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Understanding Gendered Pathways to Criminal Involvement in a Community-Based Sample: Relevance of Past Trauma with Female Offenders

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Education

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Abstract

The study explored the relevance of gender and past trauma on the pathways to criminal justice involvement in a sample of community based offenders ($N = 90$). The primary focus was on women and their experiences in examining the association between their traumatic past experiences and their current criminal behaviours. Results from correlation and Chi-Square analyses suggested that the presence of past trauma plays a relevant role in understanding criminal justice pathways for all offenders regardless of gender. Findings also indicated that the experience of trauma is an important factor in defining women's experiences with criminal justice in terms of the nature of offence, the types of issues they face, and the needs they present with as they manage the challenges with their mental health symptoms based on their past trauma experiences. These findings are discussed in the context of the need for gendered risk and needs assessment in addition to standard gender-neutral measures for accurate predictions of female offenders' risks and needs. Future directions should focus on understanding the link between prior trauma and women's offending behaviours.

Keywords: women offenders, prior trauma, community corrections.

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Introduction

The female offender population has been rapidly growing in the Canadian justice system. Between 1986 and 2005 the rate of serious violent offending amongst women increased from 25 to 46 per 100,000 population (Kong & AuCoin, 2008). The rate of women charged with the less severe assault charges has doubled during this time period (Kong & AuCoin, 2008). In addition, the gap between the number of female and male adults charged with violent crime has been narrowing; there were 9 men charged for every woman charged in 1986; however in 2005 this ratio stood at 5 to 1 (Kong & AuCoin, 2008). Even though female offenders continue to represent a small proportion of the total admissions to the federal court's jurisdiction, the number of women admitted annually increased by 32.3% from 232 in 1998 to 307 in 2008 (Correctional Service Canada, 2008). This significant increase in incarcerated women offenders has focused attention on improving and implementing treatment programs in being tailored to women's specific needs. The purpose of this study was to increase knowledge regarding gender sensitivity in relation to the development of community intervention services for the criminal population of women who have experienced past trauma, contribute to the knowledge related to the prediction of offending tendencies, and discuss the necessity to supplement existing treatments for females involved in the community corrections.

Literature Review

There is mounting evidence suggesting that women have unique life experiences which create unconventional pathways to crime and recidivism compared to men. This research suggests that certain social disadvantages and circumstances place women at risk for criminal involvement. For example, women are at a much higher risk of being victimized physically or sexually, which could be a risk factor for their perpetration of violence (Salisbury & Van Voorhis, 2009). Moreover, the experience of victimization plays an important role in a woman's response to a correctional environment and the nature of the treatment programs provided (Leschied, 2011). However, the overall research focus in criminal justice continues to be primarily on male offenders, which limits our knowledge of gender-specific factors for women in the criminal justice system. For this reason, research on gendered risk factors and offending behaviours for women is needed.

Role of Assessment

Tools for assessing risk in criminal justice have undergone various modifications in the past 50 years (Campbell, French, & Gendreau, 2011). The current major risk assessment tool used in North America is the Level of Service Inventory - Revised (LSI-R) developed by Andrews and Bonta. The LSI-R has been validated to generate information on criminogenic risk measures relevant to both genders (Smith, Cullen, & Latessa, 2009). However, the LSI-R's ability to assess the needs of women offenders in making optimal service and treatment decisions is questionable (Van Voorhis, Wright, Salisbury, & Bauman, 2010). Moreover, research exploring how the needs

in women's lives affect their offending behavior is limited. As a result, the classification of women offenders, the prediction of risk-reduction targets, and the design of the services provided specifically for institutionalized women are questionable. With the emphasis of gendered pathways to criminal involvement, The Women's Supplement Risk/ Needs Assessment developed by Van Voorhis looks at gender specific risk factors affecting women's criminality. Specifically, this assessment tool complements the LSI-R in areas of gender based violence, trauma, socioeconomic disadvantage, relationships, self-efficacy and parental issues with evidence supporting the predictability of recidivism if used in combination with the LSI-R (Van Voorhis, Salisbury, Wright, & Bauman, 2008). However, this assessment measure requires further validation in order to estimate its effectiveness for predicting the risks and needs of female offenders.

Community Corrections

According to the annual report on corrections and conditional release from Public Safety Canada in 2011, the supervised federal offender population in the community has increased by 7% since 2004 (Public Safety Canada, 2011). Specifically, the number of women on statutory release in this five-year period has increased by 40%, and the number of women on full parole increased by 21% (Public Safety Canada, 2011). Statistics Canada also reported probation was the most common type of sentence imposed in the adult criminal courts in 2010/2011, at 45% of all guilty cases (Statistics Canada, 2012). As a consequence, offenders' needs for intervention services at the community level should be looked at in greater depth to determine appropriate and effective

services in preventing recidivism and providing necessary assistance in helping them to become functional members in the community.

Community corrections residential facilities represent transitional programming for inmates released from prisons. Prior to admission to a residential facility, all inmates complete a needs assessment with a community corrections staff. Once their needed treatment and rehabilitation services are identified, offenders are linked to the appropriate services in the community.

The goals of community corrections include: 1) reducing the prison population and the financial cost of incarceration; 2) allowing individuals to retain their family, community, and social support networks while receiving adequate monitoring and supervision by correctional staff, and 3) reducing offender recidivism by offering rehabilitative and educational programs targeting areas of needs, such as living skills, anger management, substance abuse treatment, job training and skills, and other ones that help with their reintegration into the community (Barton-Bellessa, 2012). Even though one objective of community corrections is meting out punishment that corresponds to the violation of the rules and conditions, the emphasis is on reducing recidivism through offering rehabilitative services. This is particularly important for women offenders in helping them to develop necessary and adequate skills for self-care and gain knowledge of childcare and parental responsibilities if they had children removed from care.

Gendered Pathways to Criminal Involvement

There is research suggesting that the gendered experience of abuse, mental health and

lack of education should be considered in evaluating the risk and needs of women offenders. Belknap and Holsinger (2006) studied gendered risk factors with 163 girls and 281 boys incarcerated in Ohio in 1998. Participants were surveyed about their family, school and peers, victimization and mental health histories and experiences. Results revealed that girls experienced a significant extent of abuse and were more likely to view their victimization as influential in their subsequent offending. Girls in this study also reported more mental health problems and higher levels of self-harm than boys. Additionally, they were more likely to report abandonment by parents and admit they would rather live in delinquent institutions than at home. Girls were also more likely than boys to report they dropped out of or quit school because they "could not keep up" at school and because they had "left home" (Belknap & Holsinger, 2006).

Further evidence supporting a gendered pathway for women came from Salisbury and Van Voorhis (2009). Their study investigated women's unique routes to criminal behaviour within a sample of 313 women probationers processed by the Department of Corrections in Missouri between 2004 and 2005. Each participant was invited to a risk and needs interview with a researcher where they completed a self-report that supplemented the interview with additional gender-responsive needs. The recidivism rate of the sample was captured by a dichotomous measure of prison admissions 2 years following completion of a probation order. The results revealed that childhood victimization created five indirect pathways to reoffending. These included an examination of psychological and behavioural effects, dysfunctional relationships with partners, low self-efficacy, addictive behaviours, depressive and anxious affect, employment

and financial problems, along with lower educational achievement (Salisbury & Van Voorhis, 2009). Overall, the findings suggested that women have distinct pathways to crime compared to men. Their unique experiences, such as residing in a poverty stricken neighbourhood , lifelong traumatic and abusive events, little social support, dysfunctional intimate relationships, and difficulty managing and providing for their dependent children, are all potential factors that cause women to commit crimes.

Abuse and Trauma

Trauma and offending behaviours. According to Moloney, van den Bergh, and Moller, (2009), trauma is defined as "any form of interpersonal or domestic physical, sexual or emotional abuse or neglect which is sufficiently detrimental to cause prolonged physical, psychological or social distress to the individual" (p.427). In the criminal justice system, there is evidence suggesting gender differences in traumatic exposure. Imprisoned women are more likely to report an experience of interpersonal sexual abuse in childhood and male inmates are more likely to report witnessing harm to others in childhood and adolescence (Komarovskaya, Loper, Warren, & Jackson, 2012).

The context of childhood trauma plays an important role in the argument for a gender-specific pathway for female offenders. Topitzes, Mersky, and Reynolds (2011) investigated gender-specific models in the association between child maltreatment (CM) and offending behaviours with a sample of 1,539 economically disadvantaged African-American individuals collected from a Child-Parent-Centre (CPC) and a public kindergarten in Chicago. The cohort,

from an early age to age 24, was followed and their CM and crime data from juvenile court and child protective service were obtained for analysis. Possible mediators between CM and adult convictions were analyzed for males and females while identical sets of measures were tested across both gender models. Results showed that CM predicted juvenile delinquency for males, but not for females. In addition, troubled behaviour yielded direct mediation effects for males, whereas high school graduation and parental expectation appeared to have direct effects in the female model, suggesting a gendered pathway to criminal involvement. Although these findings for external validity are reduced due to the different sample sources, unequal number of females collected from each source, missing mediator measures and limited nature of the sample, this study indicated the importance of CM as a significant predictor of offending behaviours and provided evidence that family process and performance in school are risk factors for offending behaviours in women.

Makarios (2007) looked at the differences in the effects of child abuse in relation to violent criminal arrest across gender and race with prospective cohort data containing two groups of 862 Caucasian, African American and Native American participants. The data from the abused and neglected groups were gathered from the records of dependency petitions to the court in a large urban county in Northwest United States, whereas the data for non-abused and neglected group were gathered from birth records in the jurisdiction of the superior court in the same area. Violent arrests of the participants from the two groups were compared and examined. These authors found that female subjects with a history of childhood victimization were shown to have a

higher risk for arrest than males, but the study failed to show that childhood abuse had stronger effects on minority females than Caucasian females. Overall, these studies demonstrated the direct impact of childhood victimization on female offenders.

Recurrent trauma and offending behaviours. Existing research has documented a correlation between early trauma victimization and an increased risk for subsequent victimization(s) throughout the lifespan. Physically and sexually assaulted/abused and neglected children are particularly at an increased risk for revictimization across the various types of traumas and victimization experiences (Widom, Czaja, & Dutton, 2008). It is suggested that early trauma experiences can be "the starting point of a chain reaction of victimization across the life cycle from childhood through adolescence into adulthood" (p.319, Hosser, Raddatz, & Windzio, 2007). In addition, there is a gendered difference in the literature of offenders' revictimization experiences. Dietrich (2007) found that women with a history of childhood maltreatment were three and a half times more likely to experience revictimization relative to men.

Further, empirical evidence supports an association between recurrent victimization and involvement in serious crime. Hamilton, Falshaw, and Browne (2002) conducted a study on the link between recurrent maltreatment and offending behaviours in a sample of 60 male and 19 female adolescent offenders. In this research, the consequences of trauma reflected in the number of perpetrators and repetitions of the abuse were examined. Repeat victimization was defined as recurrent maltreatment by only one perpetrator, whereas revictimization indicated the experience of multiple victimizations by multiple perpetrators (Hamilton et al. 2002). The findings of this

research showed that young offenders with a history of revictimization were more likely to have committed a violent and/or sexual offence than those who experienced repeat victimization or no abuse. In addition, those adolescents who have had experiences of repeat and revictimization both inside and outside the family were most likely to have committed violent and/ or sexual crimes. The results of this study suggested that revictimization is more damaging than repeat victimization, and those who have suffered maltreatment by different perpetrators are more likely to commit violent or sexual crimes. It is postulated that it may be because each subsequent abusive incident leads to a generalised belief in an increased vulnerability, and every subsequent perpetrator exacerbates the negative effects (i.e. lowered self-esteem, feelings of powerlessness, etc.) from the previous incident of maltreatment. The generalizability of the results is limited because the sample size is small and participants were sampled from a specialised delinquent population of emotionally disturbed adolescents in the juvenile justice system. Moreover, participants' maltreatment experiences were retrieved in a retrospective manner, which may reflect inaccurate portrayals of the actual experience. Still, this study highlighted the cumulative effect of trauma on one's risky behaviours.

There is limited research on the cumulative effects of trauma on victims' involvement in the justice system. In fact, even less is known about the precise relationship between repetitive trauma exposure and offending behaviours with female offenders.

Existing evidence on the interrelation of victimization and crime was established with male offenders. Hosser et al. (2007) looked at the cumulative impact of trauma experiences during

the childhood and adolescent years on offending behaviours in early adulthood in a sample of 1,526 male prisoners residing in five German youth prisons. Firstly, the findings revealed that 46% of the participants with a history of childhood maltreatment became violent offenders, which is significantly higher than the group of violent offenders without a history of early childhood maltreatment, which supported previous findings that childhood victimization experiences are a risk factor for criminal involvement. Secondly, those who were maltreated as a child reported higher rates of subsequent victimization through their adolescence, which confirmed the notion that childhood victimization is associated with increased risk for lifetime revictimization. Thirdly, it also showed that those with experiences of repeated victimization during the adolescent years had a higher risk for violent offending in young adulthood suggesting a cumulative effect of trauma victimization on victims' involvement in the justice system. An unexpected finding in this research was that those youth with both childhood maltreatment and frequent victimization during adolescence were not at the greatest risk of becoming frequent violent offenders, whereas the main effects of childhood maltreatment and frequent victimization during adolescence increased the risk of violent offending. The explanation of this contradictory discovery was that violence is a reactive expression of aggression rather than a proactive act for trauma victims (Hosser et al., 2007).

The generalizability of the results from this study is limited to young German male prisoners with repetitive victimizations before entering adulthood. Research exploring the cumulative impact of childhood maltreatment and adult victimization on female inmates is scarce.

For this reason, the present study aims to explore the interrelations of victimization and violent behaviour with a group of women offenders from a community residential facility. The goal of this examination is to contribute to the existing literature with a deeper understanding of cycles of violence in women that may assist the development of effective prevention and treatment strategies and programs.

The link between trauma and offending behaviours. Adverse events such as childhood maltreatment and abuse are frequently associated with a lack of external resources and support structures that diminish the development of personal resilience (Moloney et al, 2009). A history of complex trauma experiences (i.e. severe and enduring victimization) often induces overwhelming feelings of powerlessness and disrupts emotional regulation in times of stress. Emotion regulation is a multifaceted construct involving the awareness, clarity, and acceptance of emotional response, the access of effective emotion regulation strategies, and the control of impulses and pursuit of goal-directed behaviours when experiencing negative emotions (Gratz & Roemer, 2004). Previous research has demonstrated a clear association between early trauma and difficulties in emotion regulation.

Guion (2011) examined the relationship between childhood interpersonal trauma and emotional regulation in a group of 183 offenders (54% female) residing in 2 detention and 3 diversion centres in the state of Virginia. Offenders' childhood experiences of physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect were measured by The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). This study not only confirmed

the gendered difference in the level of experienced childhood sexual abuse, but also found a positive relationship between childhood maltreatment and difficulties in emotion regulation among offenders (Guion, 2011). Explicitly, those who reported a greater exposure to childhood trauma on CTQ showed more problems in emotion regulation.

In addition, available evidence suggests a cumulative negative impact of trauma victimizations on female offenders' emotion regulation abilities (Walsh, DiLillo, & Scalora, 2011). Walsh et al. (2011) examined the association between multiple victimization experiences and emotional regulations in a sample of 168 high-risk women offenders that have suffered from either or both child sexual abuse and adult sexual victimization. Consistent with the revictimization literature (Hosser et al., 2007; Dietrich, 2007; Widom et al., 2008), findings indicated that childhood sexual abuse was positively correlated to later rape in adulthood. Moreover, results of this study showed that female offenders reporting sexual revictimization in adulthood demonstrated difficulties in emotion regulation including: emotional unacceptance, lack of emotion clarity and attention, problem accessing effective emotion regulation strategies, and difficulties in controlling impulses (Walsh et al, 2011). Limitations of this study include the use of a non-random self-selected sample and a retrospective self-report methodology indicating a possibility that the responses might have been biased by under or over reporting and/or inaccurate recall. Regardless of these possible errors in its methodology, this study highlighted the severity of emotion regulation difficulties in women with experiences of repeated sexual revictimization over the lifespan.

