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Women in prison with drug-related problems. Part II:
Contact with treatment services

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"The evidence that successful programs for female offenders include those that focus on self-awareness and self-esteem, promote community involvement and adherence to community norms, use tools validated for women and aboriginal peoples, and provide supportive environments responsive to the needs of women with less emphasis on static security measures......"

Jane Miller-Ashton

(reporting on the findings of the Task Force on Federally Sentenced Women, 1989, Correctional Service of Canada)

Preface

Research must always be located in time. This report provides a unique insight into the environment of N.S.W. correctional centres for women for the period ending, November, 1993. It is a valuable resource, documenting a period of great change in the Department's history. During the course of this research the Department has been responsive to many points raised. Practical procedures as well as some recommendations as documented here have already been implemented prior to the publication of this report. As has been the case with this study on women in prison, when attention is drawn to a specific area of concern a positive flow on effect can often occur whereby other parties will initiate reviews and modifications while the study is still in progress. In relation to this study, the Department's D&A Service is piloting a gender-sensitive reception screening procedure at Mulawa Correctional Centre with a view to setting priorities for a further diagnostic assessment and matched treatment plan. In addition, the D&A Service and the Corrections Health Service have negotiated a co-operative arrangement in the provision of drug treatment which includes exchange of information. Further, the Corrections Health Service has appointed a Director of Women's Health Services and also has standardised and refined it's reception health assessment procedure and withdrawal protocols.

During 1994 the Department promulgated the Women's Action Plan which involved review and development of a three year strategic plan. The stated objective was "to develop an equitable, realistic, cost efficient strategy designed to ensure improved access to services and programs for women inmates". Towards the completion of this study the Department commenced implementation of the Women's Action Plan which included significant structural changes in some of the areas covered by this study. The largest correctional centre for women was devolved into a number of smaller centres, with an innovative transitional centre for women being built. In addition, a Women's Services Unit was established to co-ordinate the recommendations arising from the Women's Action Plan (1994).

This focus on imprisoned women is part of an international trend in corrections whereby the suitability of facilities and service delivery are being addressed through discussion and dedicated research.

Simon Eyland
Chief Research Officer

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Executive Summary

Drug & Alcohol Services (D&A Service) of the N.S.W. Department of Corrective Services requested this survey report. It represents the second of a two-part report series which examines the patterns of drug use of imprisoned women, their treatment needs and the effectiveness of the D&A Service in reaching those women with drug and alcohol (drug) problems. This survey supplements another requested by the D&A Service which surveyed mainly male inmates, about to be discharged to freedom, on the same issues (Kevin, 1992; Kevin, 1993). Subsequent to that study, the D&A Service recognised that a need existed to obtain similar data on women and also to identify any special treatment needs. The present survey was funded through a grant provided by the National Campaign Against Drug Abuse (NCADA) and this funding was administered by the Drug & Alcohol Directorate (DAD).

The following findings relate to the women's contact with the D&A Service and other services while imprisoned. Findings in relation to the drug-related background characteristics of the women surveyed are presented in the first report (Kevin, 1994a). The two reports are designed to be read in conjunction with each other.

■ The survey sample consisted of 130 women serving a sentence of a least 1 month between July and October, 1993.

Reception

- 55% of the total sample perceived that they were dependent on a drug when received for their current sentence with methadone (44%) and heroin (34%) being the most commonly cited drugs of dependence.

- 40% of the total sample reported to be withdrawing from drugs at reception. Heroin (44%) was the most commonly cited drug of withdrawal. Half of those who were withdrawing reported that they received treatment for their withdrawal syndrome.

- 64% of the total sample reported that they were assessed on their use of drugs at reception. Of those who were assessed 98% reported that they were assessed by a nurse. Only 1 woman reported that she was assessed by a D&A Worker [At the time of the study the D&A Service did not systematically assess inmates and also had no access to the assessments completed by the nursing staff. Therefore the Service relied, for the most part, on inmate self-referrals].

Use of D&A Service

- 45% of the total sample had used the D&A Service on at least one occasion during their current sentence. 55% of those classified as 'regular-heavy users' of drugs prior to imprisonment had used the D&A Service.

- 60% of those women who had received methadone treatment from the Corrections Health Service had also used the D&A Service.

- Predictive factors which were found to be significantly related to whether 'regular-heavy users' of drugs used the D&A Service or not were: needle use prior to imprisonment; court referral to corrections-based drug treatment; pre-sentence referral option to a community-based drug treatment program; drug dependency and drug withdrawal syndrome on reception.

- 78% of those who used the service were self-selecting. The remaining referrals were mostly from correctional management (9%). Those who were recruited by the D&A Service represented 3% of this group.

- Of those who received treatment from the D&A Service significantly more received one-to-one counselling (81%) than any

other form of treatment. The next most commonly received treatment was Narcotics Anonymous (40%).

- The majority (66%) of those who received counselling had sessions at least every 3 weeks and 32% received counselling on an at least weekly basis.

- Of those who used the D&A Service 41% had experienced difficulties in accessing it. The most frequently cited difficulty was that the D&A Worker was too busy to see them.

- When compared to a previous male sample (32%), a higher proportion of this female sample (42%) had used the D&A Service.

Those who did not use the D&A Service

- The most common reason provided by potential clients for not using the service was that they did not have a drug problem (24%).

- The majority (62%) of those who did not receive treatment (excluding those who stated that they did not have a problem) thought that it was not important for them to receive corrections-based drug treatment.

Use of Corrections Health Service (CHS)

- All of the sample had used the CHS at some time during their current sentence and 97% of the sample had reportedly received medication from the CHS.

- The following sub-groups showed significantly greater frequency of use of the CHS: those with sentences under 6 months; those under 35 years of age; those who received methadone treatment; and those of Aboriginal background.

- 30% of the total sample stated that they received medication on a daily basis and 56% had reportedly received medication within the previous week.

- The most common type of medication received on the most recent occasion (from the medication classification used by the study) was analgesics (49%).

- 34% of the total sample stated that they had received methadone treatment at some stage during their current sentence. Of this group the majority (95%) had been on a community-based methadone program at some time prior to imprisonment.

In-custody behavioural indicators

- Of the total sample: 6% had been charged with assault; 3% had attempted to deliberately harm themselves; and 32% had committed prison offences during the 4 month period of the survey.

- Using a scale designed to measure emotional well-being (GHQ-28) 55% of the total sample were classified as having poor emotional well-being at the time of interview. Anxiety related symptoms appeared to be the area of poorest adjustment.

- Using a scale designed to measure self-esteem 51% of the total sample received a score under 60, with 100 representing the maximum score obtainable. 27% of the sample scored above 70.

Key informants

- Key informants employed within the system identified the following as being the most important treatment needs for the women: separate drug detoxification unit; self-esteem programs; stress management and relaxation programs; women's programs; increased and greater variety in terms of training and employment opportunities; increased Works-Release opportunities; and pre and post release support programs.

Recommendations

Reception to the correctional system

- All new receptions be held in a separate residential section to the general population of inmates for their first few days in custody (generally this is the case for male inmates). This strategy would allow these women to be properly assessed and monitored.

- The reception screening interview be conducted in a safe, comfortable and private location within the centre.

- A separate detoxification unit be established on-site at Mulawa Correctional Centre for those experiencing drug withdrawal syndrome (see Appendix A: Miner & Gorta, 1986: Recommendations)

Allocation of D&A Service resources

- Given funding levels, the D&A Service allocate resources on a systematic basis according to level of need.

- The level and timing of intervention offered by the D&A Service be ascertained by the level of risk of drug-related harm present in the individual. This level of risk be determined by the use of a valid and reliable screening scale.

- High risk cases, such as those who are experiencing drug withdrawal syndrome, those who share needles, those who present with emotional distress due to drug use and serious recidivists whose crime is drug-related should be specifically targeted for treatment intervention. Subsequent to identification through screening, these women be prioritised for diagnostic assessment and motivational interview with a view to matching them with an appropriate treatment plan.

- Diagnostic assessment should include a dual diagnosis (presentation of concurrent psychiatric disorder) component.

- D&A Service management acknowledge that present staff feel overloaded and potentially are unable to carry out new initiatives and establish programs. A systematic risk-based approach to the provision of treatment would to some extent reduce the overload reportedly experienced by D&A Workers. Additionally, management should document guidelines pertaining to where the responsibilities of D&A Workers begin and end in the correctional environment with particular reference to crisis intervention and classification and program review meetings.

- A systematic approach to the provision of drug treatment be adopted as follows:

    - screening and drug withdrawal management;
    - diagnostic assessment of medium-high risk cases;
    - motivational interview and treatment plan. Low intensity program (education-based group program) or high intensity program (one-to-one counselling or separate unit program) to be determined by level of risk;
    - follow-up interview - assessment of progress;
    - community-based referrals.

    For short-term inmates (less than one month) the entire corrections-based intervention may involve a contact screening procedure and referrals to community-based programs.

Treatment Planning

- Supplementary services are viewed as integral to the well being of women with

drug-related problems and therefore an essential component of effective drug treatment. The D&A Service and other rehabilitation services approach treatment from an holistic perspective.

- An holistic treatment continuum is best managed through multi-disciplinary team work whereby those staff best qualified to deliver a specific treatment, do so.

- The continuum of treatment services include the following areas:

  - specific to drug use, such as relapse prevention ;
  - medical;
  - psychological;
  - vocational;
  - general skills-based: self-esteem, problem-solving, self-efficacy;
  - child care, parenting;
  - interpersonal relationships, sexuality & intimacy;
  - welfare/legal: child-custody, domestic violence orders, housing.

- Empirical evidence supports the continued provision of a continuum of drug treatment programs ranging from drug education, skills-based groups, NA and AA meetings to a rehabilitation unit approach.

- A drug rehabilitation unit be introduced as a treatment option for women towards the end of their sentence and be established either on-site in a separate area of the correctional centre or in the community.

- Consideration be given to contracting an outside organisation to manage the rehabilitation unit. Should the unit program be conducted off-site, the women be transported to the community-based program on a day-release arrangement. The correctional centre would retain responsibility for housing, security, meals and medical care.

- A program which specifically addresses both women's issues and drug use be developed and piloted. The program be based on an empowerment model whereby the women perceive they have choices, alternatives and self-control.

- Attention be given to the provision of culturally-sensitive services for Aboriginal women with drug problems. As is the case for male Aboriginal inmates, there should be a specially designed program to address the needs of Aboriginal women with drug-related problems.

- Approaches which have been evaluated as being effective in reducing injecting behaviour and other high risk behaviours that are likely to occur in a correctional setting should be investigated and implemented or expanded and refined if currently being offered.

- A program specific to the development of drug coping skills and relapse prevention skills in the correctional environment should be offered.

- Further development of inmate peer support programs. Logically, inmate support groups offer a cost-effective approach to relapse prevention and drug coping skills in the correctional environment.

- The formation of 'outmate' support groups which provide the ongoing post-release support that has been associated with successful outcomes, such as reduced recidivism and reduced drug use.

- Continued and expanded provision of corrections-based AA and NA meetings as linkage with these support groups in the community is assured.

- Drug treatment goals be realistic. Those with drug dependencies show a high rate of relapse often going through several cycles of treatment and relapse. Outcome

measures, such as increased employability or pro-social behaviour also be considered in evaluating program effectiveness.

- Treatment programs for women have evaluation built into the design. Evaluation to include outcome and process measures.

Other services and areas of concern

- The Corrections Health Service (CHS) introduce health promotion and prevention initiatives. These include low cost education interventions, such as: stress techniques and sleep hygiene; taking control of one's health and being assertive with health care providers.

- The CHS conduct a regular audit of medication orders across correctional centres and present a report of the findings to the Department of Health and the Department of Corrective Services.

- The Department investigate treatment approaches adopted by other correctional administrations for those women who have a history of physical/sexual abuse. Research suggests that treatment for these issues needs to be staffed by specialists and conducted in a therapeutic setting.

