Vigod, S. N., Wishart, J., Waese, M., Spence, J. D., Oliver, J., Chambers, J., Anderson, S., & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: A qualitative study. *BMC Family Practice, 16*(135). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4604001/.

Salem, L., Crocker, A. G., Charette, Y., Seto, M. C., Nicholls, T. L., & Cote, G. (2015). Supportive housing and forensic patient outcomes. *Law and Human Behaviour*, *39*(3), 311-320.

Shimrat, I. (2002). *What women want: The Vancouver Richmond Mental Health Network Society Safehouse project*. Vancouver, Canada: Status of Women Canada BC/Yukon Division.

Simpson, A., & Penney, S. (2011). The recovery paradigm in forensic mental health services. *Criminal Behaviour and Mental Health*, *21*, 299-306.

Smart, C. (1976). *Women, Crime and Criminology*. London, England: Routledge.

Status of Women Canada (2016). *Gender-Based Analysis Plus.* Retrieved from http://www.swc-cfc.gc.ca/gba-acs/index-en.html

Suttor, G. (2016). *Taking stock of supportive housing for mental health and addictions in Ontario*. Toronto, Canada: The Wellesley Institute.

Usher, J. (2011). *The madness of women: Myth and experience.* New York, NY: Routledge.

Wright, T. (2019, February 2). External docs show many federal departments are not meeting gender analysis targets. *The Toronto Star*. Retrieved from https://www.thestar.com/news/canada/2019/02/02/internal-docs-show-many-federal-departments-not-meeting-gender-analysis-targets.html