Emotional dysregulation, reflected in difficulty controlling impulses and difficulties engaging in goal-directed behaviors when experiencing negative emotions, is associated with aggression (Roberton, Daffern, & Bucks, 2012). When an individual experiences difficulties in regulating a negative or unpleasant emotional state (i.e. fear), he or she may be more likely to engage in aggressive behaviours in an attempt to repair, terminate or avoid that emotional state. There is also evidence suggesting that aggression is sometimes used to alleviate negative emotions, especially uncomfortable feelings associated with personal danger and vulnerability (i.e. anger, anxiety, or shame) (Bushman, Baumeister, & Phillips, 2001; Gardner & Moore, 2008). As a result, female trauma survivors' violent offending behaviours in responding to an environmental trigger could be mediated by their incompetency in regulating emotions.

Also suggested by Walsh et al. (2011) was a possible relation between poor emotion regulation abilities in victimized women and their engagement in risky behaviours, such as substance abuse, and managing negative affect. It is noted that drug abuse can lead to imprisonment directly via drug-related offences or indirectly by increasing the likelihood of violent behaviours (Moloney et al, 2009). With a sample of 111 incarcerated women with a history of child sexual abuse, Asberg and Renk (2012) found that the relationship between trauma and negative consequences, such as legal problems, was mediated fully by participants' use of substance as a coping of negative emotions. In this study, among the 111 female child abuse survivors, 74% reported incarceration for drugs or illicit substances, confirming a link between experiences of childhood trauma and substance use behaviours. Moreover, the motives for these

trauma survivors to engage in substance use appeared to be related to emotion management of their trauma symptoms. Despite the self-report nature of this study and the utilization of jail inmates (rather than prison inmates), this research emphasized the role of substance use in the relationship between management of trauma symptoms and illegal criminal behaviours among women with a history of childhood sexual abuse.

Increase in the severity of emotion dysregulation can result in a decrease in the competency to effectively defend oneself with adaptive emotion regulation strategies in times of danger. These maladaptive responses may increase exposure to potential perpetrators and heighten the risk of revictimization as a result (Grayson & Nolen-Hoeksema, 2005; Walsh et al., 2011). Emotion management problems and revictimization in female trauma survivors may be mutually influential: "Repeated victimization experiences may increase emotion regulation problems, which then further increases risk for subsequent victimizations" (Walsh et al., 2011, p.1113). The ultimate outcome of this cycle may be an elevated risk of violence. Taken together, emotion regulation abilities may have a role in the relationship between trauma and violent offending behaviours in female offenders.

The goal of this study was to explore the gendered effect of past trauma on the pathways to criminal convictions within a sample of community based offenders. With consideration of the concepts from the formal LSI-R and the gender-responsive supplement, this study described the following:

1. The gendered pathways to criminal involvement

2. The impact of trauma experiences on women's offending behaviours

    a) Trauma experiences and the nature of offence

    b) Trauma history and women's experiences with the criminal justice system

    c) Emotion management and its role between trauma and offending behaviours

Method

Participants

This research was a descriptive field study drawing on data from a total of 90 case files of individuals in the crisis care program at a community corrections agency in a large urban area in Ontario. All of the participants were at least 18 years of age and were involved with the criminal justice system during the past two years and may be considered as representative of offenders admitted to community correctional residential facilities in Canada over the past two years.

Procedure

Participant case files maintained by the agency were the source of information for this study. The data was collected by a research team of two master's students under the supervision of two principal investigators. The case files were reviewed and data retrieved based on items related to the concepts of nature of offense, psychiatric history, trauma history, and client needs were collected and coded by the students. Every 10th case file was reviewed by both student researchers to ensure reliability. The identifiable information of the subjects was protected and no one outside of the research team had access to the collected data for this study. Descriptive data were generated, then a series of Chi-Square analyses with the items of abuse and trauma, nature of offense, and client needs were carried out to examine their contributions to participants' offending behaviours were generated.

Materials, Instrument and Measures

Data retrieval instrument. The data retrieval instrument used for data collection of this study consisted of 506 items capturing participants' demographic information, criminal history, source of referral, pre- and post- program legal status, living situations, education levels, employment status, and primary income source; as well as their presenting issues, mental health background, psychiatric symptoms, past and current treatment regime, past and current use of substance, trauma experience and risk factors, client presentation on admission and client goals for their stay in this residential program. These items were put together by principle investigators in collaboration with staff at the agency for the use of this research project (see Appendix B for a copy of the data retrieval instrument).

Variable clusters. The psychiatric symptoms checklist was based on participants' self-reported symptoms experienced on a regular basis or during their stay. This data was collected by the two research students based on their review of case notes prepared by staff at the residential facility. The symptoms were later categorized and clustered with consideration of the symptom description of each psychiatric diagnosis on the DSM-IV. The emotional dysregulation symptom cluster is comprised of emotional symptoms and symptoms described in the diagnosis of impulse control disorder in the DSM-IV. This cluster also included any symptoms that are in line with the emotional dysregulation definition used in the study of Roberton et al. (2012): any negative emotions reflected by difficulty controlling impulses and difficulties engaging in goal-directed behaviors (see Appendix C for a detailed list of each symptom cluster).

The past and current medication treatment data was collected and clustered based on the nature of the drugs and the medical illnesses that these medications were prescribed for (see Appendix D for a detailed list of each treatment cluster).

Demographic statistics. This study consisted of a total of 90 participant files, 48 (53%) female and 42 (47%) male. The mean age of participants was 30.5 years (*SD* = 10.1), with a maximum reported age of 66 and minimum of 18 years. Of the 90 participants, 88 (97.8%) indicated English as their primary language and 54 (60%) identified themselves as non-aboriginal. The maximum length of stay in this crisis program was 98 days and the minimum length of stay was 0 days with a mean of 19.52 days in care (*SD* = 16.1). The major sources of referral for their involvement in this community residential program included: correctional facilities (19%), criminal justice system - other sources (14%), criminal justice system - case management (13%), other institutions (11%), and referrals by self, family and friend (11%). Only 1 person in this sample indicated that her enrollment was following a community treatment order. About 64% of this sample indicated that they had attended secondary/ high school in the past, and 67% of the participants were not in school at the time of their termination. Of the 90 participants involved in this residential program, 41% were successfully discharged (33.3% of the women; 50% of the men), 28% were terminated due to violation of the rules (27.1% of the women; 28.6% of the men) and 27% withdrew from the program at their own volition (37.5% of the women; 14.3% of the men). Two men were terminated because of imposed new charges and one woman was relocated to another institution.

Prior to being admitted to the crisis program, 39% of the participants lived by themselves and 41% resided with non-relatives; at termination, 29% went on to live on their own, 13% reported residing with non-relatives and 43% of the participants declined to provide this information. Approximately 62% of the participants (34 women; 22 men) were residing in a correctional / probation facility prior to attending this community program; 30% of the total sample reported that they were moving into private houses or apartments upon program completion, 8% were going to reside in a hostel or shelter and 41% of the participants declined to provide their current residence type.

Of the 90 individuals, 80 (88%) reported they were unemployed before coming to this facility and 51 (57%) reported no employment at their termination. With respect to participants' primary income source at the time of their intake, 36% indicated that they were on Ontario Disability Support Program [ODSP] and 37% of the participants were on Social Assistance. At their terminations, 29% reported they were on ODSP, 26% were on Social Assistance, and 30% declined to provide information on their current primary income source.

Criminal history. In the total sample (N = 90), 76 participants (84.4%) indicated that they were previously involved in the criminal justice system. At the time of their admission, 50% of the sample were on probation; 47.8% were identified as being at risk for legal problems; the same proportion (45.6%) was on bail and awaiting trial; and 17.8% were incarcerated. At the time of their termination, 44.4% of the total sample was on probation; 38.9% reported they were at risk for legal problems; 35.6% was on bail and awaiting trail; 10% of the sample declined to identify

their current legal status; and 7.8% was incarcerated at the end of the program.

In regard to participants' current nature of offence, 31.3% of the female sample in this study were charged with property crimes, followed by crimes against persons (20.8%), crimes against both persons and property crimes (18.8%), drug charges (12.5%), breach and administrative charges (8.3%). In the male population, 40.5% came in with a charge of crimes against persons, 19% of the men were involved with property crime, another 19% were charged with both violent and property crimes, followed by breach and administrative charges (9.5%) and drug charges (4.8%). Of the total sample ($N = 90$), 7 participants (7.8%) indicated that they didn't have current charges at the time of the intake.

Mental health background. In the total sample, 68 participants (75.6%) were formally diagnosed with a mood disorder (39F; 29M), 52 (57.8%) indicated that they had a concurrent disorder (35F; 17M), 38 participants (42.2%) were admitted with a diagnosis of an anxiety disorder (22F; 16M), 29 participants (32.2%) said they were diagnosed with a disorder of childhood or adolescence (9F; 20M), 28 participants (31.1%) had post-traumatic stress disorder diagnoses (19F; 9M) and 25 participants (27.8%) had schizophrenia or another psychotic disorders (16F; 9M).

With respect to reported psychiatric symptoms, the majority of the sample (86.7%) indicated that they experienced at least one mood disorder symptom, about half of the sample (46.7%) reported to have at least one anxiety symptom. Statistics for participants' past use of medications shows that 48.9% of the sample was on at least one of the antipsychotic drugs, and

38.9% were on at least one of the antidepresant medications. For current treatment during their stay at the residential facility, 44.4% of the sample was prescribed with at least one of the antipsychotic drugs, 33.3% was prescribed with at least one type of the antidepressant medications, and 14.4% was on treatment for medical illnesses.

The issues that were planned to be addressed at the participants' intake were as follows: housing (82.2%), problems with substance abuse/ addictions (70%), specific symptoms of serious mental illness (62.2%), financial (46.7%), legal (35.6%), other (31.1%), relationship (30%), occupational/ employment/ vocational (26.7%), activities of daily living (24.4%), physical/ sexual abuse (20%), threat to others/ attempted suicide (17.8%) and educational (13.3%). There were 5 participants for whom presenting issues were not identified.

In terms of client goals for their stay at this residential facility, looking for proper housing was the goal for the majority of the participants (83.3%), followed by attending mental health programming (55.6%), connecting with other services (46.7%), abstaining from substances (43.3%) and sorting out financial issues (36.7%).

Substance use history. In the total sample ($N = 90$), 83 participants (92.2%) indicated that they had a habit of substance use in the past. With respect to the use of different substances, information was taken from the files such that all substances reported for each participant were noted, and are summarized here: alcohol was used by 59.5% of the men and 35.4% of the women; cocaine or crack cocaine was used by 47.9% women and 31% men; marijuana was used by 40.5% of the men and 33.3% of the women; Oxycontin/ Oxycodone was used by 37.5% of the female

participants and 19% of the male participants; Opiates was used by 29.2% of the women and 19% of the men; prescription medications was abused by 27,1% of the women and 16.7% of the men; Methamphetamine was used by 18.8% of the female participants and 11.9% of the male participants; and Morphine was used by 16.7% of the men and 12.5% of the women. In addition, 9 women and 4 men reported that they had been engaged in some sort of treatment for their substance use in the past.

Reports of current substance use for this sample showed results favouring a similar trend - women in this sample were more likely than men to use substances. Explicitly, drug paraphernalia was found in 11 women's rooms (22.9%) and only in 1 of the men's (2.4%) during their stay at this residential facility.

Trauma history. The trauma experiences of participants in this study were described by 12 items on the data retrieval instrument. Out of the 12 items, 6 described childhood trauma and these included: involved in the child welfare system as a child (1F; 3M), emotional abuse as a child (16F; 17M), maltreatment as a child (5F; 4M), neglect as a child (0F; 1M), physical abuse as a child (13F; 22M), and sexual abuse as a child (11F; 8M). Three items were used to categorize different trauma experiences in adulthood: sexual violence as an adult (7F; 2M), intimate partner violence (20F; 5M), and children removed from care (22F; 14M). The other 3 items described other reported trauma experiences: historical grief, current grief, and historical trauma (trauma information identified as neither child nor adult trauma experiences) (See Table 1 for Descriptive Statistics for Participants' Trauma Experiences).

A total of 66 participants (73.3% of the total sample) indicated experience of at least one type of the identified trauma items. Specifically, 38 of the 66 participants in the sub-sample with a reported trauma history were female (79.1% of the female population in the sample). Statistics showed 45.8% of the women and 33.3% of the men in this sample said they had children removed from their care; 41.7% of the women and 11.9% of the men reported they had experienced intimate partner violence as an adult; 22.9% of the women and 19% of the men said they experienced sexual abuse as a child; 14.6% of the women and 4.8% of the men experienced sexual violence as an adult; 10.4% of the women and 9.6% of the men had experiences of childhood maltreatment; 33.3% of the women and 40.5% of the men indicated experience of emotional abuse as a child; 27.1% of the female and 52.2% of the male participants indicated experiencing physical abuse as a child. Two individuals said they had historical trauma (1F; 1M), 2 experienced current grief (1F; 1M), 1 woman experienced historical grief and 1 man reported experience of child neglect.

Table 1

Descriptive Statistics for Participants' Trauma Experiences.

	Female		Male		All	
Characteristic	*n*	%	*n*	%	*n*	%
Trauma experienced as a child						
Child welfare as a child	1	2.1	3	7.1	4	4.4
Emotional abuse as a child	16	33.3	17	40.5	33	36.7
Maltreatment as a child	5	10.4	4	9.6	9	10
Neglect as a child	0	0	1	2.4	1	1.1
Physical abuse as a child	13	27.1	22	52.4	35	38.9
Sexual abuse as a child	11	22.9	8	19	19	21.1
Trauma experienced as an adult						
Sexual violence as adult	7	14.6	2	4.8	9	10
Intimate partner violence (adult)	20	41.7	5	11.9	25	27.8
Children removed from care (adult)	22	45.8	14	33.3	36	40
Other trauma experiences						
Historical grief	1	2.1	0	0	1	1.1
Current grief	1	2.1	1	2.4	2	2.2
Historical trauma	1	2.1	1	2.4	2	2.2
Experience of at least one type of trauma	38	79.1	28	66.7	66	73.3

Statistics showed that women reported more trauma experiences in the past compared to men. Of the 9 trauma items measuring childhood and adult trauma, there were more female than male participants reporting having experienced on 6 of the items identified: emotional abuse as a child, maltreatment as a child, sexual abuse as a child, sexual violence as adult, intimate partner violence, and children removed from care. This trend confirmed the need to look at women with histories of adult and childhood trauma and their experience with the criminal justice system in a greater depth as these trauma experiences may impact women and their risk of becoming an offender in a different way. Hence, this study is focused on women and their experiences for the examination of the association between their traumatic past and their current criminal behaviours for a purpose to facilitate our understanding of gendered pathways to crime and women's needs in community correctional settings.

Results

The focus for the analysis in this study was to identify the unique factors that lead women who experience trauma into being involved in the criminal justice system relative to women who do not have similar trauma histories. Participants' trauma experiences, criminal history, and emotional dysregulation symptoms, their presenting issues and goals for the particular residential program were examined in accordance with the rationale.

Differentiated Trauma by Gender

Gender and the presence of trauma experience. Chi-square goodness-of-fit tests were performed to look at the differences in proportion of people with trauma experiences within each gender group (Table 2). In the female sub-sample, there was a significant difference in the proportion of women offenders with at least one trauma experience (83%) as compared with the expected proportion (50%) based on the assumption that there was no difference between the two trauma groups, χ^2 (1, n = 48) = 21.33, $p < .001$. Within the female offender sub-sample this means that the number of women with an experience of trauma is significantly higher than the number of women who did not experience trauma. Likewise, there was a significant difference in the proportion of male offenders with at least one trauma experience identified in the current male sample (67%) as compared with the expected proportion (50%) based on the assumption that there was no difference between the two trauma groups, χ^2 (1, n = 42) = 6.10, $p < .014$. Within the male offender sub-sample, the number of men with an experience of trauma was significantly higher than the number of men who did not experience trauma.