- The Department investigate options, including the provision of a mother and babies unit, in relation to meeting the needs of those women with young children and the needs of their children.

- Corrections-based education programs for women be generally predicated on principles of social and economic independence. Hence, programs need to emphasise the development of living skills and market-based vocational opportunities.

- The reported inequity between men and women in relation to the level and variety of Works-Release opportunities needs to be investigated by the Department. If women are not being offered proportionately the same amount and variety of options as men then this imbalance needs to be rectified.

- Training and vocation opportunities need to place less emphasis on the traditional low-paying jobs for women and move in the direction of more creative, market-based opportunities, such as male-dominated construction trades (electrical, mechanical and landscaping) which offer higher income.

- The comparatively high incidence of deliberate self-harm among imprisoned women needs to be continually monitored and the causes addressed. The correctional environment and any immediate situational, practical or relationship concerns need to be addressed in any explanation of destructive behaviour in a correctional setting. Any research which is conducted should investigate the qualitative aspects of imprisonment for women.

- To facilitate reintegration of inmates into the community the Department should support the provision of additional resources to transitional halfway houses and co-operative living arrangements.

- The Department promote and train inmates in the formation of a network of inmate support groups. Such groups can fulfil the role of grievance support; companion; and diversion and play an integral role in the safe and secure management of the correctional centre.

- In employing staff to work with female inmates, the Department selects those who demonstrate an interest in working with women. Specialised training be provided to those officers working with female inmates on the issues and concerns of imprisoned women making reference to information arising from this study.

Introduction

This project on the treatment needs of women in prison with drug-related problems and the effectiveness of the D&A Services in reaching those with problems was initiated by Drug & Alcohol Services (D&A Service), Inmate Development Services of the N.S.W. Department of Corrective Services.

▸ The need for research on gender specific drug treatment programs.

At present there is insufficient empirical evidence to suggest that treatment approaches for women with drug-related problems and women offenders should be significantly different to those for men. Hence a number of sources have argued for further empirical information and program trials in relation to these women.

For the most part, correctional facilities, practices and programs have been designed for men. If the treatment needs of women are different to those of men, it logically follows that there are many women in prison who have unmet treatment needs.

Empirical information is needed in order to determine how to structure programs to be of greatest benefit to imprisoned women.

Currently many correctional jurisdictions would find it difficult to determine the treatment requirements of women who are imprisoned as they do not systematically record information on the following:

- prevalence and type of drug-related crime;
- prevalence of unemployment and employment history;
- those who are parents and who had primary responsibility for their children prior to imprisonment and also those who will be responsible for their children on release;
- prevalence, type and history of emotional disorder/s; and
- prevalence and history of sexual or physical abuse.

An association has been documented between prior physical and sexual abuse and drug dependencies in women (Bollerud, 1990; Newkirk, 1992). Both authors also reported on the prevalence of Post Traumatic Stress Disorder[1] (PTSD) in women who have experienced prior abuse.

Newkirk (1992) of the Georgia State Department of Corrections reported that about 66% of the imprisoned women who were receiving counselling for abuse-related issues had been given a diagnosis of PTSD.

Newkirk outlined the treatment regime adopted by the Department in response to the prevalence of this disorder. Outside consultants with experience in treating women who had been abused were employed to assess women in relation to prior abuse and to conduct individual therapy and group therapy mainly dealing with abuse issues. Further, a multi-disciplinary approach was adopted including medical, psychology, drug and alcohol education, vocation and chaplaincy. This strategy was based on the premise that an inmate should receive services from the staff best able to deliver those services.

Newkirk contended that crises occurring in prison, such as fights and deliberate self-harm often represent attention seeking behaviour from those who need interventions. She predicted that there would be a reduction in the rate of such crises as result of this

treatment strategy. An evaluation of the program is planned.

According to Liebling (1994) the specific requirements of women in prison are often neglected because of their small numbers. Liebling's research on inmates in the U.K. found that the impact of imprisonment differs greatly for men and women. She reported that when compared to male prisoners female prisoners were more likely to raise concerns about family and children. Other concerns more often raised by women were loss of tenancies, sexist and racist treatment and the frustration of dependence on outside agencies for help.

- **Use of health-related services by imprisoned women and men**

Limited early findings suggest that women while imprisoned are more likely to seek treatment from health-related services compared with imprisoned men (Newkirk, 1992; Maden, Swinton and Gunn, 1994). Newkirk (1992) addressed the mental health treatment needs of imprisoned women in her jurisdiction (Georgia State Department of Corrections). The Newkirk study reported on 1560 women who were imprisoned in state institutions representing 5.8% of the total population of inmates.

Of these 1560 women 15% were reportedly receiving mental health services compared to 6.6% of men. In addition 280 women (18%) were receiving medication for psychological problems. Of this group approximately 50% were being treated for depression, 18% for psychotic disorders (bipolar disorder[2] and schizophrenia[3]). Further, about 15% of the mental health caseload were diagnosed as having PTSD.

Maden, Swinton and Gunn (1994) from their study of offenders imprisoned in the United Kingdom concluded that when compared with men, women made greater demands on health-related services in prison due to higher rates of personality disorder, substance dependency and neurosis. Using case notes and standardised measures of psychological state they concluded that when compared with men, women had a higher prevalence of learning disabilities (6% versus 2% of men), personality disorder (18% versus 10% of men), neurotic disorder (18% versus 10% of men), and substance dependency (26% versus 12% of men). Women and men were matched on prevalence of psychosis (2%).

At present there is insufficient documented evidence to suggest that women in N.S.W. correctional centres show a higher incidence of psychiatric morbidity than men. Further, the interpretation of findings from other jurisdictions, such as described above, should be undertaken with caution as there exists the potential to over-medicalise or pathologise the problems of imprisoned women. The social and economic circumstances of these women in society and their experience of prison life should be taken into account in any explanation of psychological well being.

Predictably many offenders are received into correctional centres in poor physical and psychological condition because of the risky lifestyle which they lead. Further, this poor level of health would be further exacerbated for drug users who are supporting drug dependencies through criminal activity.

Arguably women show greater utilisation of health-related services for reasons including the following:

- more complicated reproductive system - obstetric and gynaecological matters;

- sexually transmitted diseases;
- separation from children for whom they are the primary care givers;
- type of drug-related problems - higher proportion of narcotic injecting drug use and its associated health risks and treatment options, such as methadone maintenance.

▸ Programs specifically designed for women with drug-related problems

Most of the documented programs specifically developed for women offenders with drug problems appear to emanate from the United States. Wellisch, Anglin and Predergast (1993) estimated that about 10% of women with drug problems receive prison-based drug treatment in the United States. In addition, the United States has community-based drug treatment programs which serve only clients referred from the courts.

In their review of the literature Wellisch et al reported that the majority of empirical evidence indicated that treatment for women with drug problems had been effective and that its effectiveness was not diminished when treatment was made mandatory by the criminal justice system. Effectiveness was measured in terms of reduced drug use, reduced crime and more pro-social behaviour. Also they concluded that treatment outcomes vary widely usually depending on how the programs are implemented.

It is noteworthy that most of the treatment evaluations to which they referred were conducted on community-based programs. However, long term users in the community-based programs often have engaged in criminal activity and have problems similar to those in prison. At times they can be the same population at different stages of their drug using careers.

Current drug treatment programs for women appear to be characterised by two main approaches:

- **empowerment: so the women perceive themselves as actors rather than victims (self-directing behaviour);**
- **coping skills: using a cognitive-behavioural approach to provide women with the skills in order to make positive changes in their lives.**

In addition to components specifically related to drug using behaviour many prison-based drug treatment programs include strategies and services aimed at addressing other identified needs of imprisoned women:

- status as single parents;
- parenting;
- health and nutrition education;
- family planning;
- assertiveness training and vocational training;

Due to the reported high relapse rates in the drug using population, programs have emphasised the critical importance of continued supervision and support after release through transitional programs and after-care programs.

A description of two of the drug treatment demonstration programs for imprisoned women reviewed by Wellisch and colleagues follow.

The 'Passages' program of the Wisconsin Department of Corrections was developed in 1988 as a non-traditional demonstration program for women offenders. Prior to this initiative, staff had observed that traditional confrontational approaches based on the disease model did not appear to be associated with positive change in women offenders with drug problems.

Passages had places for 15 participants at any one time and 60 participants per year. Program duration was 12 weeks and participants were required to have minimum security classification status to enrol. Participants resided in the correctional facility and attended the community-based program 6 days per week.

The program was conducted over 3 stages. Stage 1 focussed on self-awareness and insight, including: a 12-step program; responsibility for decisions and behaviour; relapse and values clarification. Stage 2 addressed skills for personal development and social skills. Stage 3 involved participants continuing to work on their skills and pursuing individual treatment issues. Throughout the program attendance at self-help meetings (AA, NA) was made mandatory as was random urinalysis. An initial plan for after-care was omitted from the program and on completion of the program the women were encouraged to enter works-release or study leave. Passages arranged half-way house accommodation. When interviewed, both uniformed and non-uniformed staff were of the opinion that the Passages program had not only benefited the participants but also the general atmosphere of the prison.

A demonstration program which has recently been developed is the Californian Institute for Women (CIW), administered by the Californian Department of Corrections. The program is designed to run for 4 months and there are places for 120 women at a time. It is conducted for 4 hours per day. The program is designed for those women with drug problems who are nearing the end of their sentence. It includes 4 months after-care in community-based residential programs. In addition, intense supervision is provided by parole staff. Reportedly, an evaluation of the program is planned.

The Californian administration contracted an outside organisation to run the program. The program involves 6 components:

- model of relapse prevention;
- aggression replacement training;
- 12 steps program [Alcoholics Anonymous/Narcotics Anonymous];
- small group activities (such as, parenting skills);
- individual counselling;
- case management (release transition plan).

Reportedly participants are given the option of substituting the 12 step or small group work with individual counselling. Aggression replacement training uses a cognitive-behavioural skills approach. It emphasises alternatives to aggression and arrested moral development.

For the most part, the components of the prison-based drug treatment programs for women (relapse prevention, skills-based

approaches, 12 steps, case management and follow up) match those found in programs designed for men. The main areas of difference seem to be in the underlying philosophical approach of the women's programs (empowerment) and also the content of skills-based activities, such as parenting skills.

▸ On the local front

In 1984 a N.S.W. Government Task Force on Women in Prison was set up to review the management of female inmates and make recommendations on policy. One of the terms of reference was an examination of the current policies and practices relating to the high proportion of women in custody for drug and drug-related offences. Born out of the above was a report, "Drugs and Women in Prison", Miner and Gorta (1986). The authors found that 78% of their sample (n=90) were drug users prior to imprisonment, 66% were heroin users with largely long-term, daily habits prior to imprisonment and 75% of heroin users reported that the expense of a drug habit motivated their crime. Almost one third of the heroin users in the study had not been involved in any community-based drug treatment program in the past and those who commenced treatment tended not to complete it. Further, the inmates strongly criticised the prison drug detoxification procedures at the time.

Based on their findings, Miner and Gorta put forward recommendations in relation to prison-based drug detoxification approaches and drug treatment programs (see Appendix A). In the ensuing 8 years, the following treatment and management initiatives have been introduced. While no separate detoxification facility has been established, the women have access to a bath, for the relief of withdrawal symptoms, while being held and observed in the medical annexe (see Appendix A: 1(2)). As part of a general health assessment the women are asked some drug use questions by nursing staff, however this is not as comprehensive as recommended by Miner and Gorta. Further, should a woman seek treatment through the D&A Service she will receive a comprehensive assessment (however the assessment procedure is not standardised). A methadone maintenance program is now provided at Mulawa Correctional Centre and women are transferred to community-based programs on release.