Table 2

Chi-Square Test Goodness-of-Fit for Gender and the Presence of Trauma Experience

	Trauma Experience				
Gender	Yes	No	χ^2	df	*p*
Female	38	10	21.333	1	.000
	(14.0)	(-14.0)			
Male	28	13	6.095	1	.014
	(8.0)	(-8.0)			

A Chi-square test for independence using the Yates Continuity Correction was performed to compare the observed frequencies of cases that occur in each of the gender and trauma categories reflecting the presence of trauma and absence of trauma (Table 3). Yates' Correction for Continuity is a statistical procedure that compensates for the overestimate of the chi-square value when testing two variables that have two categories each (a 2 x 2 table). The analysis indicated no significant association between gender and participants' experience of trauma, $\chi 2$ (1, N = 90) = 1.82, p > .05. In the current sample, the proportion of males who experienced at least one type of trauma was not significantly different from the proportion of females who experienced at least one type of trauma.

Table 3

Crosstabulation of Gender and Presence of Any Trauma Experience (N = 90)

Trauma	Gender				
Experiences	Female	Male	χ^2	df	*P*
Yes	38	28	1.819	1	.177
	(42.2%)	(31.1%)			
No	10	14			
	(11.1%)	(15.5%)			

Gender and the nature of trauma. A Chi-square test for independence was performed to compare the observed frequencies of female and male cases that occur in different trauma categories. These categories included: no trauma experiences, childhood trauma experience, adult trauma experience, and both child and adult trauma experience (Table 4). The analysis indicated a significant association between gender and the identified types of trauma history, χ^2 (1, N = 90) = 22.66, $p < .001$. In the current sample, the proportion of males who experienced different types of trauma was significantly different from the proportion of females that experienced these types of trauma.

Table 4

Crosstabulation of Gender and the Nature of Trauma Experience (N = 90)

	Gender			
Trauma Experience	Female	Male	χ^2	*p*
No trauma experience	10	14	22.663	.000
	(11.1%)	(15.5%)		
Childhood trauma experience	5	13		
	(5.6%)	(14.4%)		
Adult trauma experience	21	1		
	(23.3%)	(1.1%)		
Both child and adult trauma experience	14	15		
	(15.6%)	(16.7%)		

Gender and number of trauma experiences. Descriptive analysis was performed to look at the average number of trauma experienced by different gender groups (Table 5). This analysis indicated that women reported a slightly higher number of trauma experiences in the past than male participants. Women had an average of 2.08 traumatic experiences; whereas men, on average, had 1.88 experiences of trauma in the past.

Table 5

Statistics for Gender and Number of Trauma Experience (N = 90)

	Number of Different Trauma Experienced							
Gender	0	1	2	3	4	5	6	*M*
Female	10	12	11	3	9	2	1	2.08
	(11.1%)	(13.3%)	(12.2%)	(3.3%)	(10 %)	(2.2%)	(1.1%)	
Male	14	5	8	8	4	3	0	1.88
	(15.5%)	(5.6%)	(8.9%)	(8.9%)	(4.4%)	(3.3%)	0	

Gender and childhood trauma. A Chi-square goodness-of-fit test was performed to examine the differences in proportion of people with childhood trauma experiences in each gender group (Table 6). This analysis reflected a significant difference in the proportion of males with at least one type of childhood experience indentified in the current male sample (67%) as compared with the expected proportion (50%) based on the assumption that there was no difference between the two groups, χ^2 (1, n = 42) = 4.67, $p < .03$. Within the male sample, the number of men with an experience of child trauma is significantly higher than the number of men who did not have an experience of child trauma. However, there was no significant difference in the proportions of women with child trauma experience, χ^2 (1, n = 48) = 2.10, $p > .05$.

Table 6

Chi-Square Test Goodness-of-Fit for Gender and the Presence of Childhood Trauma Experience

	Childhood Trauma Experience				
Gender	Yes	No	χ^2	df	*p*
Female	19	29	2.083	1	.149
	(-5.0)	(5.0)			
Male	28	14	4.667	1	.031**
	(7.0)	(-7.0)			

A Chi-square test for independence using the Yates Continuity Correction was also performed to compare the observed frequencies of cases that occur in each of the gender and childhood trauma categories that included the presence of childhood trauma and absence of childhood trauma (Table 7). The results of this analysis indicated a significant association between gender and the presence of childhood trauma history, χ^2 (1, N = 90) = 5.54, $p < .05$. This means in the current sample, the proportion of males who experienced at least one type of childhood trauma is significantly different from the proportion of females that indicated an experience of child maltreatment. In other words, this result suggests a trend that men are more likely than women to report trauma as a child.

Table 7

Crosstabulation of Gender and Childhood Trauma Experience (N = 90)

	Gender			
Childhood trauma experience	Female	Male	χ^2	*p*
Yes	19	28	5.544	.019**
	(21.1%)	(31.1%)		
No	29	14		
	(32.2%)	(15.6%)		

Gender and adult trauma. A Chi-square goodness-of-fit test was performed to look at the differences in proportion of people with adult trauma experiences in each gender group (Table 8). This analysis indicated a significant difference in the proportion of females with at least one type of adulthood experience indentified in the current female sample (73%) as compared with the expected proportion (50%) based on the assumption that there was no difference between the two groups, χ^2 (1, n = 48) = 10.08, $p < .001$. Within the female sub-sample, the number of women with an experience of adult trauma is significantly higher than the number of women who had no adult trauma history. However, there was no significant difference in the proportions of men with adult trauma experience, χ^2 (1, n = 42) = 2.38, $p > .001$

Table 8

Chi-Square Test Goodness-of-Fit for Gender and the Presence of Adult Trauma Experience

	Adult Trauma Experience				
Gender	Yes	No	χ^2	df	*p*
Female	35	13	10.083	1	.001**
	(11.0)	(-11.0)			
Male	16	26	2.381	1	.123
	(-5.0)	(5.0)			

A Chi-square test for independence using the Yates Continuity Correction was also performed to compare the observed frequencies of cases that occur in each of the gender and adult trauma categories that included the presence of adult trauma and absence of adult trauma (Table 9). The result of this analysis indicated a significant association between gender and the presence of adult trauma history, χ^2 (1, N = 90) = 9.67, p < .002. This means in the current sample, the proportion of female who experienced at least one type of adult trauma is significantly different from the proportion of males that indicated an experience of adult trauma. In other words, this result suggests a trend that women in this sample are more likely than men to experience trauma as an adult.

Table 9

Crosstabulation of Gender and Adult Trauma Experience (N = 90)

	Gender			
Adult trauma experience	Female	Male	χ^2	*p*
Yes	35	16	9.688	.002**
	(38.9%)	(17.8%)		
No	13	26		
	(14.4%)	(28.9%)		

Correlations between childhood and adulthood trauma. Correlations were calculated using Spearman's nonparametric correlation coefficient to examine the association first in the overall sample between the presence of childhood trauma and adult trauma experiences, then for females and males separately; the results are summarized in Table 10. In the overall sample, there was a small positive correlation between participants' childhood trauma and their experience of adult trauma, $r = .11$, $N = 90$, $p < .001$ (2-tailed). In the male sample, there was a moderate positive correlation between the experience of childhood trauma and adult trauma experience, $r = .45$, $n = 42$, $p < .001$ (2-tailed). However, in the female sample, the result showed no significant correlation between the presence of childhood trauma and their experience of adult trauma, $r = .01$, $n = 48$, $p > .05$ (2-tailed).

Table 10

Spearman's Nonparametric Correlations between Childhood and Adulthood Trauma Experiences

	Females		Males		All	
Scale	1	2	1	2	1	2
1. Childhood trauma experience	-	.01	-	.45**	-	.11**
2. Adult trauma experience		-		-		-

** $p < .001$ (2-tailed)

Differentiated Nature of Offence by Gender

A Chi-square test for independence analysis of the overall sample ($N = 90$) for gender and nature of offence indicated no significant associations between gender and the five types of crime: crimes against person, property crimes, both violent and property crimes, drug offences and administrative crime such as breach, χ^2 (4, $N = 90$) = 5.72, $p > .05$. However, statistics suggests a trend that female offenders were more involved in property (15F; 8M) and drug offences (6F; 2M) than male offenders in this sample. In addition, it shows that the men in this sample were more involved in violent crimes (17M; 10F) (see Table 7 in Appendix A).

Trauma Experiences Related to the Nature of Offence

A Chi-square test for independence analysis of the overall sample ($N = 90$) for trauma experienced and nature of offending behaviours indicated no significant associations between trauma presence and the five types of crime: crimes against person, property crimes, both violent

and property crimes, drug offences and administrative crime such as breach, χ^2 (4, N = 90) = 4.97, $p > .05$. Even though the associations between the sub-groups of offending behaviours in participants with trauma experiences did not vary from one group to another, the results indicate that the presence of trauma is weighted in favour of more criminal involvement overall in the group of trauma survivors. Furthermore, statistics suggest that participants that experienced trauma are more likely to be involved in all types of offence (see Table 8 in Appendix A).

Trauma experienced related to the nature of offence in women offenders. A Chi-square test for independence analysis of the female sub-sample (n = 48) for general trauma experienced and nature of offending behaviours indicated no significant associations between trauma presence and the five types of crime that were categorized as crimes against person, property crimes, both violent and property crimes, drug offences and administrative crime such as breach, χ^2 (4, n = 48) = 3.10, $p > .05$ (see Table 9 in Appendix A). However, statistics showed a tendency for higher rates of offending in the group of women with a trauma history. Table 11 presents the details of women with presence of at least one type of identified trauma experience and the trend of their offending behaviours.

Table 11

Statistics for Women with General Trauma Experience and Their Offending Behaviours (n = 48)

	Nature of offence					
Trauma Experience	Violent crime	Property crime	Both	Drug offence	Breach	Total
Yes	9	11	8	6	3	37
	(18.8%)	(22.9%)	(16.7%)	(12.5%)	(6.3%)	(77.1%)
No	1	4	1	0	1	7
	(2.1%)	(8.3%)	(2.1%)	(0%)	(2.1%)	(14.6%)

Note: Both = both violent and property crimes.

In terms of types of trauma experience and women's offending behaviours, Chi-square test for independence analysis did not reflect a significant association between the experience of adult trauma and the five types of crime, χ^2 (4, n = 48) = 8.85, $p > .05$. Despite this non-significant association, statistics suggests that female participants with an adult trauma experience are more likely to be involved in almost all types of offence (all types except property crimes) (see Table 10 in Appendix A). The Chi-square test of independence for childhood trauma history and women's nature of offence also did not provide significant result, χ^2 (4, n = 48) = 7.23, $p > .05$; but it indicates a trend favouring a correlation between women with childhood trauma experience and general criminal involvement (see Table 11 in Appendix A).

Emotion Dysregulation Symptoms in Offenders' with Traumatic Past

Emotion dysregulation symptoms and gender. A Chi-square test for independence using the Yates Continuity Correction indicated no significant association between gender and the presence of any emotion dysregulation symptoms, χ^2 (1, n = 66) = .122, p > .05. Nevertheless, statistics showed that more women than men in the trauma sub-group indicated having emotion dysregulation symptoms (32F; 25M) (see Table 12 in Appendix A). This suggests a possibility that women are more likely than men to develop dysfunctional emotion-coping strategies after experiencing trauma.

Emotion dysregulation symptoms and trauma in women. A Chi-square goodness-of-fit test indicated there was a significant difference in the proportion of individuals with emotion dysregulation symptoms identified in the sub-sample of female offenders that reported an experience of trauma in their past (80%) compared with the expected proportion (50%) based on the assumption that there was no difference between the two groups, χ^2 (1, n = 38) = 14.4, p < .001 (Table 12). In other words, within the female sub-sample, the number of women with an experience of trauma that indicated having emotional dysregulation symptoms is significantly higher than the number of women who experienced trauma that reported no emotion dysregulation symptoms.

Table 12

Chi-Square Test Goodness-of-Fit for the Presence of Emotion Dysregulation Symptoms in Female Offenders with Traumatic History (n = 38)

ED Symptoms	Women with Trauma	χ^2	df	*p*
Yes	31 (12.0)	14.400	1	.000
No	7 (-12.0)			

Note: ED Symptoms = Emotion Dysregulation Symptoms

Emotion dysregulation symptoms and the nature of trauma in women. A Chi-square test for independence analysis of the female sub-sample ($n = 48$) was performed to look at the association between the presence of emotion dysregulation symptoms and the nature of trauma experiences. The results indicated no significant associations between symptom presence and the four types of trauma: no trauma of any kind, childhood trauma, adult trauma, both adult and childhood trauma, χ^2 (3, $n = 48$) = 2.03, $p > .05$. However, these results do reflect that women with an experience of adult trauma had the highest tendency to experience some form of emotional dysregulation symptoms (18F; 37.5% of the females in this sample), followed by those

that experienced both adult and childhood trauma (11F; 22.9% of the females in this sample) (see Table 13 in Appendix A).

Emotion dysregulation symptoms and women's nature of offending. The Chi-square test for independence analysis of the female sub-sample ($n = 48$) for the presence of emotion dysregulation symptoms and nature of offence did not indicate a significant association between symptom presence and the five types of offence: crimes against person, property crimes, both violent and property crimes, drug offences and administrative crime such as breach, χ^2 (4, $n = 48$) = 3.85, $p > .05$. While the relationship between women offender's emotional dysregulation symptom and violent offending was non-significant, there is an increased likelihood for women with emotion dysregulation symptoms to get involved in violent crimes if looked at independently (see Table 14 in Appendix A).

Women's Unique Needs and the Focus of Intervention in the Community Setting

Differentiated presenting issues by gender. Statistics showed that at the time of admission, there were more women than men identified as a presenting issue of physical and sexual abuse (12F; 6M). In contrast, more men had issues with being a threat to others/ attempted suicide (14M; 2F), in need of financial support (29M; 13F) and problems with activities of daily living (17M; 5F) (see Table 4 in Appendix).

Women's needs. Table 13 presents the women offenders' self-proposed goals for their stay in the crisis program. The priority for women with traumatic history in their past and women in general lies in finding proper housing, followed by attending available mental health programs

(i.e. symptom management, development of healthy living style, and anger management etc) and abstaining from substances (see Table 15 in Appendix A for a complete listing of women's goals). Statistics for the presenting issues of women with trauma experience at admission showed consistent results with housing, problem with substance abuse/ addiction and specific symptoms of serious mental illness being the top 3 concerns that needed to be addressed (see Table 16 in Appendix A).

Table 13

Statistics for Women with Past Trauma and Their Proposed Goals in the Crisis Program (n = 48)

	Trauma Experience	
Goals	Yes	No
1. Housing	35	8
	(72.3%)	(16.7%)
2. Mental health programming	23	5
	(47.9%)	(10.4%)
3. Abstain from substances	21	5
	(43.8%)	(10.4%)

One major concern for women with trauma experiences seems to be abstaining from substance use. With respect to women that experienced trauma and their tendency to be more involved in drug related offences than male offenders as mentioned previously, substance use appears to be a more significant issue for females with traumatic histories. In the sub-group of women trauma survivors, a Chi-square test goodness-of-fit (Table 14) indicated a significant difference in the proportion of women with past substance use (97.5%) as compared with the expected proportion (50%) that assumes there was no difference between the two groups, χ^2 (1, n = 38) = 36.1, $p < .001$. In other words, within the female trauma survivor sub-sample, the number of individuals that indicated a past use of substance is significantly higher than the number of individuals that did not have a history of substance use. This result suggests a trend for women with past trauma experiences to use at least one type of substance. Furthermore, the substance use statistics for this sample also showed that women offenders in general have a pattern of using certain drugs. Women more than men indicated an abuse history involving cocaine/ crack cocaine, oxycodone, opiates, prescription medication, methamphetamine, and hydro-morph in the past (see Table 5 in Appendix A). There is also a higher tendency for women with a traumatic past to abuse these types of drugs compared to women who did not experience trauma (see Table 17 in Appendix A for a comparison of women's trauma experience and their past substance use pattern).