As yet a therapeutic community has not been established specifically for those with drug-related problems. In addition, no welfare worker has been appointed specifically to assist heroin users on release, however the D&A Service provides pre-release programs. The D&A Service did not exist at the time of the Miner and Gorta study. The D&A Service currently employs 2 full-time workers and 1 part-time worker at Mulawa. The D&A Workers provide counselling and other treatment programs for women with drug-related problems.

Since the Miner and Gorta study a second correctional centre for female inmates of minimum security classification has been established in N.S.W. (Norma Parker Centre). The D&A Service employs 1 full-time worker at Norma Parker.

Noteworthy, is that under the Department's Women's Action Plan (1994) a number of smaller correctional centres will be established for women. It was anticipated that inmates of minimum classification status would be transferred from Mulawa to an alternative centre (Emu Plains) by February, 1995.

▸ **Rationale**

The drug-crime link is well documented. However, the reach of drug treatment in a prison setting has only recently been addressed (Chaiken, 1989; Bureau of Justice Statistics, 1992; Kevin, 1993). A study of inmates about to be discharged to freedom from N.S.W. correctional centres found that less than half of those classified by the study as "regular-heavy users" prior to imprisonment had actually received drug treatment while in custody (Kevin, 1993). This discharge study was for the most part a study of male inmates (significantly less women are imprisoned).

In N.S.W. corrections-based drug treatment programs currently match those offered in the community with the exception of a therapeutic community approach.

There is a need to examine: the prevalence of women with drug problems who receive drug treatment while in custody; any barriers to accessing treatment; and any special treatment needs.

Methodology

Aims

The primary aim of this study was to examine whether those women received into the N.S.W. correctional system with drug-related problems were provided with the opportunity to receive treatment and further to identify the special treatment needs of women in prison with drug-related problems. Specifically stated the study aimed to:

(i) gather data on the prevalence of women in prison with drug-related problems and other personal problems and also their treatment history prior to imprisonment;

(ii) investigate whether women with drug-related problems had accessed the D&A Service while in custody and identify what, if any, were the barriers to accessing treatment;

(iii) examine the prevalence of sanctioned prescription drug use, including methadone by women in prison;

(iv) assess the treatment needs of women with drug-related problems in prison.

The results pertaining to (ii-iv) of the above are presented in this report while (i) is presented in Kevin (1994a).

(1) Inmate phase

▸ *Sampling*

The survey used a stratified random sample design. Those female inmates (excluding remandees, fine defaulters and periodic

detainees) with sentences of one month or more and who had already been imprisoned for at least a month, at both Mulawa and Norma Parker correctional centres, were stratified by security classification (this was based on security classification data for a given day). A random sample was drawn from within the three security classification frames (151 women in total). This design was selected in order to achieve a sample which was representative of the population in terms of security classification. The security classification breakdown for the population of sentenced women on 12 July, 1993 was as follows: maximum (8%); medium (20%); and minimum (72%). The achieved sample security classification breakdown was as follows: maximum (9%); medium (20%); minimum (71%).

Table 1: Number of interviews - sampled and recruited

	Count	%
Interviewed	130	86
Refusals	15	10
Unavailable - no escort, illness, etc.	6	4
Total	151	100

As Table 1 shows 130 women were interviewed. This represents approx. 50% of sentenced women as at 12 July, 1993. Table 1 also shows that 10% of those whom the researchers attempted to recruit, refused to take part in the study. There was a higher proportion of refusals in the medium security centre (18%) when compared to the minimum security centre (5%). A number of women refused to take part in the study prior to personal contact with the researchers (either by informing the officer who was assigned to escort them to the interview area or by informing the officer on duty in their wing). It was unfortunate that the researchers were unable to speak to these women in person. Where possible an attempt was made to contact these women on a subsequent day.

Anecdotal information provided by the staff at Mulawa, during the time the researchers were interviewing, indicated that a number of women had been using the drug, Rivotril (minor tranquilliser/benzodiazepine in tablet form). Reportedly, Rivotril had been brought into the centre illegally. This may possibly explain why the researchers found some of the women unco-operative and agitated during recruitment.

► *Interview Schedule*

The data were collected by personal interviews.

The interview schedule contained 4 identifiable areas of investigation:

(i) demographic characteristics;

(ii) prior to current imprisonment - drug-related background, criminal history, history of physical/sexual abuse, history of psychological problems and information in relation to the custody and care of children;

(iii) current episode of imprisonment - specific to the use and perceived effectiveness of the D&A Service;

(iv) current episode of imprisonment - specific to sanctioned prescription drug use;

(v) current mental health needs - social support network, satisfaction with child care arrangements and also eating disorder behaviour. In addition two standardised scales were included in the schedule. The first was the psychological component of the General Health Questionnaire-28 (Goldberg & Hillier, 1988). The scale is designed to provide a general measure of current psychological adjustment. Goldberg & Williams, 1988 (in Darke et al, 1991) reported that the scale has excellent reliability and validity. The second instrument was the Coopersmith Inventory, Coopersmith (1981) which is a short scale designed to provide a measure of self-esteem.

▸ *Pilot Study*

The interview schedule was piloted on 10 women and this was done at both Mulawa and Norma Parker correctional centres. Based on information obtained from the computerised Offender Record System and the D&A Worker on site women were selected using the following criteria:

(i) sentenced and imprisoned for more than one month;

(ii) to have either used the D&A Service during their sentence or to have been identified as having drug-related offences or a known history of drug-related problems.

Inmates were selected in this way so that they were able to complete most/all of the interview. Therefore most/all of the questions were tested for methodological defects and an approximate maximum time for an interview was indicated. The latter being pertinent in relation to the time-frame specified for interviews and subsequent estimates as to the amount of time needed to complete approximately 130 interviews.

▸ *Procedure*

The survey was conducted within a 4 month period between July and October, 1993. Based on data obtained from the Offender Record System sentenced women were identified from the three stratified security classifications. Women were then randomly sampled (approx. one in every two) within these three classifications. Those women held at Mulawa with minimum security classification were interviewed in the first 2 months. Those with medium and maximum security classification were interviewed during the third month and women held at Norma Parker during the fourth month. This method assisted in the efficient administration of the fieldwork and resulted in less impact on the day to day running of both correctional centres.

Following the selection procedure, women were called up by intercom, 2 at a time, to meet the researchers. The researchers immediately attempted to recruit the women for interview. If a woman consented but was not available at the time an alternative time was arranged within the allocated month. Finally, when the women were called for interview, correctional staff were requested not to discuss the general nature of the interview with the women. The average length of time for interview was 45 minutes.

Both interviewers responsible for the fieldwork held social science degrees and were experienced counsellors. This level of expertise was necessary due to the personal and sensitive nature of the survey questions. Further, the interviewers were independent from the correctional centre environment.

Recruiting and interviewing the women relied heavily on the co-operation of the correctional centre staff. Towards this end, Governors at both centres were contacted personally and in writing to facilitate approval and co-operation. Generally, the correctional staff were most helpful. Not surprisingly, it was found that over time the women interviewed were informing other women of the nature of the survey. Hence, a number of the women sampled did appear to have pre-conceived ideas about the nature of the study.

(2) Key informant phase

Further data on the treatment needs of imprisoned women were gathered by conducting interviews with key informants within the centres, such as the Governor, D&A Worker, Psychologist, Psychiatrist, Doctor, Nursing Unit Manager and senior correctional officers.

A brief schedule which contained predominantly open-ended questions was used. It included the following issues: perceptions on the nature and extent of drug problems in female inmates and best practices in relation to the provision of treatment.

The key informants were interviewed at their convenience during the month the interviewers were in attendance at the correctional centre. The average length of time for each interview was 20 minutes.

Information arising from the key informant consultations was used to supplement the data (in terms of professional insight gained through working with the women) provided by the women in the sample.

Reliability of data

Some of the self-reported information was cross-referenced with departmental records for verification. The following self-report data was checked: age; sentence length; most serious offence type; use of the Corrections Health Service; and medically sanctioned medication use.

These comparisons assume the accuracy of departmental records. Some obstacles were experienced when attempting to verify the self-report data through referencing medical records. These obstacles have been documented in the results section of this report.

Results

1. Perceived drug dependence and experience of withdrawal on reception

▸ *Dependence*

Of the total sample 55% (n=71) perceived that they were dependent on a drug when received into the correctional system for their current sentence. According to Table 2 methadone was the most commonly cited drug of dependence. After methadone, heroin was the second most commonly cited drug of dependence. This question allowed for the 71 women who perceived themselves to have drug dependencies to cite more than one drug of dependence. Therefore, the percentages in Table 2 do not total to 100. Of those who were drug dependent 25% reported that they were dependent on more than 1 drug. For those with poly-drug dependencies (and who identified heroin as their first drug of dependence (n=6)) cocaine was the most commonly cited 2nd drug of dependence (n=3).

Table 2: Drugs of dependence at reception
(mult responses, base=those with drug dependencies)

	No. (n=71)	%.
Methadone	31	44
Heroin	24	34
Cocaine	12	17
Pills	12	17
Alcohol	6	9
Amphetamines	3	4
Cannabis	3	4
Cigarettes	3	4

▸ *Withdrawal*

The women were asked if they had been withdrawing from drugs when first received into the correctional system for their current sentence. Of the total sample, 40% (n=52) reported to be withdrawing from drugs at the time. The women were given the opportunity to cite more than one type of drug from which they had been withdrawing. As Table 3 shows withdrawal from heroin 44% was most commonly reported. After heroin, women were most likely to be withdrawing from methadone (27%) or pills (25%). Of those who had been withdrawing, 25% (n=13) reported to be withdrawing from more than one type of drug. For those who experienced poly-drug withdrawal (and who also identified heroin as their first drug of withdrawal (n=7)) methadone was most commonly cited 2nd drug of withdrawal (n=3). After methadone, cocaine (n=2) and pills (n=2) were the most commonly cited drugs of withdrawal for those withdrawing form heroin.

Table 3: Drugs of withdrawal at reception
(multiple responses, base=those in withdrawal)

	No. (n=52)	%.
Heroin	23	44
Methadone	14	27
Pills	13	25
Cocaine	8	15
Alcohol	4	8
Amphetamines	1	2
Cannabis	1	2
Cigarettes	1	2
Other	1	2

Half of those who were withdrawing (n=26) reported that they had received treatment for their withdrawal syndrome. The most common form of treatment received was medication under supervision (n=10) and several women (n=6) reportedly received a Valium withdrawal regime. A few women (n=3) recalled being admitted to the Corrections Health Service annexe on an in-patient basis.

2. Exposure to the D&A Service

▸ *Reception*

Only ⅓ of the sample reported that they attended a reception meeting[4] when received for their current sentence. Of these a few recalled that a D&A Worker was present at their reception meeting. It should be noted that this question relied on the women's ability to recall the circumstances of their first 74 hours in correctional custody. As many inmates are in a state of distress when received into the system the reliability of this information could be called into question. Some women reported that they were given written guidelines on the procedures and practices of the centre when first received.

The women were asked if they had received a general assessment for health-related problems when received into prison:

- 71% stated that they were given a general health assessment on reception;
- 64% stated that they were assessed in relation to their use of drugs on reception;
- Of those who were assessed on their use of drugs 98% reported that they were assessed by a nurse. Only 1 woman reported that she was assessed by a nurse and a D&A Worker.

Most of the women (95%) were aware of the existence of the D&A Service. Of the remaining 5%, 3% were unsure and 2% thought there was no service.

3. Use of the Methadone Program

Of the total sample 34% stated that they had been enrolled in the Corrections Methadone Program at some stage during their current sentence. The period of time enrolled in the methadone program ranged between 1 and 36 months. The median length of time on the program was 6 months. Of these women ¾ were reportedly still on methadone at the time of interview. All the women could recall their dosage level. Dosage levels reported by the women still on the program ranged between 4-150 mills. It was beyond the scope of this study to verify the reported dosage levels. However, it would appear that some women were reporting their dose in milligrams as opposed to mills which would account for dosage levels in excess of 40 mills. Of those on methadone during their current sentence (n=44) the majority (95%) had been on a community-based methadone program at some time prior to imprisonment.