Table 14

Chi-Square Test Goodness-of-Fit for Past Use of Substance in Women with Trauma (n = 38)

Past Substance Use	Women with Trauma	χ^2	df	*p*
Yes	37 (18.0)	36.100	1	.000
No	1 (-18.0)			

Note: Past substance use here is measured by participants' past use of at least one substance.

Differentiated exit disposition by gender. In terms of participants' exit disposition from this particular community crisis program, results showed that men are more likely to complete the program than women (21M; 16F). In contrast, women were more likely to withdraw from the program with no valid reasons (18F; 6M). Both gender groups are similar in the proportion for an early termination due to the violation of rules (13F; 12M). Only two men were terminated early due to the imposition of new charges, and one woman in did not complete the program due to relocation (see Table 18 in Appendix A). The Chi-square test for independence analysis of the overall sample for gender and their exit patterns indicated a non-significant association between gender and the five types of exit disposition: successful completion, active withdrawal, early termination due to imposed new charges, early termination due to violation of rules, and relocation, χ^2 (4, N = 90) = 9.22, $p > .05$.

For women with a history of a traumatic past, statistics showed a non-significant association between their presence of trauma experiences and the five types of exit dispositions that included successful completion, active withdrawal, early termination due to imposed new charges, early termination due to violation of rules, and relocation, χ^2 (3, n = 48) = 5.22, $p > .05$. However, the success rate of this program in the sub-group of women with trauma was 35%, suggesting that approximately 65% of the women with trauma did not successfully finish the program at the end (see Table 19 in Appendix A).

Overall, the key findings of this research include:

1. Offenders with previous trauma histories have different experiences with the criminal justice system compared with individuals who did not have similar histories suggesting that the presence of past trauma has a relevant role in understanding their criminal justice pathways for all offenders regardless of gender. Particularly, experience of trauma is a salient factor in describing women's experiences with criminal justice in terms of the nature of offence, the types of issues they face, and the needs they present with as they manage the challenges with their mental health symptoms based on their past trauma experiences;

2. Emotional dysregulation appears to be a common experience in women offenders who have experienced trauma in the past;

3. The majority of women offenders with past trauma in this community-based sample have substance abuse issues, and abstaining from drug use appears to be one of their major concerns.

Discussion

The purpose of the current study was to explore the relevance of prior trauma in understanding gendered differences in pathways to involvement in the criminal justice system. Ninety people involved in a community-based correctional facility were participants of this study. Data relevant to their demographic characteristics, criminal history, mental health background and trauma experiences were collected and analyzed for this research. Overall, findings suggested that the presence of past trauma, regardless of gender, differentiates offenders' experience within the criminal justice system, and being a woman with a traumatic past is uniquely associated with certain criminal justice variables. This discussion will explore the relevance of these findings in greater detail in the context of research, relevance to counselling psychology, community corrections and recommendations for future research.

Relevance to Previous Research

Women in the criminal justice system. As mentioned previously, the number of women in the Canadian criminal justice system has been growing rapidly since the mid-1980s (Kong & AuCoin, 2008). Correspondingly, the percentage of women involved in community corrections has shown a similar increase. Due to this change in the representation of the female population in the justice system, attention is drawn to investigate the role of unique gendered risk factors in women's pathways to crime and their needs in a community rehabilitative setting to facilitate successful reintegration back to the community.

Drawing on the notion from previous research that certain social circumstances place

women at risk of physical and sexual victimizations, in the current sample, 41.7% of the women reported an experience of intimate partner violence, 37.5% indicated being a victim of sexual violence, 33.3% were emotionally abused in their childhood and 27.1% reported that they experienced physical abuse as a child. Many of these women had experiences across multiple areas related to trauma. Therefore, the statistics from the current research validate that interpersonal violence is a particularly common past experience for women in the criminal justice system. In fact, this result shows the percentage of women in the criminal justice system that experienced interpersonal violence is about 40% higher than is estimated life-time (age 16 years onwards) self-reported IPV against women, which is 29% in the general Canadian population (Johnson, 2005).

Gendered pathways to criminal involvement. With respect to offenders' experiences prior to their involvement with the criminal justice system, 30% more women than men in the current sample reported having a diagnosis of a concurrent disorder, about 20% more women than men indicated that they had a post-traumatic stress disorder and 12% more women than men reported they had a mood disorder. In contrast, men in this sample had more childhood or adolescent disorders and personality disorder diagnoses. In terms of participants' presenting issues on admission, physical and sexual abuse was particularly common among women offenders in this sample. Conversely, males presented with needs addressing their financial and legal problems, dysfunctional relationship issues and potential harm to self or others. In addition, women in this sample had a different pattern of past substance use from men. Specifically, there were

considerably more women than men reporting abuse histories of cocaine, opiates, oxycontin/ oxycodone, and prescription drugs, whereas men reported greater abuse of alcohol. Overall, the current research shows that women and men enter the criminal justice system with different presenting issues in the context of mental health, trauma history, financial and legal needs, interpersonal relationship, and substance abuse. These findings provide support for the proposed gendered pathway to criminal involvement.

Gendered-specific assessment tools. With the emphasis of gendered pathways to criminal involvement, there is the need for implementing risk assessment protocols that are sensitive to gender in predicting offending behaviours and assessing and appropriately targeting the needs of female offenders. With the inclusion of potential gender-responsive risk factors such as trauma victimization and abuse history, relationship problems, mental illness and drug abuse, the problems of over-classifying women in regards to their risk and ignoring the relevant mental health needs may be offset by addressing the relevant needs for women. Additional assessment measures such as Van Voorhis's Women's Supplement Risk/ Need Assessment is recommended as a supplement to existing standardized measures such as the LSI-R in assessing women's specific criminogenic risk and needs for making appropriate service and treatment decisions.

Trauma. Participants' trauma histories appeared to play a significant role in offending behaviour. 77% of the total sample indicated an experience of past trauma. In the current study, two types of trauma experiences were investigated in relation to participants' gender. Childhood trauma included experiences with the child welfare system as a child, emotional abuse, child

maltreatment, child neglect, physical abuse and sexual abuse as a child. Adult trauma included experiences of sexual violence as an adult, intimate partner violence, and a child being removed from a parent's care. Consistent with the results from Topitzes et al (2011), the finding in this study indicated that male offenders experienced more childhood maltreatment than female offenders, which consisted of experiences of physical abuse as a child. However, women experienced more sexual violence, both as a child and as an adult. In addition, for women emotional abuse as a child was also a common experience.

With respect to recurrent trauma, the results from this study showed a small correlation between participants' childhood trauma experiences and their experience of adult trauma. Specifically, this association is stronger for males in this sample relative to females. Therefore, Dietrich's (2007) finding that women with a history of childhood maltreatment were more likely to experience revictimization relative to men was not supported. This finding suggested that childhood trauma experiences could not predict adult trauma victimization for women in this study. However, knowing that a large number of women were victims of sexual and intimate partner violence in both child and adulthood, the correlation between childhood maltreatment and revictimization remains an area of concern for women in the examination of the cumulative effect of trauma and their offending behaviours.

Trauma and crime in women. Five different types of crime were examined for women in this study: crimes against person, property crimes, both violent and property crimes, drug offences and administrative crimes such as a breach of probation and/or parole. Findings showed

that the majority of offences committed by women in this sample were property related or non-violent crimes. In addition, 83% of the women indicated that this was not their first encounter with the criminal justice system. In women with a traumatic past, analysis did not show a strong association between women's previous trauma and their criminal involvement. However, results in this sample still suggest that female offenders with past trauma are more likely to be involved in all types of crimes compared with those who did not have similar experiences.

Overall, these findings support the notion that the impact of childhood maltreatment and adulthood victimization is a crucial factor to consider in the development of effective treatment programs for female offenders and the planning of preventative strategies for future recidivism.

The link between trauma and crime in women. Findings in this current study are consistent with previous research that suggested a potential correlation between a history of complex trauma experiences and emotion regulation difficulties (Guion, 2011). Results showed that 80% of the women with a trauma experience reported symptoms related to emotional dysregulation and difficulties in controlling impulses, and concerns related to hopeless, fear, anxiety, mania and anger management. Moreover, results showed that women with adult trauma experiences had the highest tendency to experience emotion dysregulation symptoms.

In relation to the nature of crime in women with experiences of trauma, the results did not reflect a significant association between crime and women's emotional dysregulation symptoms. This suggests that the relationship between emotional dysregulation symptoms and each type of crime is not apparent in the current analyses. However, this is not to suggest that the

presence of emotional dysregulation symptoms do not have an impact on violent offending behaviours with women who are trauma survivors. The results still showed a pattern favouring an increased likelihood for women who have report a presence of these symptoms; this association may be more apparent if violent crimes were examined independently within this context. Overall, the role of emotion management difficulties in women remains an area of concern in the context of the cycle of victimization and the increased risk of violence.

Findings from this research, where 80% of the women sample population reported an experience of trauma, indicate that women trauma survivors are more likely to abuse substances compared to women who did not experience trauma. Specifically, female offenders in this current sample with past trauma reported greater use of cocaine, oxycontin, opiates, marijuana, prescription medications, alcohol, methamphetamine and hydro-morphine compared with women who did not experience similar trauma. This finding supports the trend in the previous research that the experience of interpersonal trauma potentially increases a woman's risk for substance abuse emphasizing the crucial role of women's substance use in the relationship between symptom management and past trauma experiences. Even though the analyses in the current study did not indicate specific direction or the means by which substance use may have impacted their offending pattern and behaviours, these results are a powerful reminder that substance use is an important factor when predicting and assessing women offenders' response to a correctional environment and treatment programs.

In conclusion, the findings of this current study add knowledge to existing research in the areas of gendered differences in offenders' experiences with the criminal justice system; the role of trauma histories in relation to gendered pathways to crime; the impact of trauma on women's offending behaviours; and the unique symptoms and strategies women developed in coping with trauma symptoms and their roles in relations to women's criminal involvement.

Relevance to Counselling

The findings of this study have considerable importance for the counselling profession in a criminal justice setting. First, it is questionable that offenders receive sufficient attention to their mental and physical health needs throughout their incarceration in the criminal justice system or prior to their involvement in community corrections. For example, statistics from this current study indicated a gap between the number of individuals with a formal psychiatric diagnosis of a mood disorder (76%) and the number of participants who reported experiences of mood disorder symptoms but received no formal diagnoses or treatment for these symptoms (87%). Offenders' access to proper psychological services such as obtaining formal diagnoses may be limited in the correctional environment. In addition, the pattern of participants' treatment regime changed after they entered community corrections. Specifically, the use of psychiatric medications such as antidepressants, antipsychotics and stimulants was reduced; in contrast, prescriptions for their medical illnesses and symptoms increased by about 50%. Hence, there may be a need for psychiatrists and counselling professionals in a criminal justice setting to pay more attention to offender's physical symptoms and their impact on offenders' response to treatment programs. In

addition, informative education for offenders on treatment compliance may be important to help this group of individuals with complex mental and physical illnesses to avoid medication misuse after they are released to the community.

Second, evidence about the mental health and substance use background of women offenders with trauma histories in the current study highlights an area of attention at the counselling level. The indication that women with histories of trauma are likely to experience specific symptoms related to post-traumatic stress disorder is especially important for counsellors when working with this group of clients. Moreover, as extensive trauma experiences are associated with a diminished development of a persons' resilience (Moloney, et al, 2009), the impact of trauma on women offenders' sense of self is of considerable significance. As identified in the existing literature, the lost sense of power and disrupted sense of the self can place women with an increased potential of exposure to future perpetrators with the corresponding heightened risk of revictimization due to their inabilities to defend themselves successfully in times of danger (Grayson & Nolen-Hoeksema, 2005; Walsh et al., 2011). Hence, the impact of trauma on women's mental health well-being should be addressed in counselling to arrest the cycle of victimization (Hosser et al. 2007).

In terms of the differences in the pattern of substance use in men and women with trauma histories, women in this sample tended to abuse drugs to cope with negative emotions and symptoms. This is important for counsellors in a correctional setting to appreciate that women have unique ways to cope with the symptoms of their trauma experiences that include

dysfunctional emotional management difficulties. It is also crucial for criminal justice professionals to recognize substance abuse as a common issue that women who experience trauma bring with them as they enter the justice system.

It is suggested that therapeutic treatment in the correctional setting should be focused on helping women process their emotions, reconstructing their sense of self-worth and finding appropriate coping strategies with their trauma symptoms. This may be beneficial in the longer term to help these individuals better respond to the other rehabilitative treatment services that focus on reducing risk behaviours and recidivism.

In conclusion, in the context of health care and counselling, the current study emphasizes the importance of increasing offenders' access to psychological and physical health services in the criminal justice setting. It also emphasizes the need to incorporate the knowledge of the impact of prior trauma on women's criminal involvement into existing treatment programs.

Relevance to Community Corrections

As mentioned previously, the female parole and probation populations have been increasing since 2004, and the majority of these clients are involved with the community corrections system (Public Safety Canada, 2011). The primary focus of community corrections services is the lowering of offenders' recidivism through rehabilitative programs and treatments. Unfortunately, due to the nature of the turnover rate in these community residential facilities, professionals may not be able to gain sufficient knowledge about the female offender population. As a result, they may not be able to effectively develop or resource appropriate treatment

programs for this group of offenders. Hence, this study focused on adding to the growing body of knowledge that is addressing this gap and prepare professionals and staff with sufficient understanding of the impact of trauma on women offenders and increase the awareness of the experiences, background, and presenting issues along with the unique needs of these individuals with past trauma victimizations.

Findings in this current study suggest that the majority of women at the time of their admission to this crisis program are in need of housing, mental health programming, attention to their physical and sexual abuse issues, and assistance with their substance abuse. First, women offenders who are released from institutional settings often need tools and resources to assist them in fulfilling basic needs such as housing, financial management, essential living skills and responsible self-care strategies. In addition to these primary goals, the unique needs of female offenders with traumatic past histories included particular attention to their underlying mental health symptoms that were related to their trauma experiences, managing their substance abuse issues, as these would influence them and their abilities to achieve their primary goals such as finding housing. For example, women's experiences of prior trauma may be related to their reluctance to change within a correctional environment (Leschied, 2011). Their emotions and memories of their traumatic past may be evoked by the nature of the program or the regulations in the correctional setting as they could be triggered in their trauma victimization in multiple ways and could prove to be a barrier to their participation in treatment programs. Effective intervention procedures should help women with trauma histories to manage their disruptive internal cognitive

process and support their moving on to the action stage of behaviour change where they could be more focused on their goals and comfortable with their participation in treatment. Specific treatment approaches within an integrated women-centred appreciation that addresses the unique concerns of this population, such as the use of empathy, building resilience and supporting self-efficacy are encouraged as a part of primary procedures.

Overall, the current study accentuates some of the needs and issues women with trauma histories bring with them as they transition from correctional institutions back into the community. For those who work within community corrections, there is a need for increased awareness of the possibilities of previous trauma for those who enter a community correctional setting, such that they can address the unique needs of this population with appropriate therapy and treatment.

Recommendations for Future Research

Future research would benefit from a larger sample for studies looking at the impact of trauma on women offenders. Studies should look more specifically at the types of trauma - child welfare involvement as a child, emotional abuse as a child, maltreatment as a child, child neglect, physical abuse, sexual abuse as a child, sexual violence as an adult, intimate partner violence, children being removed from a parent’s care, historical grief, current grief and historical trauma - independently to examine the differences in their impact on women's offending behaviours and the specific influences they create on this group of offenders. On a similar note, different types of crimes such as violent offences should be examined separately in their associations with women's experience of emotional dysregulation symptoms.

In addition, other risk factors such as family relationships and support, housing, safety and employment and parental stress should be examined as these factors could not only be linked to women's criminal convictions directly but also act mutually with trauma experiences in contributing to women's criminal involvement.

Another area of investigation should focus on women's reasons for dropping out of residential programs in the community as these may be related to their prior trauma experiences. Knowledge about these factors could be extremely beneficial in reducing barriers that prevent women's participation in treatment.

Research should also look at the effectiveness of the addition of the gendered risk assessment tools in predicting women's risk and needs in the justice system. One possible examination is the reliability of The Women's Supplemental Risk/ Needs Assessment in combination with LSI-R in predicting women's offending behaviours as this gender-responsive supplement still needs to be validated with samples from the institutions, prelease, community residential settings, probation and parole.

In the context of community programs, future studies are needed to evaluate the programs that incorporate trauma as a relevant treatment factor to look at the effectiveness of its application in treatment. Research should look at trauma-focused treatment on the adjustment of all persons and also specifically on its success on women offenders in community corrections. With similar interest, follow-up studies should evaluate counselling strategies and therapies with integrated women-centred components in the correctional setting and their effectiveness in

helping offenders with trauma to overcome their barriers to benefiting from the rehabilitative program treatments.

Limitations in the Current Study

It should be noted that the data for this study was obtained from a single community correctional residential facility in Southern Ontario. Because of the size and the characteristics of this sample population, it may not be representative of the diversity in the numerous community correctional programs in Canada. Therefore, the generalizability of the current findings is limited.

Second, certain information, such as psychiatric symptoms was recorded by different case workers who worked with these individuals. As a result, the descriptions of client symptoms and presentations were based on each case workers' own understanding and appreciation of these symptoms. No formal tools were provided to the staff as guidelines when collecting mental health information from these individuals. Thus, the description in case notes might be inconsistent in their meanings for some variables

Moreover, the data retrieval instrument used for data collection was designed based on existing items in participants' case files; hence, the instrument might not include all possible variables that may be relevant to the nature of this study.

In addition, this study was an exploratory study and hence all possible differences were investigated to inform later research that would draw on a larger sample size. It is important to note that there is a lack of variability in some of the variables, such as substance abuse at 93% overall and trauma at 80% among women. Therefore, there is the possibility of Type 1 errors when

calculating large numbers of comparison and readers should take this into account.

Lastly, many of the participants did not stay at this residential facility long enough for staff to generate meaningful reports on their experiences with this community correctional program. Hence, discretion needs to be taken in understanding the findings in relation to offenders' experiences with the treatment programs in the community correctional setting.

Summary

Notwithstanding the aforementioned limitations to the current study, this research is unique because 1) participants' information was collected using a non-structured retrieval instrument; and 2) it looks at offenders' risk and needs with a community-based sample population. Overall, this investigation addresses the relevance and importance of trauma as an important variable in understanding gendered pathways to criminal involvement. Findings in this study will assist in the development of evidence-based assessment protocols of the risks and needs in women offenders with trauma histories and enhance long-term treatment success for this specific population in community corrections. Effective changes in interventions targeting the unique needs of women offenders who process trauma histories are expected to be implemented as part of existing rehabilitative treatment programs at both the counselling level and the corrections level in general.

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APPENDIX A

Tables

Table 1

Demographic Description of the Sample (N = 90)

	Female		Male		All	
Characteristic	*n*	%	*n*	%	*n*	%
Gender	48	53	42	47	90	100
Language						
English	46	95.8	42	100	88	97.8
Unknown	2	4.3	0	0	2	2.2
Aboriginal Status						
Aboriginal	8	16.7	14	33.3	22	24.4
Non-aboriginal	27	56.3	27	64.3	54	60
Unknown	5	10.4	1	2.4	6	6.7
Community Treatment Order						
Yes	1	2.1	0	0	1	1.1
No	46	95.8	40	95.2	86	95.6
Unknown	1	2.1	2	4.8	1	1.1
Exit Disposition						

Successful	16	33.3	21	50	37	41.1
Withdrawal	18	37.5	6	14.3	24	26.7
Early termination due to charges	0	0	2	4.8	2	2.2
Early termination due to rule violations	13	27.1	12	28.6	25	27.8
Relocation	1	2.1	0	0	1	1.1
Source of Referral						
None Selected	1	2.1	1	2.4	2	2.2
Referral General Hospital	2	4.2	0	0	2	2.2
Referral from Other Institution	5	10.4	1	2.4	6	6.7
Referral from CMHA-Case Management	4	8.3	8	19	12	13.3
Referral from CJS Courts	3	6.3	3	7.1	6	6.7
Referral from CJS Correctional Facilities	10	20.8	7	16.7	17	18.9
CJS Probation	4	8.3	4	9.5	8	8.9
CJS Crisis Bed	0	0	2	4.8	2	2.2
CJS Other	2	4.2	0	0	2	2.2

Self, Family, Friend	9	18.8	1	2.4	10	11.1
Other	1	2.1	0	0	1	1.1
CMHA – other	6	12.5	7	16.7	13	14.4
SLCS	1	2.1	2	4.8	3	3.3
Lawyer	1	2.1	4	9.5	5	5.6
Highest Level of Education						
None Selected	1	2.1	1	2.4	2	2.2
Some Elementary/ Junior High	3	6.3	5	11.9	8	8.9
Some Secondary/ High School	28	58.3	30	71.4	58	64.4
Some College/ University	11	22.9	6	14.3	17	18.9
Unknown/ Declined	2	4.2	0	0	2	2.2
Secondary/ High School	3	6.3	0	0	3	3.3
Current Educational Status						
None Selected	1	2.1	1	2.4	2	2.2
Unknown/ Declined	11	22.9	11	26.2	22	24.4
Not in School	31	64.6	29	69	60	66.7
Trade School	1	2.1	0	0	1	1.1
Vocational/ Training Centre	1	2.1	0	0	1	1.1
Adult Education	1	2.1	1	2.4	2	2.2

Community College	1	2.1	0	0	1	1.1
Other	1	2.1	0	0	1	1.1
Baseline Living Arrangement						
None selected	1	2.1	5	11.9	6	6.7
Self	20	41.7	15	35.7	35	38.9
Spouse/ Partner	0	0	3	7.1	3	3.3
Spouse/ Partner/ Other	0	0	1	2.4	1	1.1
Children	1	2.1	0	0	1	1.1
Parents	2	4.2	0	0	2	2.2
Relatives	0	0	1	2.4	1	1.1
Non-Relatives	22	45.8	15	35.7	37	41.1
Unknown or Declined	2	4.2	2	4.8	4	4.4
Current Living Arrangement						
None selected	0	0	5	11.9	5	5.6
Self	14	29.2	12	28.6	26	28.9
Spouse/ Partner	1	2.1	1	2.4	1	1.1
Spouse/ Partner/ Other	0	0	1	2.4	2	2.2
Children	1	2.1	0	0	1	1.1
Parents	0	0	1	2.4	1	1.1

Relatives	1	2.1	1	2.4	2	2.2
Non-Relatives	5	10.4	7	16.7	12	13.3
Unknown or Declined	26	54.2	13	31	39	43.3
Baseline Residence Type						
Correctional/Probation Facility	34	70.8	22	52.4	56	62.2
General Hospital	1	2.1	0	0	1	1.1
Psychiatric Hospital	1	2.1	0	0	1	1.1
No Fixed Address	3	6.3	2	4.8	5	5.6
Hostel/Shelter	5	10.4	6	14.3	11	12.2
Private	3	6.3	12	28.6	15	16.7
House/Apt-Owned/Market Rent						
Unknown or Declined	1	2.1	0	0	1	1.1
Current Residence Type						
None Selected	0	0	3	7.1	3	3.3
Correctional/Probation Facility	2	4.2	7	16.7	9	10.0
No Fixed Address	2	4.2	0	0	2	2.2
Hostel/Shelter	5	10.4	2	4.8	7	7.8
Private	11	22.9	16	38.1	27	30.0
House/Apt-Owned/Market						

Rent						
Private House/Apt - Subsidized	1	2.1	0	0	1	1.1
Supportive Housing - Congregate	0	0	2	4.8	2	2.2
Supportive Housing - Assisted Living	0	0	1	2.4	1	1.1
Unknown or Declined	27	56.3	10	23.8	37	41.1
Baseline Employment Status						
None Selected	0	0	1	2.4	1	1.1
Unknown or Declined	1	2.1	0	0	1	1.1
Independent/Competitive	0	0	1	2.4	1	1.1
Non-Paid Work Experience	2	4.2	0	0	2	2.2
No Employment	21	43.8	24	57.1	45	50.0
Casual/Sporadic	0	0	5	11.9	5	5.6
No Employment of Any Kind	16	33.3	11	26.2	27	30.0
No Employment - Other Activity	8	16.7	0	0	8	8.9
Current Employment Status						

None Selected	0	0	1	2.4	1	1.1
Unknown or Declined	18	37.5	10	23.8	28	31.1
Independent/Competitive	0	0	1	2.4	1	1.1
Non-Paid Work Experience	1	2.1	0	0	1	1.1
No Employment	11	22.9	21	50	32	35.6
Casual/Sporadic	0	0	2	4.8	2	2.2
No Employment of Any Kind	13	27.1	6	14.3	19	21.1
No Employment - Other Activity	5	10.4	1	2.4	6	6.7
Baseline Primary Income Source						
None Selected	1	2.1	1	2.4	2	2.2
Employment	0	0	1	2.4	1	1.1
Employment Insurance	1	2.1	0	0	1	1.1
Pension	0	0	1	2.4	1	1.1
ODSP	17	35.4	15	35.7	32	35.6
Social Assistance	19	39.6	14	33.3	33	36.7
No Source of Income	6	12.5	9	21.4	15	16.7
Other	3	6.3	0	0	3	3.3
Unknown or Declined	1	2.1	1	2.4	2	2.2

Current Primary Income Source						
None Selected	0	0	3	7.1	3	3.3
Employment	0	0	1	2.4	1	1.1
Employment Insurance	1	2.1	0	0	1	1.1
Pension	0	0	1	2.4	1	1.1
ODSP	15	31.3	11	26.2	26	28.9
Social Assistance	16	33.3	7	16.7	23	25.6
No Source of Income	0	0	4	4.8	4	4.4
Other	3	6.3	0	0	3	3.3
Unknown or Declined	13	27.1	14	33.3	27	30.0

Table 2

Age and Days in Care Statistics of the Sample (N = 90)

	Female		Male		All	
Characteristics	*M*	*SD*	*M*	*SD*	*M*	*SD*
Age	30.26	9.7	31.2	10.2	30.5	10.1
Days in Care	17.98	19.1	21.3	11.8	19.5	16.1

Table 3

Criminal History of the Sample (N = 90)

	Female		Male		All	
Characteristic	*n*	%	*n*	%	*n*	%
Previous Involvement in the Criminal Justice System	40	83.3	36	85.7	76	84.4
Nature of Offence						
Crimes against person	10	20.8	17	40.5	27	30
Property crimes	15	31.3	8	19	23	25.6
Both	9	18.8	8	19	17	18.9
Drug offences	6	12.5	2	4.8	8	8.9
Breach	4	8.3	4	9.5	8	8.9
No current charges	4	8.3	3	7.1	7	7.8
Baseline Legal Status						
At Risk for Legal Problems	21	43.8	22	52.4	43	47.8
No Legal Problems	1	2.1	1	2.4	2	2.2
On Bail - Awaiting Trial	24	50	17	40.5	41	45.6
On Probation	27	56.3	18	42.9	45	50
Unknown or Declined	1	2.1	0	0	1	1.1

In Community on own Recognizance	0	0	1	2.4	1	1.1
Suspended Sentence	1	2.1	0	0	1	1.1
Incarcerated	7	14.6	9	21.4	16	17.8
Current Legal Status						
None Selected	1	2.1	2	4.8	3	3.3
At Risk for Legal Problems	17	35.4	18	42.9	35	38.9
No Legal Problems	3	6.3	0	0	3	3.3
On Bail - Awaiting Trial	22	45.8	10	23.8	32	35.6
On Probation	22	45.8	18	42.9	40	44.4
On Parole	2	4.2	0	0	2	2.2
Unknown or Declined	8	16.7	1	2.4	9	10
In Community on own Recognizance	0	0	3	7.1	3	3.3
Charges Withdrawn	0	0	1	2.4	1	1.1
Incarcerated	1	2.1	6	14.3	7	7.8

Table 4

Mental Health Background of the Sample (N = 90)

	Female		Male		All	
Characteristic	*n*	%	*n*	%	*n*	%
Diagnoses						
None Selected	2	4.2	2	4.8	4	4.4
Adjustment Disorder	1	2.1	2	4.8	3	3.3
Anxiety Disorder	22	45.8	16	38.1	38	42.2
Chronic Illness	8	16.7	2	4.8	10	11.1
Concurrent Disorder	35	72.9	17	40.5	52	57.8
Delirium, Dementia, and Amnestic or Cognitive Disorder	3	6.3	11	26.2	14	15.6
Developmental Handicap	0	0	7	16.7	7	7.8
Disorder of Childhood or Adolescence	9	18.8	20	47.6	29	32.2
Dissociative Disorder	0	0	2	4.8	2	2.2
Dual Diagnosis	1	2.1	3	7.1	4	4.4
Eating Disorder	1	2.1	0	0	1	1.1
Hyper Sexuality	1	2.1	0	0	1	1.1

Mood Disorder	39	81.3	29	69	68	75.6
Personality Disorder	3	6.3	8	19	11	12.2
Post-traumatic stress disorder	19	39.6	9	21.4	28	31.1
Schizophrenia or Other Psychotic Disorder	16	33.3	9	21.4	25	27.8
Sleep Disorder	1	2.1	0	0	1	1.1
Substance Related Disorder	0	0	1	2.4	1	1.1
Reported Psychiatric Symptoms[a]						
Mood Disorder Symptoms	45	93.8	33	78.6	78	86.7
Anxiety Symptoms	20	41.7	22	52.4	42	46.7
Schizophrenia Psychosis Symptoms	8	16.7	9	21.4	17	18.9
Substance Dependence Symptoms	11	22.9	5	11.9	16	17.8
Disorder of Childhood Symptoms	6	12.5	5	11.9	11	12.2
Dissociative Symptoms	1	2.1	0	0	1	1.1
Sexual Identity Symptoms	1	2.1	1	2.4	2	2.2
Personality Disorder Symptoms	2	4.2	4	9.5	6	6.7
Impulsive Control Disorder Symptoms	11	22.9	12	28.6	23	25.6

Delirium Cognitive Disorder Symptoms	2	4.2	2	4.8	4	4.4
PTSD Symptoms	11	22.9	6	14.3	17	18.9
Past Treatment[b]						
Antidepressants	19	39.6	16	38.1	35	38.9
Stimulants	6	12.5	8	19	14	15.6
Antipsychotics	21	43.8	23	55	44	48.9
Mood Stabilizers	1	2.1	3	7.1	4	4.4
Anxiolytics	6	12.5	4	9.5	10	11.1
Depressants	4	8.3	1	2.4	5	5.6
Analgesics	1	2.1	1	2.4	2	2.2
Antibiotics	0	0	1	2.4	1	1.1
Anti-addictive	3	6.3	2	4.8	5	5.6
Muscle Relaxants	2	4.2	0	0	2	2.2
Non-steroidal anti-inflammatory drugs	3	6.3	4	9.5	7	7.8
Treatment for stomach, GERD, intestinal ulcers	1	2.1	2	4.8	3	3.3
Treatment for Allergies	0	0	1	2.4	1	1.1