▸ *Community-based methadone treatment*

In terms of enrolment in a community-based methadone program prior to imprisonment (n=47), time spent on methadone in the community ranged between 1 and 96 months (8 years). The median length of time spent on a community-based methadone program was 10 months.

4. Use and expectations of the D&A Service

As Table 4 shows, the majority of women who were either serving time or had served time in Mulawa and Norma Parker centres made some use of the D&A Service. This

presentation allowed for transfers to other centres and also previous imprisonment Therefore, if a woman used the D&A Service at more than 1 centre during her current sentence and also used the service in a previous sentence she would be counted more than once in the presentation.

Table 4: Use of the D&A Service
(base= total sample excl. those who had not used drugs/alcohol beyond experimentation, n= 104)

	Mulawa (n=101)		Norma Parker (n=31)		Grafton (n=8)	
Centre	No	%	No.	%	No.	%
Yes- D&A Service: **current** sentence	50	50	19	61	2	25
Yes- D&A Service: **previous** sentence	18	18	5	16	1	13
Total number who used D&A Service	68	68	24	77	3	38

When interviewed, 45% of the women had used the D&A Service on **at least one occasion during their current sentence.** Following is a breakdown on the percentage of women who had used the D&A Service during their current sentence, within each of the drug-related measures used by the study:

- 57% of those who stated that they were withdrawing from drugs at reception;
- 78% of those who stated that they were drug dependent on reception;
- 55% of those classified as 'regular-heavy users' of drugs (users[5]) in the 6 months prior to imprisonment;
- 62% of those who stated they had drug problems in the 6 months prior to imprisonment;
- 57% of those who perceived that there was a relationship between their crime and their use of drugs;
- 65% of those who were under the influence of drugs only (excluding alcohol); 50% of those under the influence of alcohol only; and 53% of those under the influence of both drugs and alcohol at the time of their offence; and
- 52% of those who stated that heroin was their primary problem drug.

Therefore, it appears that at least half the women, who were identified as having drug-related problems by one of the drug measures used in the study had received treatment from the D&A Service at the time of interview. It should be noted that this sample was not a discharge sample, therefore some of the women who had not utilised the D&A Service at the time of the study would have had the opportunity to utilise the D&A Service while serving the remainder of their sentence.

Noteworthy is that 60% (n=26) of those women who had been enrolled in the Prison Methadone Program had also used the D&A Service during their current sentence.

Finally, 70% of users had received some form of intervention from either the D&A Service or the Prison Methadone Program during their current sentence.

▸ *Characteristics of those who used the D&A Service*

Predictive factors which were found to be significantly related to whether users of drugs received treatment from the D&A Service or not were as follows:

- needle use prior to imprisonment;
- court referral;
- self-perceived drug dependency on reception;
- pre-sentence referral to a drug treatment program as an alternative option to imprisonment;
- withdrawal syndrome on reception.

Those who reported to have used needles in the past were significantly more likely to have used the D&A Service than those who had not (χ^2_1=13.63, p<.0005). Those who were reportedly withdrawing on reception were significantly more likely to use the service than those who were not (χ^2_1=4.4, p<.05). Similarly, those who perceived that they were drug dependent were significantly more likely to use the service than those who did not (χ^2_1=8.9, p<.005). Not surprisingly, those who were advised by the magistrate or judge, who presided over their case, to seek counselling in prison were significantly more likely to use the service than those who were not (χ^2_1=8.99, p<.005). Finally, those whose solicitor or Probation & Parole Officer put before the court a recommendation for enrolment in a community-based drug treatment program as an alternative sentencing option were significantly more likely to use the service (χ^2_1=7.95, p<.005). Use of the service did not appear to be associated with sentence length, however the women would have been at various stages of their sentence.

Not surprisingly, there were interaction effects between the predictors mentioned above.

▸ *Source of referral*

As with the previous study on mainly male offenders (Kevin, 1993) those women who used the service were mostly self-selecting (78%). Table 5 shows that the remaining referrals (9%) were mostly from management (Inmate Classification and Placement Committee, Young Adult Program and officers). Similar to the previous study's findings, no inmate reported being referred by other professional services, such as psychology or education and only one inmate reported being referred by the Corrections Health Service. It is the policy of the Corrections Health Service to conduct a drug & alcohol assessment on all inmates when received into the correctional system. Therefore this would be an opportune time to refer women with drug problems to the D&A Service. Only 2 women stated that it was made mandatory for them to enrol in treatment with the D&A Service.

Table 5: Source of referral to the D&A Service
(base=those who used the service)

	No.	%.
Self	45	78
Other inmate	3	5
Inmate classification meeting	3	5
D&A Services	2	3
Parole Officer	2	3
Young Adult Program	1	2
Correctional Officer	1	2
Corrections Health Service	1	2
TOTAL	**58**	**100**

▸ *Expectations and satisfaction*

The women were asked what they expected to gain from using the D&A Service. This was an open-ended question, therefore the categories presented in Table 6 are based on the

women's responses. About ¾ of responses were directly related to drug use and about ⅓ of these concerned assistance in either reduction or abstinence from drug use. Of the responses, 10% directly related to methadone treatment. Other intentions, such as; having someone to talk to, satisfying curiosity, or overcoming boredom made up 21% of responses. Further, 5% were based on obtaining favourable reports for either court, parole or re-classification conditions.

The women were asked whether their expectations were satisfied once they used the service. Of this group 64% stated that their expectations were satisfied, 21% stated that they were not and 16% were unsure.

Table 6: What women hoped to gain from the D&A Service

(mult. responses, base=those who used D&A Service)

	No. (n=58)	%
Advice/guidance/insight re. problem	21	36
Support re. reduction/abstinence	12	21
Information about effects of drugs	9	16
Someone for talking & listening	8	14
Methadone treatment	6	10
Unsure	5	9
Satisfy curiosity/boredom	4	7
Parole/court report/reclassification	3	5
Other	3	5

- *Type of treatment received and level of help derived*

The number of women who received the various treatment options provided by the D&A Service and the perceived level of help derived from each of these treatments is presented in Table 7. It can be seen that markedly more women received one-to-one counselling than any other form of treatment. As with the previous exit study on mostly male inmates, a binomial statistical test found that significantly more women received one-to-one counselling than any other form of treatment.

After counselling, the second most common form of treatment received by the women was Narcotics Anonymous and the next most common was group-based programs. Only a small number of women had received some of the treatments (e.g., Alcoholics Anonymous, n=5). Therefore, the following findings on perceptions of the level of help derived from treatment should be interpreted with caution and only seen as indications of difference. Half of those who had counselling reported it to be very helpful.

Across all forms of treatment the majority of women found the treatment they received to be helpful (either very helpful or quite helpful). A higher proportion of women perceived group programs to be helpful (very helpful or quite helpful) when compared to the other forms of treatment.

Those women who had received more than 1 form of treatment (n=27) were asked to identify: (i) which form of treatment they had found to be most useful; and also (ii) which treatment they felt would be most useful towards the end of their sentence. The findings arising from the 2 questions did not vary markedly. For both questions preferences were fairly evenly spread across treatment types. However, one-to-one counselling appeared to be the most commonly preferred treatment with about a third of this sub-group selecting it as most useful.

Table 7: Type of treatment received from the D&A Service by the perceived level of help derived
(multiple responses, base=those who used D&A Service).

	Total		Very Helpful		Quite Helpful		Neither		Not very helpful		Not helpful at all	
	No. (n=58)	%	No.	%	No.	%	No.	%	No.	%	No.	%
One-to-one counselling	47	81	24	51	13	28	2	4	3	6	5	11
Group-based programs*	15	26	6	43	7	50	-	-	-	-	1	7
Alcoholics Anonymous	5	9	3	60	1	20	1	20	-	-	-	-
Narcotics Anonymous	23	40	5	22	10	43	3	13	2	9	3	13
Inmate support group	1	2	-	-	1	100			-	-	-	-

* 1 inmate was unsure about level of satisfaction derived from treatment.

▸ *Duration of counselling*

Of those who had one-to-one counselling (n=47), 57% had received counselling over a period of between 1 and 6 months at the time of interview. In addition, 23% had received counselling for more than 6 months and 19% for a period of less than a month.

▸ *Frequency of counselling*

As Table 8 shows the majority (66%) of those who had counselling had sessions at least every 3 weeks and 32% had sessions on an 'at least weekly' basis. Those women who had received only 1 counselling session made up 15% (n=7) of this group.

Table 8: How often women received one-to-one counselling
(base=those who received counselling)

	No.	%
Once	7	15
Half yearly	1	2
Every 2/3 months	3	6
Monthly	5	11
Every 2/3 weeks	16	34
Weekly	10	21
More than weekly	5	11
TOTAL	47	100

▸ *Satisfaction with frequency of counselling*

Just over half of those who received one-to-one counselling (57%) were of the opinion that the number of counselling sessions which they had received was sufficient with 34% stating that they would have liked more. Of the remaining 9%; 4.5 % were of the opinion that they had too many sessions and 4.5 % were unsure.

▸ *Ways in which the service had helped*

Using an open-ended format the women were asked to generally describe the ways in which the service was useful to them. Based on the women's responses the most likely forms of help cited were: talking about problems/ building trust/support (30%); increased self-awareness/understanding (28%); ways/skills to control use/abstinence from drugs (15%); no help (15%); and community-based treatment referrals (8%).

In addition, the women were presented with a number of key areas (forced choice format) and were asked to indicate whether they received help in these areas. These findings are shown in Table 9. The majority perceived that they received help in terms of having someone in whom to confide (72%) and improving self-esteem (52%). Half the women perceived that they were helped in terms of breaking through denial about their drug problem and also in changing their lifestyle. Further, 47% were helped in terms of plans for their release. As with the previous study on mainly male inmates, findings indicated that the service was contributing to the safe and secure management of the institution. Over a ⅓ of the women (38%) stated that they were helped in terms of managing their anger and 47% were helped in relation to overcoming depression. In addition, 29% were helped concerning their relationships with other inmates and 14% were helped in their relationships with officers.

Table 9: Women's perception of help received from the D&A Service in relation to key areas
(mult.response, base= those who used the D&A Service)

	Yes	%. (n=58)	No	%.
Someone with whom to talk	42	72	16	28
Self-esteem	30	52	28	48
Breaking through denial	29	50	29	50
Changing lifestyle	29	50	29	50
Family/friends	28	48	30	52
Depression	27	47	31	53
Plans for release from prison	27	47	31	53
Relapse prevention	26	45	32	55
Anger management	22	38	36	62
Health	19	33	39	67
Ways to reduce harm caused by drugs	19	33	39	67
Relationships with other inmates	17	29	41	71
Help with court matters	16	28	42	72
Security rating re-classification	13	22	45	78
Parole	9	16	49	84
Relationships with officers	8	14	50	86

5. Problems experienced and suggestions for improving the D&A Service.

▸ *Barriers to accessing the service*

When those who had used the D&A Service were asked if they had experienced any problems in trying to access the service 41% (n=24) reported that they had experienced problems. The most common type of problem encountered was that the D&A Worker was too busy to see them (n=19). In addition, 4 women reported that correctional officers were unco-operative when they were trying to gain access to the D&A Worker (such as opening gates so they can reach the D&A Worker).

▸ *Dislikes*

Of those who used the service, 29% (n=17) identified aspects of it which they disliked. In terms of identifying key areas of dislike responses were fairly evenly spread. Following are some of the categories of dislike derived from the women's responses:

- not enough workers/worker unavailable (n=6);
- lacked faith in confidentiality of service (n=3);
- D&A worker inconsistent with follow-up (n=3);
- other inmates participating in groups whose intentions were not sincere in relation to changing their behaviour/or those who have another agenda (e.g., parole) (n=2);
- D&A Worker lacked knowledge (n=2).