Treatment for Parkinson's Disease	1	2.1	0	0	1	1.1
Treatment for other medical illness or symptoms	4	8.3	3	7.1	7	7.8
Treatment for Asthma	1	2.1	1	2.4	2	2.2
Treatment for seizures	2	4.2	3	7.1	5	5.6
Current Treatment[b]						
Antidepressants	16	33.3	14	33.3	30	33.3
Stimulants	4	8.3	4	8.3	8	8.9
Antipsychotics	18	37.5	22	52.4	40	44.4
Mood Stabilizers	2	4.2	1	2.4	3	3.3
Anxiolytics	6	12.5	3	7.1	9	10
Depressants	4	8.3	1	2.4	5	5.6
Analgesics	4	8.3	3	7.1	7	7.8
Antibiotics	7	14.6	4	9.5	11	12.2
Anti-addictive	4	8.3	1	2.4	5	5.6
Muscle Relaxants	2	4.2	0	0	2	2.2
Non-steroidal anti-inflammatory drugs	6	12.5	4	9.5	10	11.1
Treatment for stomach, GERD,	4	8.3	2	4.8	6	6.7

intestinal ulcers						
Treatment for Allergies	1	2.1	2	4.8	3	3.3
Treatment for sexual symptoms	1	2.1	0	0	1	1.1
Treatment for Parkinson's Disease	1	2.1	1	2.4	2	2.2
Treatment for other medical illness or symptoms	6	12.5	7	16.7	13	14.4
Treatment for Asthma	1	2.1	3	7.1	4	4.4
Treatment for seizures	2	4.2	6	14.3	8	8.9
Presenting Issue Addressed						
None Selected	2	4.2	3	7.1	5	5.6
Threat to Others/Attempted Suicide	2	4.2	14	33.3	16	17.8
Specific Symptoms of Serious Mental Illness	29	60.4	27	64.3	56	62.2
Physical/Sexual Abuse	12	25	6	14.3	18	20
Educational	6	12.5	6	14.3	12	13.3
Occupational, employment, vocational	12	25	12	28.6	24	26.7
Housing	37	77.1	37	88.1	74	82.2

Financial	13	27.1	29	69	42	46.7
Legal	13	27.1	19	45.2	32	35.6
Relationship	12	25	15	35.7	27	30
Problem with substance abuse/ addictions	33	68.8	30	71.4	63	70
Activities of daily living	5	10.4	17	40.5	22	24.4
Other	18	37.5	10	23.8	28	31.1
Client Goals						
Housing	43	89.6	32	76.2	75	83.3
Connection with other services	22	45.8	20	47.6	42	46.7
Abstain from substances	26	54.2	13	31	39	43.3
Attend to physical health concerns	6	12.5	5	11.9	11	12.2
Basic necessities (clothing, eye glasses)	2	4.2	2	4.8	4	4.4
Community service	4	8.3	0	0	4	4.4
Connect with child/children	9	18.8	2	4.8	11	12.2
Dentist	2	4.2	1	2.4	3	3.3
Education	12	25	9	21.4	21	23.3
Employment research/support	5	10.4	10	23.8	15	16.7

Finances (ODSP, OAS, OW, banking services)	15	31.3	18	42.9	33	36.7
Follow bail and/or probation order	10	20.8	6	14.3	16	17.8
Leisure/recreation	4	8.3	2	4.8	6	6.7
Medication compliance/regime	4	8.3	3	7.1	7	7.8
Mental health programming	28	58.3	22	52.4	50	55.6
Obtain documentation	23	47.9	9	21.4	32	35.6
Obtain prescription medications	9	18.8	5	11.9	14	15.6
Parenting support	1	2.1	1	2.4	2	2.2
Physician	11	22.9	10	23.8	21	23.3
Psychiatrist	11	22.9	12	28.6	23	25.6
Reintegration program referral	0	0	2	4.8	2	2.2
Symptom management	7	14.6	7	16.7	14	15.6
Victim compensation	0	0	1	2.4	1	1.1

[a] Frequency represents the population that reported having at least one symptom identified in each cluster. For a list of identified symptoms in each psychiatric symptom cluster, see Appendix C.

[b] Frequency represents the population that reported being on at least one medication identified in each cluster. For a list of identified medications in each treatment cluster, see Appendix D.

Table 5

Substance Use History of the Sample (N = 90)

	Female		Male		All	
Characteristic	*n*	%	*n*	%	*n*	%
Past use of substance						
Used in the past	46	95.8	37	88.1	83	92.2
Alcohol	17	35.4	25	59.5	42	46.7
Crack cocaine/ Cocaine	23	47.9	13	31	36	40
Ecstasy	2	4.2	3	7.1	5	5.6
Hallucinogens (aka mushrooms, acid	2	4.2	1	2.4	3	3.3
Hydro-morph	5	10.4	3	7.1	8	8.9
Ketamine (i.e., anesthetic)	1	2.1	0	0	1	1.1
Marijuana	16	33.3	17	40.5	33	36.7
Methamphetamine (aka Crystal meth, speed, crank, chalk etc.)	9	18.8	5	11.9	14	15.6
Morphine (aka Heroin)	6	12.5	7	16.7	13	14.4
Opiates (i.e., Fentanyl)	14	29.2	8	19	22	24.4
Oxycontin/ Oxycodone	18	37.5	8	19	26	28.9

PCP	1	2.1	2	4.8	3	3.3
Prescription medications	13	27.1	7	16.7	20	22.2
Treatment in the past	9	18.8	4	9.5	13	14.4
Current Use of substance						
Alcohol	4	8.3	3	7.1	7	7.8
Crack cocaine/ Cocaine	2	4.2	0	0	2	2.2
Hydro-morph	1	2.1	0	0	1	1.1
Marijuana	7	14.6	9	21.4	16	17.8
Methamphetamine (aka Crystal meth, speed, crank, chalk etc.)	0	0	1	2.4	1	1.1
Morphine (aka Heroin)	1	2.1	0	0	1	1.1
Opiates (i.e., Fentanyl)	1	2.1	0	0	1	1.1
Oxycontin/ Oxycondone	1	2.1	0	0	1	1.1
Prescription medications	3	6.3	3	7.1	6	6.7
Appeared under influence	3	6.3	3	7.1	6	6.7
Current drug paraphernalia found	11	22.9	1	2.4	12	13.3
Current treatment	7	14.6	2	4.8	9	10

Table 6

Trauma History of the Sample (N = 90)

	Female		Male		All	
Characteristic	*n*	%	*n*	%	*n*	%
Trauma experienced as a child						
Child welfare as a child	1	2.1	3	7.1	4	4.4
Emotional abuse as a child	16	33.3	17	40.5	33	36.7
Maltreatment as a child	5	10.4	4	9.6	9	10
Neglect as a child	0	0	1	2.4	1	1.1
Physical abuse as a child	13	27.1	22	52.4	35	38.9
Sexual abuse as a child	11	22.9	8	19	19	21.1
Trauma experienced as an adult						
Sexual violence as adult	7	14.6	2	4.8	9	10
Intimate partner violence (adult)	20	41.7	5	11.9	25	27.8
Children removed from care (adult)	22	45.8	14	33.3	36	40
Other trauma experiences						
Historical grief	1	2.1	0	0	1	1.1
Current grief	1	2.1	1	2.4	2	2.2
Historical trauma	1	2.1	1	2.4	2	2.2
Experience of at least one type of trauma	38	79.1	28	66.7	66	73.3

Table 7

Chi-Square Test of Independence for Gender and the Nature of offence (N = 90)

	Nature of offence							
Gender	Violent crime	Property crime	Both	Drug offence	Breach	χ^2	df	*p*
Female	10 (11.1%)	15 (16.7%)	9 (10%)	6 (6.7%)	4 (4.4%)	5.724	4	.221
Male	17 (18.9%)	8 (8.9%)	8 (8.9%)	2 (2.2%)	4 (4.4%)			

Note: Both = both violent and property crimes.

Table 8

Chi-Square Test of Independence for Presence of Trauma and the Nature of offence (N = 90)

	Nature of offence							
Trauma Experience	Violent crime	Property crime	Both	Drug offence	Breach	χ^2	df	*p*
Yes	22 (24.4%)	14 (15.6%)	14 (15.6%)	7 (7.8%)	7 (7.8%)	4.972	4	.290
No	5 (5.6%)	9 (10%)	3 (3.3%)	1 (1.1%)	1 (1.1%)			

Note: Both = both violent and property crimes

Table 9

Chi-Square Test of Independence for Presence of Trauma and the Nature of offence in Women Offenders (n = 48)

	Nature of offence							
Trauma Experience	Violent crime	Property crime	Both	Drug offence	Breach	χ^2	df	*p*
Yes	9 (18.8%)	11 (22.9%)	8 (16.7%)	6 (12.5%)	3 (6.3%)	3.096	4	.542
No	1 (2.1%)	4 (8.3%)	1 (2.1%)	0 0	1 (2.1%)			

Note: Both = both violent and property crimes.

Table 10

Chi-Square Test of Independence for Presence of Adult Trauma and the Nature of offence in Women Participants (n = 48)

	Nature of offence							
Adult trauma experience	Violent crime	Property crime	Both	Drug offence	Breach	χ^2	df	*p*
Yes	8	7	8	6	3	8.848	4	.065
	(16.7%)	(14.6%)	(16.7%)	(12.5%)	(6.3%)			
No	2	8	1	0	1			
	(4.2%)	(16.7%)	(2.1%)	0	(2.1%)			

Note: Both = both violent and property crimes.

Table 11

Chi-Square Test of Independence for Presence of Childhood Trauma and the Nature of offence in Women Participants (n = 48)

	Nature of offence							
Adult trauma experience	Violent crime	Property crime	Both	Drug offence	Breach	χ^2	df	*p*
Yes	8	7	5	2	4	7.229	4	.124
	(16.7%)	(14.6%)	(10.4%)	(4.2%)	(8.3%)			
No	2	8	4	4	0			
	(4.2%)	(16.7%)	(8.3%)	(8.3%)	0			

Note: Both = both violent and property crimes.

Table 12

Chi-Square Test of Independence for Gender and Presence of Emotion Dysregulation Symptoms in Offenders with Traumatic Past (n = 66)

	Gender				
ED Symptoms	Females	Males	χ^2	df	*p*
Yes	31	24	.122	1	.727
	(46.9%)	(36.3%)			
No	7	4			
	(10.6%)	(5.8%)			

Note: ED Symptoms = Emotion Dysregulation Symptoms

Table 13

Chi-Square Test of Independence for Presence of Emotion Dysregulation Symptoms and the Nature of Trauma Experiences in Female Participants (n = 48)

	Nature of Trauma						
ED Symptoms	No Trauma	Childhood Trauma	Adult Trauma	Both	χ^2	df	*p*
Yes	8 (16.6%)	3 (6.3%)	18 (37.5%)	11 (22.9%)	2.028	3	.567
No	2 (4.2%)	1 (2.1%)	2 (4.2%)	3 (6.3%)			

Note: ED Symptoms = Emotion Dysregulation Symptoms; Both = both adult and child trauma.

Table 14

Chi-Square Test of Independence for Presence of Emotion Dysregulation Symptoms and the Nature of Offence in Female Participants (n = 48)

	Nature of offence							
ED Symptoms	Violent crime	Property crime	Both	Drug offence	Breach	χ^2	df	*p*
Yes	6 (12.5%)	10 (20.8%)	5 (10.4%)	5 (10.4%)	3 (6.3%)	3.852	4	.426
No	3 (6.3%)	1 (2.1%)	3 (6.3%)	1 (2.1%)	0 0			

Note: ED Symptoms = Emotion Dysregulation Symptoms; Both = both violent and property crimes.

Table 15

Statistics for Women with Past Trauma and Their Proposed Goals for the Crisis Program (n = 48)

	Trauma Experience			
	Yes		No	
Goals	*n*	%	*n*	%
4. Housing	35	72.9	8	16.7
5. Mental health programming	23	47.9	5	10.4
6. Abstain from substances	21	43.8	5	10.4
7. Connection with other services	19	39.6	3	6.3
8. Obtain documentation	17	35.4	6	12.5
9. Finances	12	25	3	6.3
10. Physician	11	22.9	0	0
11. Psychiatrist	10	20.8	1	2.1
12. Connect with child/children	9	18.8	0	0
13. Follow bail and/or probation order	9	18.8	1	2.1
14. Education	9	18.8	3	6.3
15. Attend to physical health concerns	6	12.5	0	0
16. Obtain prescription medications	7	14.6	2	4.2
17. Symptoms management	6	12.5	1	2.1

18. Employment research and support	5	10.4	0	0
19. Leisure	4	8.3	0	0
20. Medication compliance and regime	4	8.3	0	0
21. Community service	3	6.3	1	2.1
22. Dentist	2	4.2	0	0
23. Parenting support	1	2.1	0	0
24. Basic necessities	0	0	2	4.2

Table 16

Statistics for Women with Past Trauma and Their Presenting Issues on Admission (n = 48)

	Presence of Trauma Experience			
	Yes		No	
Presenting Issues	*n*	%	*n*	%
1. Housing	30	62.5	7	14.6
2. Problem with substance abuse/ addictions	29	60.4	4	8.3
3. Specific Symptoms of Serious Mental Illness	24	50	5	10.4
4. Other	17	35.4	1	2.1
5. Relationship	11	22.9	1	2.1
6. Occupational, employment, vocational	10	20.8	2	4.2
7. Legal	11	22.9	2	4.2
8. Physical/Sexual Abuse	10	20.8	2	4.2
9. Financial	10	20.8	3	6.3
10. Educational	5	10.4	1	2.1
11. Activities of daily living	4	8.3	1	2.1
12. None Selected	2	4.2	0	0
13. Threat to Others/Attempted Suicide	1	2.1	1	2.1

Table 17

Statistics for Women with Past Trauma and Their Past Use of Substances (n = 48)

	Trauma Experience			
	Yes		No	
Past Use of Substance	*n*	%	*n*	%
Crack cocaine/ Cocaine	21	43.8	2	4.2
Oxycontin/ Oxycodone	15	31.2	3	6.3
Opiates (i.e., Fentanyl)	12	45.8	2	4.2
Marijuana	12	45.8	4	8.3
Prescription medications	10	20.8	3	6.3
Alcohol	11	22.9	6	12.5
Hydro-morph	4	8.3	1	2.1
Morphine (aka Heroin)	4	8.3	2	4.2
Methamphetamine (aka Crystal meth, speed, crank, chalk etc.)	6	12.5	3	6.3
Ecstasy	1	2.1	1	2.1
Hallucinogens (aka mushrooms, acid	1	2.1	1	2.1
PCP	0	0	1	2.1
Ketamine (i.e., anesthetic)	0	0	1	2.1

Table 18

Chi-Square Test of Independence for Gender and Exit Disposition (N = 90)

	Exit Disposition							
Gender	Successful	Withdrawal	ET Charges	ET Rules	Relocation	χ^2	df	*p*
Female	16	18	0	13	1	9.222	4	.056
	(17.8%)	(20%)	0	(14.4%)	(1.1%)			
Male	21	6	2	12	0			
	(23.3%)	(6.7%)	(2.2%)	(13.3%)	0			

Note: ET Charges = early termination due to imposed new charges; ET Rules = early termination due to violation of rules

Table 19

Chi-Square Test of Independence for Presence of Trauma and Exit Disposition in Women (n = 48)

	Exit Disposition						
Trauma Experience	Successful	Withdrawal	ET Rules	Relocation	χ^2	df	*p*
Yes	13	15	10	0	5.215	3	.157
	(27.1%)	(31.2%)	(20.8%)	0			
No	2	4	3	1			
	(4.2%)	(8.3%)	(6.3%)	(2.1%)			

Note: ET Charges = early termination due to imposed new charges; ET Rules = early termination due to violation of rules

Appendix B

Instrument

FILE#:_____

Data Retrieval Instrument

Item		***Enter***	***Code***
1	Gender		0 = Female 1= Male
2	Age		DOB: calculate age to number of months (rounded)
3	Language		1 English; 2 French; 3 Other; 4 none selected; 5 unknown
4	Aboriginal Status		1: Aboriginal; 2 Non-Aboriginal; 3 Unknown
5	Type of care		1=Crisis
6	Days in Care		continuous
7	Community Treatment Orders		0= no; 1=yes; 2 = unknown
8	Exit Disposition		1= Successful Completion; 2= Withdrawal (Escape, failure to come back); 3= Early Termination Due to Incurrence of New Charges; 4= Early Termination Due to Lack of Cooperation (Violation of rules)
	Nature of Offense		1=Yes (code all that appear)
	Violent Crime:		
9	Firearms		
10	Robbery		
11	Common Assault		
12	Domestic Assault		
13	Sexual Assault		
14	Threats/harassment		

15	Other violent Crime		
	Property Crime:		
16	Theft under $5000		
17	Theft over $5000		
18	Theft of motor vehicle		
19	Break and Enter		
20	Possession of stolen property		
21	Fraud		
22	Arson		
23	Other non-violent crime		
	Drug Offences:		
24	Possession		
25	Trafficking		
	Other		
26	Prostitution		
27	Breach		
28	Other violations		
29	Previous involvement in the Criminal Justice System		0=no; 1=Yes (PEST)
30	***Nature of offense***		**0=crimes against persons** **1=property crimes;** **3=both;** **4= drug offences** **5=breach of existing order** **6=prostitution**
z	Baseline Legal Status		1=Yes (code all that appear)
31	None Selected		
32	At Risk for Legal Problems		
33	No Legal Problems		
34	Pre-Charge Diversion		
35	Court Diversion Program		
36	Conditional Discharge		
37	Awaiting Fitness Assessment		
38	Awaiting NCR Assessment		
39	On Bail - Awaiting Trial		
40	Awaiting Sentence		
41	On Probation		
42	On Parole		

43	Unknown or Declined		
44	In Community on own Recognizance		
45	Unfit to Stand Trial		
46	Charges Withdrawn		
47	Stay of Proceedings		
48	NCR		
49	Conditional Sentence		
50	Restraining Order		
51	Peace Bond		
52	Suspended Sentence		
53	ORB - Detained- Community Access		
54	ORB- Conditional Discharge		
55	Incarcerated		
	Current Legal Status		1=Yes (code all that appear)
56	None Selected		
57	At Risk for Legal Problems		
58	No Legal Problems		
59	Pre-Charge Diversion		
60	Court Diversion Program		
61	Conditional Discharge		
62	Awaiting Fitness Assessment		
63	Awaiting NCR Assessment		
64	On Bail - Awaiting Trial		
65	Awaiting Sentence		
66	On Probation		
67	On Parole		
68	Unknown or Declined		
69	In Community on own Recognizance		
70	Unfit to Stand Trial		
71	Charges Withdrawn		
72	Stay of Proceedings		
73	NCR		
74	Conditional Sentence		
75	Restraining Order		
76	Peace Bond		

77	Suspended Sentence		
78	ORB - Detained- Community Access		
79	ORB- Conditional Discharge		
80	Incarcerated		
	Source of Referral		1=Yes (code all that appear)
81	None Selected		
82	General Hospital		
83	Psychiatric Hospital		
84	Other Institution		
85	CMHA - Case Management		
86	Other Community Agency		
87	Family Physician		
88	Psychiatrist		
89	Mental Health Worker		
90	Criminal Justice System - Police		
91	Criminal Justice System - Courts		
92	Criminal Justice System -Correctional Facilities		
93	Criminal Justice System - Probation		
94	Criminal Justice System - Parole		
95	Criminal Justice System - Crisis Beds		
96	Criminal Justice System - Other		
97	Self, Family , Friend		
98	Other		
99	CMHA - Other		
100	SLCS		
101	Lawyer		
	Presenting Issues Addressed		1=Yes (code all that appear)
102	None Selected		
103	Threat to Others/Attempted Suicide		
104	Specific Symptoms of Serious Mental Illness		
105	Physical/Sexual Abuse		
106	Educational		

107	Occupational/Employment/Vocational		
108	Housing		
109	Financial		
110	Legal		
111	Problems with Relationships		
112	Problems with Substance Abuse/Addictions		
113	Activities of Daily Living		
114	Other		
	Diagnoses		0=no evidence; 1 = present
115	**None Selected**		
116	**Unknown or declined**		
117	Adjustment Disorder		
118	Anxiety Disorder		
119	Chronic Illness		
120	Concurrent Disorder		
121	Delirium, Dementia, and Amnestic or Cognitive Disorder		
122	Developmental Handicap		
123	Disorder of Childhood or Adolescence		
124	Dissociative Disorder		
125	Dual Diagnosis		
126	Eating Disorder		
127	Factitious Disorder		
128	Hyper Sexuality		
129	Impulse Control Disorder No Elsewhere Classified		
130	Mental Disorder due to General Medical Condition		
131	Mood Disorder		
132	Personality Disorder		
133	Post-traumatic stress disorder		
134	Schizophrenia or Other Psychotic Disorder		
135	Sexual and Gender Identity Disorder		

136	Sleep Disorder			
137	Somatoform Disorder			
138	Substance Related Disorder			
139	Highest level of education		None Selected	1
			No Formal Schooling	2
			Some Elementary/Jr. High	3
			Some Secondary/High School	4
			Some College/University	5
			Unknown/Declined	6
			Secondary/High school	7
140	Current Educational Status		None Selected	1
			Unknown or Declined	2
			Not in School	3
			Elementary/Junior School	4
			Trade School	5
			Vocational/Training Centre	6
			Adult Education	7
			Community College	8
			University	9
			Other	10
141	Baseline Living Arrangement		None Selected	1
			self	2
			spouse/partner	3
			spouse/partner/other	4
			Children	5
			Parents	6
			Relatives	7
			Non-Relatives	8
			Unknown or declined	9
142	Current Living Arrangement		Code as above	
143	Baseline Residence Type		None Selected	1
			Approved Homes and Homes for Special Care	2
			Correctional/Probation Facility	3
			Domiciliary Hostel	4
			General Hospital	5

			Psychiatric Hospital	6
			Other Speciality Hospital	7
			No Fixed Address	8
			Hostel/Shelter	9
			Long Term Care Facility/Nursing Home	10
			Municipal Non-profit housing	11
			Private Non-Profit Housing	12 13
			Private House/Apt-Owned/Market Rent	14
			Private House/Apt - Subsidized	15
			Retirement/seniors home	16
			Rooming/Boarding Home	17
			Supportive Housing - Congregate	18
			Supportive Housing - Assisted Living	19
			Other	20
			Unknown or Declined	21
144	Current Residence Type		Code as above	
145	Baseline Employment Status		None Selected	1
			Unknown or Declined	2
			Independent/Competitive	3
			Assisted/Supportive	4
			Alternative Business	5
			Sheltered Workshop	6
			Non-Paid Work Experience	7
			No Employment	8
			Casual/Sporadic	9
			No Employment of Any Kind	10
			No Employment - Other Activity	11
146	Current employment Status		Code as above	

147	Baseline Primary Income Source		None Selected	1
			Employment	2
			Employment Insurance	3
			Pension	4
			ODSP	5
			Social Assistance	6
			Disability Assistance	7
			Family	8
			No Source of Income	9
			Other	10
			Unknown or Declined	11
148	Current Primary Income Source		Code as above	
Drawing from the Program Eligibility Screening Tool				
Psychiatric Symptoms			1=Yes (code all that appear)	
149	Abuses alcohol/drugs			
150	Agitated			
151	Anger management issues			
152	Anger/aggression outbursts			
153	Antisocial personality disorder			
154	Anxiety			
155	Attention deficit disorder			
156	Auditory hallucinations			
157	Autism spectrum disorder			
158	Compulsive spending			
159	Conduct disorder			
160	Cravings			
161	Delusions			
162	Depression			
163	Deteriorating mental health			
164	Developmentally delayed			
165	Difficulty reading/ writing			
166	Disorganized speech and thinking/ incoherent thoughts			
167	Dissociation			
168	Dizziness			
169	Drug addiction			
170	Fear			
171	Feeling triggered			

172	Fetal alcohol syndrome		
173	Fixates on problems		
174	Frustration		
175	Gambling addiction		
176	Grandiose ideas		
177	Grief		
178	Homicidal ideation		
179	Hopeless		
180	impulsive		
181	Inappropriate social interactions		
182	Irrational		
183	Irregular sleeping patterns		
184	Irritable		
185	Lack of cooperation		
186	Lack of energy		
187	Low motivation		
188	Mania		
189	Memory/ intellectual impairment,		
190	Migraines		
191	Mood swings/bipolar/ instability		
192	Nausea		
193	Negative affect		
194	Nervous breakdown		
195	Nightmares		
196	No Appetite		
197	Nymphomaniac		
198	Obsessive compulsive disorder		
199	Oppositional defiant disorder		
200	Pacing		
201	Panic		
202	Panic attacks		
203	Paranoid		
204	Physically aggressive		
205	Poor concentration		
206	Poor memory		
207	Postpartum depression		
208	Preoccupation of religious beliefs		
209	Previous hospitalization (for		

	mental instability)		
210	Previous suicidal ideation		
211	Previous suicide attempts		
212	Psychosis		
213	PTSD symptoms		
214	Racing thoughts		
215	Rapid eye movements		
216	Rapid Speech		
217	Schizophrenia		
218	self-esteem issues		
219	Self-harm		
220	Sexual frustration		
221	Social anxiety disorder		
222	Stressed		
223	Substance induced psychosis		
224	Substance misuse		
225	Suicidal ideation		
226	Threat to others		
227	Verbally assaultive/ use of disrespectful language		
228	Violence		
229	Visual hallucinations		
230	Withdrawal symptoms		
231	Withdraws/isolates self		
232	Worries constantly		
Psychiatric History			Any indication of the length (number of years) since onset
233	Time		
Past	Treatment		Drug name
234	Med 1		Acetaminophen (novo-gesic forte)
235	Med 2		Acetylsalicylic acid (i.e., aspirin)
236	Med 3		Adderall (ADHD)
237	Med 4		Amitriptyline (Elavil..)
238	Med 5		Amoxicillin (antibiotic drug)
239	Med 6		Apo-fluvoxamine (i.e., Luvox – antidepressant)
240	Med 7		Apo-Levocarb
241	Med 8		Apo-nortriptyline (Sensoval, Aventyl,

			Pamelor etc)
242	Med 9		Apo-ramipril (i.e., heart drug)
243	Med 10		Aripiprazole (i.e., Ambilify)
244	Med 11		Arthrotec (rheumatoid arthritis)
245	Med 12		Azithromycin (Zithromax – antibiotic)
246	Med 13		Baclofen (i.e., muscle relaxants – GABA)
247	Med 14		Beclomethasone (i.e., nasal spray, Mylan)
248	Med 15		Benztropine
249	Med 16		Benzodiazepines (i.e., lorazepam, Ativan, Xanax)
250	Med 17		Bupropion (i.e., Wellbutrin)
251	Med 18		Carbamazepine (Carbamaz, epilepsy)
252	Med 19		Cephalexin (Novo-Lexin)
253	Med 20		Ciclesonide nasal spray (Alevesco for asthma)
254	Med 21		Ciprofloxacin
255	Med 22		Citalopram (i.e., celexa, cipramil)
256	Med 23		Clarithromycin (Mylan-Clarithromycin)
257	Med 24		Clomipramine (i.e., antidepressant)
258	Med 25		Clonazepam (i.e., anti-anxiety)
259	Med 26		Clindamycin (antibiotic)
260	Med 27		Clonodine
261	Med 28		Clotrimaderm ointment
262	Med 29		Corticosteroid nasal spray
263	Med 30		Cyclobenzaprine (i.e., muscle relaxant)
264	Med 31		Diazepam (i.e., valium)
265	Med 32		Diclofenac (i.e., anti inflammatory)
266	Med 33		Diltiazem (for high blood pressure)
267	Med 34		Divalproex (i.e., anticonvulsant, aka epival)
268	Med 35		Docusate sodium (stool softener)
269	Med 36		Escitalopram (i.e., cipralex – SSRI)
270	Med 37		Ferrous phosphate
271	Med 38		Flovent

272	Med 39		Fluoxetine (i.e., Prozac, Sarafem, Fontex..SSRI's)
273	Med 40		Fluanxol
274	Med 41		Fluticasone
275	Med 42		Fuciclin ointment
276	Med 43		Gabapentin (Neurontin)
277	Med 44		Garamycin
278	Med 45		Hydroxyzine
279	Med 46		Ibuprofen (i.e., antiphatelet drug)
280	Med 47		Imovane (i.e., zopiclone)
281	Med 48		Lansoprazole (aka prevacid)
282	Med 49		Levothyroxine (i.e., levoxyl, synthroid, eltroxin)
283	Med 50		Lisdexamfetamine Dimesylate (i.e., Vyvanse)
284	Med 51		Lithium (ie., mood stabilizer for bipolar)
285	Med 52		Metformin (i.e., diabetic drug)
286	Med 53		Methadone
287	Med 54		Methylphenidate (i.e., Ritalin, Concerta)
288	Med 55		Metoprolol
289	Med 56		Metronidazole (i.e., antibiotic)
290	Med 57		Mirtazapine (Remeron, Avanza, Zispin)
291	Med 58		Musillium
292	Med 59		Nabilone
293	Med 60		Naproxen (i.e., anti-inflammatory)
294	Med 61		Nasonex
295	Med 62		Novo-Gesic (acetaminophen)
296	Med 63		Olanzapine (i.e., Zyprexa – anti-psychotic)
297	Med 64		Olopatadine (aka patanol)
298	Med 65		Omeprazole (i.e., Prilosec – for GERD,stomach acid..)
299	Med 66		Oxycodone (i.e., Percocet
300	Med 67		Paliperidone (i.e., Invega)
301	Med 68		Paroxetine

302	Med 69		PMS – pantoprazole
303	Med 70		Polysprin (antibiotic)
304	Med 71		Prednisone
305	Med 72		Quetiapine (i.e., Seroquel)
306	Med 73		Rabeprazole (i.e., Aciphex)
307	Med 74		Ranitidine
308	Med 75		Risperidone (i.e., Risperdal – antipsychotic)
309	Med 76		Rosuvastatin (i.e., cholesterol)
310	Med 77		Salbutamol ventolin (i.e., inhaler)
311	Med 78		Sandoz Anuzinc
312	Med 79		Sertraline HCL (Zoloft)
313	Med 80		Soflax (i.e., stool softener)
314	Med 81		Teva-Telmisartan (high blood pressure)
315	Med 82		Temazepam (i.e., restoril, insomnia)
316	Med 83		Tenofovir/emtricitabine
317	Med 84		Tetracycline (i.e., antibiotics)
318	Med 85		Trazodone (i.e., Desyrel, Oleptro, Trazorel..class of antidepressants)
319	Med 86		Triacinolone
320	Med 87		Tylenol #2
321	Med 88		Tylenol #3
322	Med 89		Valproic acid – (ie., mood stabilizer)
323	Med 90		Venlafaxine (i.e., Effexor)
324	Med 91		Ziprasidone (Geldon, Zeldox)
Current Treatment			Drug name
325	Med 1		Acetaminophen (novo-gesic forte)
326	Med 2		Acetylsalicylic acid (i.e., aspirin)
327	Med 3		Adderall (ADHD)
328	Med 4		Amitriptyline (Elavil..)
329	Med 5		Amoxicillin (antibiotic drug)
330	Med 6		Apo-fluvoxamine (i.e., Luvox – antidepressant)
331	Med 7		Apo-Levocarb
332	Med 8		Apo-nortriptyline (Sensoval, Aventyl, Pamelor etc)
333	Med 9		Apo-ramipril (i.e., heart drug)

334	Med 10		Aripiprazole (i.e., Ambilify)
335	Med 11		Arthrotec (rheumatoid arthritis)
336	Med 12		Azithromycin (Zithromax – antibiotic)
337	Med 13		Baclofen (i.e., muscle relaxants – GABA)
338	Med 14		Beclomethasone (i.e., nasal spray, Mylan)
339	Med 15		Benztropine
340	Med 16		Benzodiazepines (i.e., lorazepam, Ativan, Xanax)
341	Med 17		Bupropion (i.e., Wellbutrin)
342	Med 18		Carbamazepine (Carbamaz, epilepsy)
343	Med 19		Cephalexin (Novo-Lexin)
344	Med 20		Ciclesonide nasal spray (Alevesco for asthma)
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346	Med 22		Citalopram (i.e., celexa, cipramil)
347	Med 23		Clarithromycin (Mylan-Clarithromycin)
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350	Med 26		Clindamycin (antibiotic)
351	Med 27		Clonodine
352	Med 28		Clotrimaderm ointment
353	Med 29		Corticosteroid nasal spray
354	Med 30		Cyclobenzaprine (i.e., muscle relaxant)
355	Med 31		Diazepam (i.e., valium)
356	Med 32		Diclofenac (i.e., anti inflammatory)
357	Med 33		Diltiazem (for high blood pressure)
358	Med 34		Divalproex (i.e., anticonvulsant, aka epival)
359	Med 35		Docusate sodium (stool softener)
360	Med 36		Escitalopram (i.e., cipralex – SSRI)
361	Med 37		Ferrous phosphate
362	Med 38		Flovent
363	Med 39		Fluoxetine (i.e., Prozac, Sarafem, Fontex..SSRI's)