▸ *Suggestions*

When asked to identify the types of things which would improve the service only 21% (n=12) of the women put forward suggestions. The responses did not lend themselves to categorisation as the number was nominal.

More group work was the most commonly suggested improvement (n=5). In addition to this, the following suggestions were made by a single individual:

- improvement in officer attitudes (n=1);
- more regular Narcotics Anonymous meetings (n=1);
- increased interest and care in relation to the women's needs (n=1);
- a pre-release program(n=1).

6. Those who did not use the D&A Service

Table 10 shows the reasons provided by potential clients[6] as to why they had not made use of the service. The most commonly cited reason provided was that they did not have a problem (24%). In addition, 17% (n=8) stated that they were able to control their drug use independently.

Of potential clients (excluding the 11 who stated that they did not have a problem) 17% (n=6) stated that they had made attempts to use the service. Of this group 4 reported that their names had been placed on a waiting list to use the service.

As Table 11 shows, potential clients who did not receive treatment were most likely to state that it was not at all important for them to receive treatment (46%). However, 23% of potential clients perceived that it was very important for them to receive treatment and most of this group stated it was important because they either needed professional support or were unable to control their drug use without support (n=7).

Table 10: Reasons provided by potential clients as to why they did not use the D&A Service
(multiple responses, base =those who were classified by the drug-related measures used in the study as potential clients)

	No. (n=46)	%
No drug or alcohol problem	11	24
Able to control use independently	8	17
Waiting period/list is too long	4	9
Don't care/not worried	4	9
No faith in service/waste of time	3	7
No trust in service	3	7
Abstinent in prison	2	4
On methadone program	2	4
In protection wing so access is more difficult	2	4
Other	2	4
Tried treatment before	1	2
Short sentence	1	2
Unsure of how to access service	1	2
Early stage of sentence	1	2
Unaware of service	1	2

Table 11: The perceived importance of receiving drug treatment by potential clients who did not undertake treatment with the D&A Service
(Base=potential clients excluding those who stated that they did not have a drug problem), n=35)

	Very important		**Quite important**		**Neither**		**Not very important**		**Not important at all**		**Total**	
Potential clients	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
	8	23	2	6	3	9	5	15	16	47	34*	100

** 1 missing case*

7. Women's suggestions on optimal treatment programs

Those who actually used the D&A Service during their current sentence (n=58) and those classified as potential clients were asked to provide suggestions relating to:

(i) different programs for women and men;

(ii) the importance of being offered a choice and the sorts of things a program should include;

(iii) the best people and the best time to run programs;

(iv) content of pre-release programs.

On the issue of whether programs for women and men should differ women were most likely to state that they should not differ (48%). However, responses to this issue were fairly spread with 37% stating that they should differ and 15% stating that they were unsure.

Out of those women who used the service and potential clients of the service 63% (n=59) put forward ideas on the sorts of things a treatment program should include. This question allowed for more than 1 response. The most commonly put forward suggestion was women's issues and relationships (24%). As this question followed that on whether programs for men and women should differ there was possibly a recency effect occurring in the women's responses. Some of the other ideas for program content follow:

- regular counselling (19%);
- self-esteem work (10%);
- parenting skills (9%);
- health/HIV education (9%);
- groupwork/support groups (9%);
- physical/sexual abuse issues (3%).

The majority of women (77%) were of the opinion that it was very important to have a choice of programs with another 11% perceiving it to be quite important. D&A Workers (54%) were considered to be the most suitable people to run treatment programs. The second most suitable category of people were 'ex-users from outside the prison system' (50%). Other groups selected were: 'ex-users from inside prison' (34%); psychologists (23%); Narcotics/Alcoholics Anonymous (20%); and officers (2%). This question allowed women to nominate more than 1 category of treatment provider. The majority of women were of the opinion that treatment programs should be run throughout the entire sentence (65%). A smaller group (11%) stated that reception was the most suitable time and some (9%) stated that it should depend on sentence length.

With regards to pre-release programs, 84% of the women put forward suggestions on program content. These included the following:

- living skills - budget, stress, nutrition, parenting (37%);
- housing (36%);
- support networks and referrals (35%);
- de-institutionalising (24%);
- relapse prevention (17%); and
- interpersonal relationships (10%).

As reported in Kevin (1994a) 48% (n=62) of the sample had been either physically or sexually assaulted in the past. Of these women 76% (n=47) were of the opinion that physical/sexual abuse issues should be included in drug treatment programming.

Table 12: A selection of the women's ideas on optimal treatment

Improvements to the D&A Service

"More staff, more groups..currently a limit of 12 in a group."

"Long termers get onto the programs...there should be more programs for short termers."

"More qualified counsellors.. more groups addressing particular problems."

Types of D&A Programs

"To be reassured that the support is going to be continued, that it won't drop off all of a sudden."

"NA (Narcotics Anonymous) on a more regular basis."

"About getting started ... I've got nothing to loose. If I had things to loose I might consider stopping."

"We (women and men) turn to drugs for similar things, but some things are more important for women - family life, sexual assault and it is hard for women to talk about these things."

Pre-release issues

"Would like a program to address the fear-of-leaving-gaol ....to be able to talk to someone to reassure you."

"Dealing with not busting, not mixing with the same crowd, housing and employment".

"Help with housing ...whether you need a half-way house or rehab (rehabilitation unit)."

"We need a pre-release officer who is independent and stable...no use sending them out without support."

"How to communicate properly...."

"Learning to live with the stigma..our self-image is not high ...how to deal with friends and family."

"Having time in the community before being released...."

"Being able to cope with life where you are not institutionalised .. you can't trust the women in here ...it makes you very cynical, very hard and negative."

"Booklet on where to go for help...where to live, where to meet people. Right now the 'screws' (correctional officers) can't get it together to give the 'split- kits'[7] to the girls".

"How to deal with society .. a lot of girls here are institutionalised."

"How to cope with children.. problems with spouse....."

"Handling money and staying in the one place..............."

8. Comparison with previous male sample on use and experience of D&A Service

The former sample on mainly male inmates (Kevin, 1992; Kevin, 1993) was a flow sample in that it captured the flow of inmates leaving the correctional system. The women's sample was similar to a 'stock' sample (comparable to the census, being biased towards long term inmates). A flow sample is considered more illuminating with regard to identifying the target population for drug treatment as it provides a better picture of movement through the system. Therefore, the data obtained from the female sample was manipulated (inversely weighted by the minimum sentence length for each individual) to simulate a discharge flow sample and therefore be comparable to the male data. A flow sample design was not used in the women's study because the time required to recruit an adequate sample size would have been too great.

The following comparisons are based on the actual data from the male sample (the 11 females in the study were excluded in this analysis) and the weighted data from the current female sample:

► *On reception to correctional system*

- Perceived drug dependency - 65% of women versus 19% of men.
- Experience of withdrawal syndrome on reception - 51% of women versus 20% of men.

► *Those who used D&A Service*

- Use of D&A Service - 42% of women versus 32% of men.
- Use of D&A Service by those classified as 'users' of drugs - 49% of women versus 42% of men.
- Use of D&A Service by those who perceived there to be a relationship between their use of drugs and their imprisonment - 52% of women versus 46% of men.
- Use of the D&A Service by those who were intoxicated at the time of their offence - 50% of women versus 43% of men.
- Received methadone treatment during current sentence - 43% of women versus 8% of men.
- Use of D&A Service by those receiving methadone treatment - 51% of women versus 46% of men.
- Use of the D&A Service by those who were advised to have prison-based D&A counselling by the Court - 100% of women versus 73% of men.

► *Aspects of treatment*

- Received 1 to 1 counselling - 82% of women who used D&A Service versus 85% of men.
- Received group-based programs - 40% of women who used D&A Service versus 51% of men.
- Attended Alcoholics Anonymous meetings - 4% of women who used D&A Service versus 36% of men.
- Attended Narcotics Anonymous meetings - 38% of women who used D&A Service versus 23% of men.
- Participated in inmate support group - 1% of women who used D&A Service versus 13% of men.
- Frequency of counselling sessions - of those women who received counselling from the D&A Service 58% reportedly had sessions on a 'greater than monthly basis' versus 44% of men.

► *Those potential clients who did not receive treatment*

- The primary reason provided by potential clients as to why they did not use the D&A Service was that

they did not have a problem - 13% of women versus 44% of men.

- Those potential clients who made unsuccessful attempts to use the D&A Service - 28% of potential female clients versus 8% of potential male clients.
- The perceived level of importance by potential clients to receive treatment from the D&A Service - 56% of women perceived it to be not important, while 30% perceived it to be important. 78% of men perceived it to be not important, while 4% perceived it to be important.

The previous study (Kevin, 1993) found that the main barriers to access for potential male clients were self-imposed barriers. It appears the same pattern applies for the women, however this pattern is not as marked as it was for the men. When compared to the men, a lower proportion of women stated that they did not have a problem and a higher proportion reported that they had made unsuccessful attempts to use the service. In addition, when compared to men, a higher proportion of women perceived it to be very important for them to receive prison-based drug treatment.

9. Use of the Corrections Health Service

The women were asked a series of questions on their use of the Corrections Health Service (CHS). All the women surveyed had reportedly used the CHS (saw doctor or nurse) during their current sentence. Table 13 shows how frequently the women used the CHS. Over half the women (60%) reportedly used the CHS on a monthly to fortnightly basis and 27% used the service either weekly or more.

Almost all the women (97%) reported receiving medication from the CHS during their current sentence. Table 14 shows how frequently the women reportedly received medication during their current sentence. Almost a third of the women (31%) reportedly received medication on a daily basis and just under half the women (47%) were receiving medication on an 'at least weekly' basis.

Table 13. Frequency of use of the CHS
(Base=total sample)

	No.	%.
Daily	1	1
2 to 3 times per week	21	16
Weekly	13	10
2 to 3 times per month	47	36
Monthly	31	24
Less than monthly	17	13
Total	130	100

Table 14. Frequency of sanctioned medication use
(Base=those who used medication)

	No.	%.
Daily	39	31
2 to 3 times per week	15	12
Weekly	5	4
2 to 3 times per month	22	17
Monthly	21	16
Less than monthly	24	19
Total	126	99

Table 15. Day last received medication
(Base=those who used medication , 1 missing case)*

	No.	%.
Today	19	15
Yesterday	25	20
Few days ago	21	17
A week ago	8	6
More than a week and up to a month ago	16	13
More than a month previous	36	29
Total	125*	100

Table 16. Type of medication on last occasion
(Multiple responses, base= medication users).

	No. (n=126)	%.
Other*	68	54
Analgesic	62	49
Hormonal	41	33
Antidepressant	37	29
Anticonvulsant	30	24
Antibiotic	26	21
Antihistamine	22	18
Antipsychotic	18	14
Antimigraine	9	7

* includes medications which did not fall into the above categories, such as non-steroidal anti-inflammatory agents, bronchospasm relaxants, antiemetics and anti-hypertensives. (Re. benzodiazepines - 1 women had received Valium and 2 had received Temazepam)

Table 15 shows the last occasion on which the women reportedly received medication. Of the total sample, 15% had received medication on the day of interview and 19% had received medication the day before being interviewed. Just over half of the women (56%) had received medication within the previous week. Table 16 shows the types of medication reportedly received by the women on the last occasion. This presentation allowed for more than 1 type of medication per individual. Of the total sample, 47% (n=61) of the women had received more than one type of medication on the last occasion. Table 17 shows the type of symptoms the women were reportedly experiencing when prescribed the medication received on the last occasion.

Table 17. Type of symptoms experienced on last occasion
(Multiple responses, base= medication users).

	No. (n=125*)	%.
Pain(general)	49	39
Other*1	45	36
Infection	20	16
Migraine	19	15
Depression	13	10
Asthma	11	9
Psychosis	10	8
Insomnia	10	8
Stress	6	5

* 1 missing case
*1 Unable to be categorised as a general category

- *Factors associated with frequency of use of the CHS and frequency of sanctioned medication use.*

To determine whether any demographic or other factors were associated with the

frequency at which the women used either: (i) the CHS (saw doctor or nurse) or (ii) sanctioned medication, tests of association were conducted. Significantly more Aboriginal women used the CHS on an 'at least weekly basis' when compared to non-Aboriginal women (χ^2_1=6.7, p<.01). However, caution should be exercised when interpreting the findings in relation to Aboriginal women as the total number of Aboriginal women in the sample, while being representative, was small. Women receiving methadone treatment were more likely to use the CHS on an 'at least monthly basis' than those who were not receiving methadone (χ^2_1=7.7, p<.01). This is not surprising as the CHS administers the methadone program. Those under 35 years of age were significantly more likely to use the CHS on an 'at least monthly basis' than those 35 years and over (χ^2_1 =5.3, p<.05). Surprisingly, those with sentences under 6 months were more likely to use the CHS on a frequent basis (more than monthly) when compared to those with sentences greater than 6 months (χ^2_2=9.03, p<.05). Those women in maximum security accommodation showed a higher frequency of use of the CHS compared to those in medium and minimum security accommodation, however this finding was not statistically significant. Other background factors, such as ethnicity, marital status, educational level, prior imprisonment, drug-related problems, history of emotional disorder and responsibility for dependent children were not found to be associated with use of the CHS. The study collected no information on pre-existing medical disorders or frequency of use of community-based medical facilities. This data would have been useful for comparative purposes, however data collection of this kind was beyond the scope of the study.

With regards to frequency of sanctioned medication use the following was found. Those women who had been hospitalised at some stage in the past for an emotional problem were significantly more likely to have received medication frequently (more than once per week) than those who had not been hospitalised (χ^2_2=7.4, p<.05). Of the women aged over 34 years, 50% received medication weekly or more often and this was higher, but not significantly higher than for those who were aged 34 years and under (39%). Women in maximum security accommodation (59%) received medication more frequently (weekly or more often) than those in lower security (medium & minimum) accommodation (41%). However, this finding was not statistically significant. No other factors were found to be associated with frequency of sanctioned medication use.

Interestingly those classified as users of drugs and those who stated that they were dependent on drugs on reception to the system did not receive sanctioned medication more frequently than those who were not classified as users or drug dependent.

10. Assaults, deliberate self-harm and prison offences

Using official records it was found that of the 130 women surveyed, 6% (n=8) had been charged with assault as a prison offence during the 4 month period over which the survey was conducted. These comprised 6 assaults against other inmates and 2 assaults against officers. Of these 8 women, 7 were classified by the study as users of drugs. Further, 4 of the 8 had reported experiencing drug-related problems prior to imprisonment.

With regard to deliberate self-harm 3% (n=4) of the women surveyed had attempted to physically harm themselves in some way (e.g., self-mutilation, attempted suicide) in the 4

month period. All 4 of these women were classified as users of drugs and only 1 of the 4 had used the D&A Service. When findings on the prevalence of self-harm in the total population of women for the same 4 month period were examined 9% of women reportedly self-harmed. Differences between the sample and the population on the prevalence of self-harm may be explained by the following:

(i) sampling frame of study - those on remand, those with sentences under 1 month and those who had been imprisoned for under 1 month were excluded from the study; and

(ii) those who refused to take part in the study and those who were unable to be reached by the study, e.g., those on protection classification.

The above differences in the composition of the sample and the population would explain why the prevalence of deliberate self-harm was under-represented in the sample.

In relation to prison offences 32%, (n=41) of the women surveyed had been charged with a prison offence during the 4 month period and just under half these women had received more than 1 misconduct charge. Those classified as users of drugs were more likely to be charged with a prison offence than those who were not (χ^2_2=9.03, p<.05). Of those with self-perceived drug problems who stated that pills were their primary problem drug (n=11) the majority were charged with a prison offence (n=9) during the 3 month period. This pattern was not evident for any other primary problem drug group.

There did not appear to be an association between other factors examined (such as prior hospitalisation for emotional disorders, prior experience of physical/sexual abuse, psychological adjustment as measured by the GHQ-28, etc.) and destructive behaviour patterns in prison by the women during the time of the survey. However, a larger sample of women who commit acts of assault and deliberate self-harm while imprisoned would have to be examined and the causes addressed before any firm conclusions could be drawn.

Tables 19 to 21b (Appendix B) provide a general picture of incidence of assault, deliberate self-harm and misconduct behaviour patterns over the period of the survey (July-October 1993). It should be noted that these are records of incidence, therefore an individual may have been recorded more than once. In examining Tables 19 & 20 it can be seen that the rate of assaults at Mulawa Correctional Centre was the second highest in the state for the period and the rate of deliberate self-harm at Mulawa was the highest in the state for the same period. With regards to misconduct charges (Tables 21a & 21b), the rates for Mulawa were also high compared to other centres. There were no incidents of self-harm or assaults reported by Norma Parker correctional centre for the period. Incidences of misconduct were reported by Norma Parker, however the rates were not extreme.

It should be noted that differences between correctional centres on rates of assault and deliberate self-harm are in part determined by the reporting practices of a correctional centre. Some centres which show low rates may be under-reporting the incidence of these behaviours, whereas a centre, such as Mulawa, may be highly rigorous in its reporting practices. Additionally, across centres there may be differences in definition as to what level of behaviour constitutes an assault or an act of deliberate self-harm.

Notwithstanding the above, the rates of assaults and deliberate self-harm reportedly occurring at Mulawa warrant continual monitoring and attention to the causes.

11. General emotional well-being of the women at the time of interview

The General Health Questionnaire-28 (GHQ-28) developed by Goldberg and Hillier (1988) was used to obtain a general indication of the level of psychological adjustment of the women at the time of the survey. The GHQ consists of 28 items and scores can range from 0-28. It also provides 4 subscales of 7 items each: (a) somatic symptoms; (b) anxiety; (c) social dysfunction; (d) severe depression. Goldberg and Hillier presented the findings on 16 studies which used the GHQ-28 and the most commonly used cut-off score to indicate psychopathology (or a positive case) was 4/5. The mean overall score obtained from the women in the survey was 8.9 with a standard deviation of 0.6. The scores ranged from 0 to 27. This mean score was close to that reported by Darke et al (1991) from their study on intravenous drug users (mean=8.6). The majority of the people in the Darke et al study were enrolled in community-based treatment programs (mainly methadone maintenance). As the present study was conducted on an institutionalised population the cut-off score used to indicate some degree of psychopathology at the time of interview was 6/7. Using this criteria 55% of the sample were classified as having poor psychological adjustment (positive cases). When compared to the other subscales, the women's scores loaded most highly on the anxiety subscale. With regard to sleeping disturbance 52% reported that they had lost sleep over worry (more so than usual), within the previous few weeks. In addition, 46% reported that they had difficulty staying asleep (more so than usual), in the previous few weeks.

Not surprisingly, those who had been hospitalised for an emotional problem in the past showed a higher percentage classified as positive cases by the GHQ-28 than those who had not been hospitalised (67% & 51% respectively).

Those who had been sentenced to prison before were also significantly more likely to be classified as positive cases on the GHQ-28 than those who had not been sentenced to prison before (χ^2_1=3.8, p<.05).

Users of drugs were significantly more likely to be classified as positive cases on the GHQ-28 than 'non-users' (χ^2_1=3.8, p<.05). Similarly, those who stated that they experienced drug-related problems in the 6 months prior to imprisonment (n=60) were significantly more likely to be classified as positive cases on the GHQ-28 than those who did not (χ^2_1=10.7, p<.005). This possibly indicates a relationship between psychopathology and problem drug use.

Much has been written about the low self-esteem of imprisoned women (American Correctional Association, 1990; Carp & Schade 1993; Criswell, 1989; Miller-Ashton, 1993; Wellisch, Anglin & Prendergast, 1993). The present study used a standardised scale (Coopersmith Inventory) to measure self-esteem in the women surveyed. The scale was designed to provide a score out of 100. Normative data based on American college student samples indicated a mean score of approx. 71 for women. Obviously local population norms would be most appropriate for comparative purposes, however none were identified. The mean score obtained by the women in the sample was 56 with a standard deviation of 23.3. Scores ranged from 12 to 99. Of the total sample, 27% scored above

75. Copeland & Hall (1992) using the same scale, found that participants enrolled in a specialist women's drug treatment program in the community showed a mean self-esteem score of 27.

A series of Kruskal-Wallis tests were used to investigate whether there were differences in the level of self-esteem between different groups of women in the current sample.

There was not a marked difference between users of drugs and non-users on level of self-esteem. However, those who stated that they were drug dependent (n=71) were significantly more likely to show lower self-esteem than those who stated they were not (χ^2=4.3, p<.05).

Those who had been hospitalised for an emotional disorder in the past were significantly more likely to show lower self-esteem than those who had not been hospitalised (χ^2 =6.1, p<.02).

12. Service delivery - other

As reported in Kevin (1994a) 66% (n=86) of the sample either had children and/or were pregnant. Those women with dependent children (n=72) nominated the following groups as being the guardians of their children while they were in prison. The most frequently cited current guardians were grandparents (36%). After grandparents, the natural father (28%) was the second most frequently cited guardian. Of those remaining, 24% reported that their children were with other family members, 4% reported that their children were with foster parents, 3% reported that children were with friends, 3% reported that their children were in an institution and 1% reported that their children were with their current de-facto husband.

The majority of these women (85%) stated that they were satisfied with the current care arrangements for their children.

Those women who either had children of pre-school age or were pregnant (n=30) were asked if they would like to have their children with them while in custody. The majority (70%) stated that they would. The most common explanation given for this was for mother-child bonding or because they missed their children.

13. Interviews with key informants

In order to supplement the information provided by the women a number of individuals (n=20) either working in a professional or managerial capacity with the women were interviewed in relation to treatment issues.

- *Perceptions on the prevalence of women with drug-related and other issues*

The key informants were asked to provide estimates on the prevalence of drug-related and other problems in imprisoned women in N.S.W. as a means of identifying their treatment needs. Estimates on the prevalence of imprisoned women with drug problems ranged between 40%-90% with a mean of 78%. All except 1 key informant put forward an estimate.

Perceptions put forward by key informants on the primary problem drug for women when first received into the N.S.W. correctional system were quite varied. The drugs identified as being the primary drug problem for women were: heroin (n=5); pills (n=5); pills and heroin

(n=3); poly-drug (n=3); alcohol and pills (n=1); heroin and cocaine (n=1); pills and cocaine (n=1); and amphetamines (n=1).

When asked to identify the primary problem drug for women held within the correctional system all except 1 key informant identified pills as the primary problem drug. The remaining key informant identified cannabis as the primary problem drug.

The key informant's estimates of prior sexual abuse experienced by the women ranged between 20%-95% with a mean of 62%. Three of the key informants were unsure.

Estimates on the percentage of women who would choose to have their children (under 5 years of age) in prison with them were widely spread, ranging from 0-100% with a mean of 66%. Of the 20 key informants 6 were unsure in relation to this question.

▸ *Treatment strategies*

All the key informants were of the opinion that women with drug-related problems should be offered treatment while imprisoned.

Key informants were asked to identify what they perceived to be the most important treatment needs of imprisoned women. Several (n=7) recommended that a detoxification unit be established for women withdrawing from drugs. The following treatment strategies were put forward by more than 1 key informant:

- self-esteem issues;
- stress management and relaxation;
- women's issues (family issues, abuse);
- increased number and variety in terms of training opportunities;
- increased number and variety in Works-Release opportunities; and
- pre and post release support services.