364	Med 40		Fluanxol
365	Med 41		Fluticasone
366	Med 42		Fuciclin ointment
367	Med 43		Gabapentin (Neurontin)
368	Med 44		Garamycin
369	Med 45		Hydroxyzine
370	Med 46		Ibuprofen (i.e., antiphatelet drug)
371	Med 47		Imovane (i.e., zopiclone)
372	Med 48		Lansoprazole (aka prevacid)
373	Med 49		Levothyroxine (i.e., levoxyl, synthroid, eltroxin)
374	Med 50		Lisdexamfetamine Dimesylate (i.e., Vyvanse)
375	Med 51		Lithium (ie., mood stabilizer for bipolar)
376	Med 52		Metformin (i.e., diabetic drug)
377	Med 53		Methadone
378	Med 54		Methylphenidate (i.e., Ritalin, Concerta)
379	Med 55		Metoprolol
380	Med 56		Metronidazole (i.e., antibiotic)
381	Med 57		Mirtazapine (Remeron, Avanza, Zispin)
382	Med 58		Musillium
383	Med 59		Nabilone
384	Med 60		Naproxen (i.e., anti-inflammatory)
385	Med 61		Nasonex
386	Med 62		Novo-Gesic (acetaminophen)
387	Med 63		Olanzapine (i.e., Zyprexa – anti-psychotic)
388	Med 64		Olopatadine (aka patanol)
389	Med 65		Omeprazole (i.e., Prilosec – for GERD,stomach acid..)
390	Med 66		Oxycodone (i.e., Percocet
391	Med 67		Paliperidone (i.e., Invega)
392	Med 68		Paroxetine
393	Med 69		PMS – pantoprazole
394	Med 70		Polysprin (antibiotic)

395	Med 71		Prednisone
396	Med 72		Quetiapine (i.e., Seroquel)
397	Med 73		Rabeprazole (i.e., Aciphex)
398	Med 74		Ranitidine
399	Med 75		Risperidone (i.e., Risperdal – antipsychotic)
400	Med 76		Rosuvastatin (i.e., cholesterol)
401	Med 77		Salbutamol ventolin (i.e., inhaler)
402	Med 78		Sandoz Anuzinc
403	Med 79		Sertraline HCL (Zoloft)
404	Med 80		Soflax (i.e., stool softener)
405	Med 81		Teva-Telmisartan (high blood pressure)
406	Med 82		Temazepam (i.e., restoril, insomnia)
407	Med 83		Tenofovir/emtricitabine
408	Med 84		Tetracycline (i.e., antibiotics)
409	Med 85		Trazodone (i.e., Desyrel, Oleptro, Trazorel..class of antidepressants)
410	Med 86		Triacinolone
411	Med 87		Tylenol #2
412	Med 88		Tylenol #3
413	Med 89		Valproic acid – (ie., mood stabilizer)
414	Med 90		Venlafaxine (i.e., Effexor)
415	Med 91		Ziprasidone (Geldon, Zeldox)
Past Use of Substances			No use for at least 3 months (don't include periods of incarceration)
416	**Used in the past**		0=no; 1=yes; 2=unknown
417	**Duration history**		Time (in years) used
418	Alcohol		1=yes
419	Crack cocaine/ Cocaine		1=yes
420	Ecstasy		1=yes
421	Hallucinogens (aka mushrooms, acid		1=yes
422	Hydro-morph		1=yes
423	Ketamine (i.e., anesthetic)		1=yes
424	Marijuana		1=yes
425	Methamphetamine (aka Crystal meth, speed, crank, chalk etc.)		1=yes

426	Morphine (aka Heroin)		1=yes
427	Opiates (i.e., Fentanyl)		1=yes
428	Oxycontin/ Oxycondone		1=yes
429	PCP		1=yes
430	Prescription medications		1=yes
431	**Treatment in past**		1=yes Engagement
Current Use of Substances			1=yes
432	Alcohol		1=yes
433	Crack cocaine/ Cocaine		1=yes
434	Ecstasy		1=yes
435	Hallucinogens (aka mushrooms, acid		1=yes
436	Hydro-morph		1=yes
437	Ketamine (i.e., anesthetic)		1=yes
438	Marijuana		1=yes
439	Methamphetamine (aka Crystal meth, speed, crank, chalk etc.)		1=yes
440	Morphine (aka Heroin)		1=yes
441	Opiates (i.e., Fentanyl)		1=yes
442	Oxycontin/ Oxycondone		1=yes
443	PCP		1=yes
444	Prescription medications		1=yes
445	**Appeared under the influence**		1=yes
446	**Drug paraphernalia found**		1=yes
447	**Treatment currently**		1=yes
Risk Factors			1=yes
448	Child welfare as a child		(look for Changing Ways, LAWC, WCH, Second Stage)
449	Emotional abuse as a child		
450	Maltreatment as a child		
451	Neglect as a child		
452	Physical abuse as a child		
453	Sexual abuse as a child		
454	Sexual violence as adult		(look for SACL, Trauma Program at St. Joes's)
455	Intimate partner violence (adult)		
456	Children removed from care (adult)		

457	Historical grief		
458	Current grief		
459	Historical trauma		
460	Prenatal care		
Client Presentation on Admission			0=no evidence; (code all that appear) 1=poor/negative presentation; 3=good/positive presentation
Cognitive			
461	Coherence		
462	Concentration		
463	Confused		
464	Disassociation		
465	Logical		
466	Poor memory		
467	Preoccupation		
468	Rapid Speech		
469	Thoughts		
Emotional			
470	Affect		
471	Agitated		
472	Angry/aggressive		
473	Anxious		
474	Became emotional		
475	Frustrated		
476	Overwhelmed		
477	Pleasant		
478	Tearful		
479	Timid		
Physical			
480	Appearance		
481	Cooperation		
482	Drowsy		
483	Physical wellness		
484	Wounds		
Goals			1=yes
485	Housing		
486	Connection with other services		
487	Abstain from substances		

488	Attend to physical health concerns		
489	Basic necessities (clothing, eye glasses)		
490	Community service		
491	Connect with child/children		
492	Dentist		
493	Education		
494	Employment research/support		
495	Finances (ODSP, OAS, OW, banking services)		
496	Follow bail and/or probation order		
497	Leisure/recreation		
498	Medication compliance/regime		
499	Mental health programming		
500	Obtain documentation		
501	Obtain prescription medications		
502	Parenting support		
503	Physician		
504	Psychiatrist		
505	Reintegration program referral		
506	Symptom management		
507	Victim compensation		

Appendix C

Psychiatric Symptom Clusters

Cluster	**Symptoms**
Substance Dependence	Abuses alcohol/drugs
	Cravings
	Drug addiction
	Feeling triggered
	Substance induced psychosis
	Substance misuse
	Withdrawal symptoms
Anxiety	Agitated
	Anger/aggression outbursts
	Anxiety
	Dizziness
	Fear
	Fixates on problems
	Frustration
	Irritable
	Inappropriate social interactions
	Migraines
	Nausea
	Obsessive compulsive disorder
	Pacing
	Panic
	Panic attacks
	Social anxiety disorder
	Stressed
	Worries constantly
Impulse Control Disorder	Anger management issues
	Compulsive spending
	Gambling addiction
	impulsive
	Physically aggressive
	Threat to others
	Verbally assaultive/ use of disrespectful language
	Violence

Personality Disorder	Antisocial personality disorder
Schizophrenia	Auditory hallucinations
	Delusions
	Disorganized speech and thinking/ incoherent thoughts
	Grandiose ideas
	Homicidal ideation
	Paranoid
	Preoccupation of religious beliefs
	Psychosis
	Rapid eye movements
	Schizophrenia
	Visual hallucinations
Disorder in Childhood	Attention deficit disorder
	Autism spectrum disorder
	Conduct disorder
	Developmentally delayed
	Difficulty reading/ writing
	Fetal alcohol syndrome
	Lack of cooperation
	Oppositional defiant disorder
Mood Disorder	Depression
	Hopeless
	Irrational
	Irregular sleeping patterns
	Lack of energy
	Low motivation
	Mania
	Mood swings/bipolar/ instability
	Negative affect
	Nervous breakdown
	No Appetite
	Poor concentration
	Poor memory
	Postpartum depression
	Previous hospitalization (for mental instability)
	Previous suicidal ideation
	Previous suicide attempts

	Racing thoughts Rapid Speech self-esteem issues Self-harm Withdraws/isolates self Suicidal ideation
Cognitive Disorder/ Delirium	Deteriorating mental health Memory/ intellectual impairment
Dissociative Disorder	Dissociation
Grief	Grief
Post-traumatic Stress Disorder	Nightmares PTSD symptoms
Sexual Identity Disorder	Nymphomaniac Sexual frustration

Emotion Dysregulation Symptom Cluster

Cluster	Symptoms
Emotion Dysregulation	Agitated
	Anger management issues
	Anger/aggression outbursts
	Antisocial personality disorder
	Anxiety
	Compulsive spending
	Depression
	Dissociation
	Fear
	Feeling triggered
	Grief
	Hopeless
	Impulsive
	Inappropriate social interactions
	Irrational
	Irritable
	Mania
	Mood swings/bipolar/ instability
	Negative affect
	Nervous breakdown
	Pacing
	Panic
	Physically aggressive
	Postpartum depression
	PTSD symptoms
	Social anxiety disorder
	Stressed
	Threat to others
	Verbally assaultive/ use of disrespectful language
	Violence
	Worries constantly

Appendix D

Treatment/ Medication Clusters

Cluster	**Med #**	**Medications**
Antidepressants	Med 4	Amitriptyline (Elavil, tricyclic antidepressant)
	Med 6	Apo-Fluvoxamine (Luvox, SSRI)
	Med 8	Apo-nortriptyline (tricyclic)
	Med 17	Bupropion
	Med 22	Citalopram (SSRI)
	Med 24	Clomipramine (trycyclic)
	Med 36	Escitalpram (SSRI)
	Med 39	Fluoxetine (SSRI)
	Med 57	Mirtazapine (Remeron, Avanza, Zispin)
	Med 59	Nabilone (Also Analgesic)
	Med 68	Paroxetine
	Med 79	Sertraline HCL (Zoloft)
	Med 85	Trazodone (i.e., Desyrel, Oleptro, Trazorel)
	Med 90	Venlafaxine
Stimulants	Med 3	Adderall (for ADHD)
	Med 27	Clonodine
	Med 50	Lisdexamfetamine Dimesylate (i.e., Vyvanse)
	Med 54	Methylphenidate (i.e., Ritalin, Concerta)
Antipsychotics	Med 10	Aripiprazole (atypical antipsychotic)
	Med 40	Fluanxol
	Med 45	Hydroxyzine (Antihistamines)
	Med 63	Olanzapine (i.e., Zyprexa – anti-psychotic)
	Med 67	Paliperidone (i.e., Invega)
	Med 72	Quetiapine (i.e., Seroquel)
	Med 75	Risperidone (i.e., Risperdal – antipsychotic)
	Med 91	Ziprasidone
Mood stabilizers	Med 51	Lithium (ie., mood stabilizer for bipolar)
	Med 89	Valproic acid – (ie., mood stabilizer)
Anxiolytics	Med 25	Clonazepam
	Med 55	Metoprolol
	Med 82	Temazepam (i.e., restoril, insomnia)
Depressants	Med 16	Benzodiazepines (Benzodiazepine anticonvulsants)
	Med 31	Diazepam (Benzodiazepine anticonvulsants)

	Med 47	Imovane (i.e., zopiclone)
Analgesics	Med 1	Acetaminophen (novo-gesic forte)
	Med 2	Acetylsalicyclic acid
	Med 32	Diclofenac
	Med 62	Novo-Gesic (acetaminophen)
	Med 66	Oxycodone (i.e., Percocet)
	Med 87	Tylenol #2
	Med 88	Tylenol #3
Antibiotics/antineoplastics	Med 5	Amoxicillin
	Med 12	Azithromycin
	Med 19	Cephalexin
	Med 21	Ciprofloxacin
	Med 23	Clarithromycin
	Med 26	Clindamycin
	Med 42	Fuciclin Ointment
	Med 43	Garamycin
	Med 56	Metronidazole (i.e., antibiotic)
	Med 70	Polysprin (antibiotic)
	Med 84	Tetracycline (i.e., antibiotics)
Anti-addictive	Med 53	Methadone
Muscle relaxants	Med 13	Baclofen
	Med 30	Cyclobenzaprine
Nonsteroidal anti-inflammatory agents	Med 11	Arthrotec
	Med 35	Stool Softner
	Med 46	Ibuprofen (i.e., antiphatelet drug)
	Med 60	Naproxen (i.e., anti-inflammatory)
Treatment for stomach, GERD, intestinal ulcers	Med 48	Lansoprazole (aka prevacid)
	Med 65	Omeprazole (i.e., Prilosec – for GERD,stomach acid)
	Med 69	PMS – pantoprazole
	Med 73	Rabeprazole (i.e., Aciphex)
	Med 74	Ranitidine
Treatment for Allergies	Med 14	Beclomethasone (Mylan) - nasal steroids
	Med 29	Corticosteroid nasal spray - nasal steroids
	Med 61	Nasonex
	Med 64	Olopatadine (aka patanol)
	Med 71	Prednisone
Treatment for sexual symptoms	Med 83	Tenofovir/emtricitabine for HIV

Treatment for Parkinson's disease	Med 15	Benztropine
	Med 7	Apo-Levocarb
Treatment for other medical illnesses and symptoms	Med 9	Apo-ramipril for high blood pressure (angiotensin converting enzyme inhibitors)
	Med 28	Clotrimaderm ointment (Antifungals) for skin infections
	Med 33	Diltiazem for hypertension calcium channel blocking agents
	Med 37	Ferrous Phosphate for hypertension calcium channel blocking agents
	Med 41	Fluticasone = Glucocorticoid (Immunological and Metabolic)
	Med 49	Levothyroxine (i.e., levoxyl, synthroid, eltroxin) for Hypothyroidism
	Med 52	Metformin (i.e., diabetic drug) = antidiabetic
	Med 58	Musillium for constipation
	Med 76	Rosuvastatin (i.e., cholesterol)
	Med 80	Soflax (docusate sodium) for constipation
	Med 81	Teva-Telmisartan for high blood pressure
Treatment for Asthma	Med 20	Ciclesonide nasal spray
	Med 38	Flovent
	Med 77	Salbutamol ventolin for Asthma
	Med 78	Sandoz Anuzinc
Treatment for Seizures	Med 18	Carbamazepine
	Med 34	Divalproex
	Med 43	Gabapentin

VITA

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Post-secondary Education and Degrees	University of Western Ontario, London, Ontario, Canada M.Ed. Counselling Psychology	2011 - 2013
	University of Toronto, Toronto, Ontario, Canada Honours B.Sc. Psychology	2006 - 2010
Related Work Experience	Career Counselling Intern The Student Success Centre University of Western Ontario	2012 -2013
	Student Group Facilitator Merrymount Family Support and Crisis Centre London, Ontario	2012
	Crisis Intervention and Suicide Prevention Counsellor Vancouver Crisis Centre Vancouver, British Columbia	2010 -2011
	Behaviour Interventionist Vancouver, British Columbia	2010 - 2011
Research Experience	External Research Consultant The Centre for Children & Families in the Justice System London, Ontario	2012
	Research Assistant Adult Development Lab University of Toronto	2009 - 2010
	Research Assistant The StudentTalk Research Project University of Toronto	2009 - 2010