The key informants were specifically questioned on the detoxification procedures in place at the time. There were no detoxification procedures in place at Norma Parker as it is not a reception centre. Most of the key informants working either at Mulawa or head office (n=10) were of the opinion that the detoxification procedures in place at the time of the survey were unsatisfactory. Following are the key informant's suggestions for improving detoxification procedures:

- separate detoxification unit;
- assessment procedure should be reviewed and improved;
- more integrated approach to detoxification be used, including the D&A Service and psychology service;
- more use of non-medicated approaches;
- using the detoxification process as a time for intervention(treatment);
- dedicated staff.

▸ *Sanctioned use of medication*

Half the key informants were of the opinion that problems existed with sanctioned prescription drug use (medication issued by the CHS) and 4 were unsure on this issue. The identified problems were:

- varying/inconsistent prescribing practices between medical staff - lack of team approach;
- lack of alternatives to prescription drugs provided;
- cross-dependence on drugs, such as anti-histamines;
- inadequate medical management and supervision - in terms of prescription practices and the information provided to women concerning their medication;
- standover tactics by the women to obtain medication from each other;
- diverting, storing and trading tablets by the women;
- over issuing/prescribing of medication by medical staff particularly in relation to analgesics and anti-depressants.

Those medically sanctioned drugs which were perceived to be the primary problem within the system were anti-depressants (n=5).

The suggestions put forward by key informants for improving medication prescribing practices follow:

- physical facilities should be improved;
- a designated area be established for detaining women for approximately 20 minutes after they have received their medication and in addition the women should be given plenty of water to drink to ensure that they actually ingest the medication;
- team/case management approach be adopted;
- improve access to alternative treatments (reportedly the women had to pay $30 for chiropractic treatment);
- limit telephone orders (nursing staff are reportedly able to obtain approval from doctors by telephone to issue prescription medication to a patient);
- conduct regular audits on the type and quantity of medication being issued/prescribed;
- women should be fully informed on the nature of the medication they are being prescribed and the associated side effects.

▸ *Other treatment initiatives*

A slight majority (n=11) endorsed the provision of corrections-based treatment for women who had been sexually abused in the past. Another 8 endorsed corrections-based treatment, however this was subject to provisos. Some of the provisos put forward were:

- specifically qualified and experienced staff;
- multi-disciplinary team;
- needs to be a therapeutic environment - providing adequate support;
- planned and co-ordinated program.

The key informant who thought that women should not be offered treatment for prior sexual abuse while imprisoned stated that it was a completely separate issue and a very specialised treatment area.

Key informants were fairly evenly divided on whether the women would benefit from having

their young children with them in the correctional system. Out of the 19 who responded to this question just under half (n=9) stated yes the women would benefit, 7 were unsure and 3 stated no.

Of those who did not endorse the women having their young children with them, the following reasons were provided: less women would be released to the community under Section 29[8]; women would receive longer sentences from the courts; only a limited number of places could be offered to the women leading to anger and resentment among those who were not offered a place; and the environment would not benefit the children. Of the key informants who were unsure about this issue 1 stated that it would be appropriate if it was provided in secure community housing rather than on-site at the correctional centre.

Lastly, the key informants who were based on-site at the correctional centres were asked to describe the general atmosphere of their centre over the 4 month period of the survey. Those based at Norma Parker generally stated that conditions had been fairly stable, whereas all those based at Mulawa reported on problems with respect to drug-related contraband (pills) and subsequent disputes among the women.

14. Reliability of data

Information provided by the women on their age; sentence length and most serious offence type was verified using the Offender Record System data base held by the Department. Omissions were recorded as inaccurate responses.

Of the total sample of women 57% provided completely accurate information on all three of these factors.

Women were most likely to provide inaccurate information on either offence type (15%) or sentence length (15%). More than ¾ of those who were inaccurate on their most serious offence identified a related offence (e.g., goods in custody versus stealing), but not the exact offence recorded. This group were found to be accurate on age and sentence length factors.

Women who provided inaccurate information on both most serious offence type and sentence length represented 9% of the entire sample.

As reported in Kevin (1993) the identified discrepancies may have been due to factors, such as: memory, dishonesty, lack of understanding or not being fully informed by the criminal justice system. It should be noted that the Court may preside over a number of offences in the same session, therefore it may prove difficult for the offender to identify which of the offences was the most serious, i.e., received the longest sentence. Of the 130 women only 4 gave inaccurate information on their age. This suggests that dishonesty was not the main contributing factor for the 10% of women who provided inaccurate information on more than 1 factor.

Additionally, an attempt was made to compare the information provided by the women on their use of the CHS. This exercise relied on the accuracy of the information recorded in the medical files.

Following are the factors which made verification of self-report information on use of the medical service problematic. It was ascertained during the course of data collection that it was possible for the women to receive a maximum of 6 Panadol (or similar

analgesic) tablets per day on request from the nurse. This had 3 consequences in terms of verification:

(i) the inmate did not perceive that receiving minor analgesics from the nurse as 'using the medical service', however this was recorded in the medical records;

(ii) the inmate did not perceive that receiving minor analgesics to be 'receiving medication' (because it was available on request), however this was recorded on the medication sheets;

(iii) the inmate received minor analgesics from the medical service and self-reported this, however the issue was not recorded on the medical records or medication sheets. In order to account for this, discrepancies between self-report data and medication sheet data in relation to minor analgesics being the last medication received were not coded as inaccurate.

Additionally, those women on Works-Release were required to utilise community-based medical services. This proved problematic when those on Works-Release made attempts to recall the details of their last occasion of use of the CHS.

Notwithstanding the above, when the information provided by the women on both frequency of CHS use (saw doctor or nurse about a health problem) and frequency of sanctioned medication use was cross-referenced with medical files the information matched in 45% of cases.

The most common type of discrepancy was in terms of the number of occasions the women reported receiving treatment from the CHS and the number of occasions recorded in the medical files (31%). The women reported receiving treatment less frequently than recorded in the medical files (29%).

Discrepancies between self-report and medical records in relation to both frequency of use of the CHS and frequency of sanctioned medication use were found in 22% of cases.

Information on the type and quantity of sanctioned medication received from the CHS was also cross-referenced. Interestingly, self-report and medical file data matched in 76% of cases (excluding minor analgesics). However, it should be noted once again that inconsistencies with regard to the issue of minor analgesics were coded as accurate.

The finding that discrepancies on type of medication were found in 24% of cases should be noted. Over half the discrepancies identified on type of medication appeared to be due to a lack of recall or non-responding by the women.

Cross-analysis was conducted between frequency and quantity of both heroin and benzodiazepine use and these accuracy measures. Regular benzodiazepine users (weekly or more) showed a high proportion of inaccuracy (62%) on offence and sentence length information. However, no significant association was found between the self-reported frequency or quantity of either heroin or benzodiazepine use and any other accuracy measure.

Compared to the other accuracy measures the women appeared to be most accurate (76%) on type of medication received on last occasion. However, the findings in relation to verification of frequency of use of the medical service and frequency and type of sanctioned medication use should be interpreted with caution due to problems encountered with comparability as outlined above.

Table 18: A selection of the ideas put forward by key informants

Treatment needs of women

"A broad-based approach - incl. detoxification facilities, programs specifically tailored to women, such as self-esteem issues, power relationships with men, harm minimisation-using safely."

"Tailored, well planned, interdisciplinary D&A programs combining D&A Services with psychological services and the Corrections Health Service."

"If their social and economic circumstances are not attractive they will escape on medication.....therefore they have to be offered alternatives."

"Approaches for poly-drug abuse... detoxification should be conducted using proper protocols."

"Problems with their families ... 'sleep hygiene' how to get to sleep without drugs... relaxation and stress management."

"More welfare services....link-up with community-based agencies (post-release)."

"They (inmates) have a lot more health needs than the general population..car accidents, assaults, gynaecological."

"They (inmates) have so many problems, because in general women don't get to gaol until a lot further down the track than men."

"Access to proper legal representation so they don't feel the threat of their kids being taken away."

"With current resources it is very hard to do pro-active work at present, we deal with women coping with gaol.....crisis intervention."

"More attention to Works-Release for women. Women are disadvantaged compared to men."

"At times it is fertile ground for offering drug treatment, because they have reached rock-bottom."

"The current policy is to refer people on, however a multi-disciplinary team would be the best approach."

"Staff need to know if an inmate has taken a small step... this can be like they have jumped a mile...you have to be realistic in goal setting."

"I think the women are extraordinarily needy...part of this is about their socialisation... and usually they are the primary care givers of children."

"We need a larger number of workers so that the women can expect some continuity of service."

"Staff who want to work with women are needed ... some people don't want to work with women."

"Women (inmates) are much more demanding ...much less respectful than men (inmates) .. they have greater health needs."

Discussion

This discussion is based on the findings of the second of a two-part report series. The overall aim of this study was to identify the needs of women in prison with drug and other related problems and also to examine the effectiveness of the D&A Service in reaching those with problems. Those serving sentences of one month or more and who at the time of the survey, had been imprisoned for at least a month, were sampled. As with the previous study on mostly male inmates (Kevin, 1992; Kevin, 1993) the findings arising from the drug-related background characteristics of the women have been presented in the first report (Kevin, 1994a). This report addresses the women's use and perceptions of the D&A Service and based on these findings draws inferences in relation to how correctional centre-based services for women with drug problems can be improved. It is noteworthy that the present findings can only be used to draw inferences in relation to the population of sentenced women at the time of the survey. Hence ongoing data collection studies are needed.

Reception and detoxification procedures

Over ⅓ of the women interviewed reported that they were experiencing drug withdrawal syndrome when received for their current sentence and of these ½ had reportedly received treatment. As already noted there is no on-site drug detoxification unit provided.

Just under ¾ of the women reported that they received a general health assessment on reception. It is Corrections Health Service (CHS) policy that a nurse conducts a standardised health assessment on all inmates on reception. Possibly, the remaining ¼ had no recollection of the health assessment which they received. Alternatively, these findings may reflect differences in perceptions on what constitutes a health check-up (e.g., something administered by a doctor rather than a nurse or something which involves a series of physiological tests).

The CHS standardised assessment includes questions on drug use. However, only 64% of women reported that they were assessed in relation to their drug use on reception. With the exception of 1 woman, all those who reported receiving a drug assessment stated that it was administered by the nurse. The remaining woman reported that she was assessed by both the nurse and the D&A Worker.

The pattern of under-reporting in the provision of both health and drug assessments could also indicate variations in the type of assessment provided by the CHS. For example, prior to the standardisation of assessment, on a high intake day, the women may have been solely asked if they had a drug or alcohol problem. Currently, the assessment process is standardised and more comprehensive.

Even though many women are experiencing drug withdrawal syndrome on reception it appears that the D&A Workers are not making contact with these women when they are first received. However, findings did show that just over half of those who were experiencing drug withdrawal syndrome at reception subsequently sought treatment through the D&A Service.

According to key informants this lack of contact between D&A Services staff and the women when they are first received is largely due to heavy caseloads and limited resources. This situation was reportedly exacerbated by a lack of information exchange between the CHS and the D&A Service (according to key

informant reports).

It is evident that the D&A Workers manage a very heavy caseload of self-referring clients. Additionally, they have a waiting list of self-referring clients and also are involved in on-site crisis (assaults, intoxication and deliberate self-harm) intervention work.

Empirical evidence (McLaren, 1992) and duty of care provisions indicate that high risk cases should be targeted for treatment. Given the prevalence of women who are received into the correctional centre with drug dependencies it should be a priority to identify those at high risk of drug-related harm through a contact screening procedure.

If the administration of a drug screening procedure and the information arising from it was shared by the CHS and the D&A Service this would represent a more effective utilisation of limited resources. If such an initiative is not viable under current management structures a contact screening procedure (additional to that completed by nursing staff) needs to be administered by the D&A Workers. D&A Workers require this information to be able to monitor high risk cases and also to identify those who require a further diagnostic assessment and treatment plan.

The present study found an association between poor emotional adjustment (as measured by the GHQ28) and regular-heavy drug use. This indicates there is a need for any diagnostic assessment procedure to include a dual-diagnosis[9] component.

Only ⅓ of the women reported that they attended a reception meeting when first received into the correctional system. Some reportedly received written guidelines as to the day to day running of the centre and the services provided.

The nature of being received into the correctional system is undoubtably a distressing experience. In addition, many women would be experiencing distress due to separation from their children and some may not know where their children will be living or who will be responsible for them. Also, a significant number of women would be in physical and psychological distress when first received due to drug dependencies.

Hence, contact screening should be conducted in a safe, comfortable and private location within the centre.

It would seem appropriate to hold new receptions in a residential unit separate from the correctional centre population for the first few days after they are received into custody (generally this is the case for male inmates). In this way these women could be properly assessed and monitored.

In addition, key informant interviews revealed that many women are carrying drug-related contraband on reception to the correctional system. Holding new receptions in a separate residential area may to some extent circumvent the distribution of this contraband to the general population of imprisoned women. This in turn may reduce the prevalence of overdoses and the number of fights which occur as a consequence of drug-related contraband.

Prevalence of use of D&A Service

At the time of the survey just over half of the women classified by the study as 'regular-heavy' users of drugs had received treatment from the D&A Service.

Though the comparison is somewhat loosely based, it would appear that a higher proportion of women are receiving treatment for drug-

related problems in N.S.W. correctional institutions when compared to estimates (approximately 10%) on the number of women in U.S. correctional institutions receiving drug treatment (Wellisch, Anglin and Prendergast, 1993).

Consistent with international findings on use of health-related services in prison (Newkirk, 1992; Maden, Swinton and Gunn, 1994) a higher proportion of women in N.S.W. correctional institutions sought treatment from the D&A Service when compared to men.

Over ¾ of those who used the D&A Service were self-selecting. Notwithstanding the above, some high risk groups, such as needle users and those experiencing drug withdrawal on reception, were more likely to use the D&A Service than those who were not.

Hence, even though they are not being targeted by the D&A Service some high risk groups are self-selecting treatment.

While the CHS conducts a brief drug assessment on reception only 1 woman was reportedly referred to the D&A Service by the CHS. It should be noted that some women who reported to be self-referrals may have been prompted by staff on a previous occasion.

Of those who used the D&A Service just under ¾ reported that their primary motivation for doing so was directly related to their drug use.

Some women, (10%) used the service at some stage to gain information about the methadone program. The methadone program falls within the jurisdiction of the CHS and not the D&A Service.

Of note is that 21% of women used the D&A Service at some stage to either: satisfy curiosity; to overcome boredom or to have someone with whom to talk. This appears to be an inappropriate and costly use of the specialist workers which the D&A Service offers. Well established inmate support groups may fulfil the role of grievance support, company and diversion in situations, such as described above.

Of the potential clients who had not used the D&A Service 17% stated that they had made attempts to use the service. In addition, 23% were of the opinion that it was very important for them to receive treatment for their drug-related problems while imprisoned.

However, for most potential clients, the main barriers to accessing the service were, for the most part, self-imposed barriers: 24% stated that they did not have a problem; and 47% (excluding those who stated that they did not have a drug problem) thought it was not at all important for them to receive corrections-based drug treatment.

In summary, the majority of drug-involved women had received treatment from either the D&A Service or the Prison Methadone Program during their current sentence.

Just under half the women classified as 'regular to heavy users' had not received treatment from the D&A Service at the time of interview. At 3%, D&A Service recruitment of clients was nominal. Currently there is a reliance on voluntary contact with the D&A Service. However, there exists a case for increased targeting of those at high risk of drug-related harm.

Finally, consistent with earlier findings Kevin (1993) an increase in referrals to corrections-based drug treatment from the judiciary may result in more women with problems engaging in treatment.

Treatment intervention and perceptions

Currently the D&A Service in N.S.W. correctional centres offers a range of treatment options which reflect community standards, such as one-to-one counselling, group programs (e.g., relapse prevention), Narcotics Anonymous, Alcoholics Anonymous and inmate support groups. The exception to this is the rehabilitation unit or therapeutic community approach which is currently not being offered. The therapeutic community approach is to be considered in the Drug & Alcohol Strategy, 1995.

The women in the present study were significantly more likely to have received one-to-one counselling from the D&A Service compared to other forms of treatment. Given the demands on the service it would be more productive to reduce the amount of one-to-one counselling being offered.

As already noted in Kevin (1993) there is no empirical basis for offering one-to-one counselling over any other form of treatment. The women in the present study did not report receiving significantly more help from one to one counselling compared to other forms of treatment. Notwithstanding this, given the nature of prison sub-culture and problems with confidentiality, one-to-one counselling should remain a treatment option for those at high risk of drug-related harm who feel it is the only treatment which suits their needs.

Of those who used the D&A Service almost half had reportedly experienced problems when trying to see the D&A Worker because the worker was too busy. As already noted, 17% of potential clients who had not used the D&A Service had reportedly made attempts to do so.

When there is high demand for a service such as the D&A Service the allocation of resources needs to be rigorously evaluated. The advantage of group programs is that they offer greater coverage of the client population over time.

Given that present resources are not meeting the demand for treatment a systematic approach, such as described below, would appear to be the most effective way of identifying the client population and determining the type of treatment, through consultation, which to offer clients.

- screening and drug withdrawal management;
- diagnostic assessment of medium-high risk cases;
- motivational interview[10] and treatment plan. Low intensity program (education -based group program) or high intensity program (one-to-one counselling or separate unit program) to be determined by level of risk;
- follow-up interview;
- pre-release issues and community-based referrals.

For short-term inmates with drug-related problems the entire corrections-based intervention may involve a contact screening procedure and referrals to community-based programs.

A further consideration given that D&A Worker caseloads are considerable and they feel unable to meet the demands for their time is 'burn-out'. A more systematic approach to treatment planning with simple and clear guidelines as to where responsibilities begin and end should diminish some of this work-

related stress. According to a number of key informants, the D&A Workers are often asked by correctional administration to intervene when crises (fights, deliberate self-harm, intoxication, etc.) occur within the centre. Clear guidelines are needed in relation to procedures for crisis intervention which make use of on-site staff from a number of disciplines. In this way, constant reliance on the same staff to intervene would be avoided.

If staff feel overloaded they are not able to carry out new initiatives and establish programs.

The present study found that use of the D&A Service results in gains for correctional administration in terms of the safe and secure management of female inmates. Over a ⅓ of the women who used the D&A Service were helped in relation to managing their anger, 47% were helped in relation to overcoming depression, 29% concerning their relationships with other inmates and 14% concerning their relationships with officers.

Use of medically-based services

About a third of the sample had received methadone treatment during their current sentence. The majority of those on the methadone program had also used the D&A Service for counselling during their current sentence. The Corrections Health Service does not provide a counselling service.

In addition the motivation for 10% of women who used the D&A Service was reportedly to obtain information about methadone treatment. Hence, it appears that the D&A Service is providing the supplementary treatment to methadone clients that is the jurisdiction of the Corrections Health Service.

Community-based methadone programs offer counselling as an integral component of the methadone treatment regime. In recent discussions between the management of the D&A Service and the Corrections Health Service an agreement was reached whereby the D&A Service shall continue to provide methadone clients with supplementary counselling.

Consistent with international findings (Flannagan,1991) those with shorter sentences used the Corrections Health Service (for a health problem) more frequently than those with longer sentences. It is likely that the women, due to risky lifestyles in the community, are less physically healthy when first received into the correctional system. This may explain why those with shorter sentences appear to be using the Corrections Health Service more frequently.

According to Flannagan illness complaints actually decrease over time within the prison system. Flannnagan purported that prison may improve the health of the individual as s/he is often removed from a highly risky lifestyle.

With regards to sanctioned medication use nearly a ⅓ of the present sample reported receiving medication on a daily basis and over ½ had received medication during the previous week. Further, a number of key informants were of the opinion that there were problems with the issuing of medication. It would appear that current prescribing/issuing practices (particularly in relation to anti-depressants and analgesics) need to be monitored and reviewed.

To what extent imprisoned women use psychotropic medication as a means of dealing with the anxiety and the constraints of imprisonment needs to be considered. However, differential prescribing practices and the underlying assumptions of prescribers

should also be examined.

According to a Canadian study, a common explanation for the over-issuing of psychotropic medication to imprisoned women is the high demand for it (Hattem, 1994). However, alternative solutions to prescription drug use need to be addressed.

It would be advantageous for the health service to allocate resources to health promotion and prevention, particularly in the form of brief education programs addressing alternatives to medication in relation to coping with anxiety and sleeping disorders.

Other prison-based behavioural indicators

Just over half the women were classified as having poor psychological adjustment/ emotional well being at the time of interview. The women rated most poorly on anxiety measures. This suggests that the women could benefit from programs on managing stress. In addition, aspects of the correctional environment which cause most stress for the women should be investigated.

In the present study, the rates of deliberate self-harm, assaults and prison offences were generally much higher for female inmates when compared to male inmates for the same period. It should be noted that rate represents the number of incidents rather than the number of individuals. Therefore, if an individual repeatedly injures herself, and some do, each self-injury is counted as an incidence.

This study did not find an association between destructive behaviour patterns (assaults, deliberate self-harm and prison offences) and level of psychological adjustment (as measured by the GHQ 28) or prior treatment for emotional disorders. There did appear to be an association between destructive behaviour patterns and regular-heavy drug use prior to imprisonment. However, the numbers compared were too small to draw meaningful conclusions.

Data on frequency and type of prison offence combined with anecdotal reports from key informants indicated that there were problems with unsanctioned drug use (mainly in psychotropic pill form) by the women. This pattern needs to be addressed in the drug treatment programs offered to women. Specifically programs on drug coping skills and relapse prevention skills in the correctional environment should be offered. Logically inmate support groups would play an integral role in relapse prevention in the correctional environment.

The high rate of assaults and deliberate self-harm by the women need to be monitored and the aetiology addressed. Some key informants inferred an association between the prevalence of unsanctioned psychotropic pill use and the high assault and self-harm rates.

If there is an association between psychotropic drug use and deliberate self-harm then differences between male and female inmates in terms of access to medically sanctioned medication also need to be examined.

Disproportionate levels of deliberate self-harm by imprisoned women have also been recorded in Canada (Shaw, 1994) and the United Kingdom (Liebling, 1994). Another study on women in Canadian prisons has suggested a link between self-injury by women and prior sexual abuse (Heney, 1990 in Shaw 1994).

According to Liebling (1994) there is a tendency to over-medicalise the deliberate self-harming behaviour of women in prison by ascribing psychiatric labels to these women,

such as 'personality disordered' or 'clinically depressed'. In this way their behaviour is viewed as irrational rather than an expression of distress related to their current situation. As reported by Liebling, the correctional environment is not conducive to an open expression of despair. According to a number of studies only about ⅓ of prison suicides have been found to have a history of psychiatric disorder or treatment (Backet, 1987; Dooley, 1990a in Liebling, 1994).

While the presence of psychiatric illness needs to be taken into account in any explanation of destructive behaviour by imprisoned women, the correctional environment and any immediate situational or practical problems also need to be examined. Further, the gender-specific effects of custody should be addressed in any explanation of destructive behaviour. This amounts to collecting subjective, qualitative information on the women's experience of prison life.

Drug treatment programs for women - effective strategies

Certain approaches have been identified in the literature as being associated with successful treatment outcomes and these have been reported in Kevin (1993). Generally, these programs have been designed to facilitate positive alternatives and pro-social behaviours using cognitive-behavioural skills-based approaches. Skill development focuses on areas, such as problem solving, relapse prevention and self-efficacy. Programs are structured in stages with clearly defined rules and often are conducted in a separate unit. In addition, programs include a phase of transition and after-care in the community.

Generally, the principles mentioned above have featured in recent programs which have been specifically designed for women with drug-related problems. In addition, some of the programs for women appear to be approaching drug treatment from an holistic perspective. Other issues such as parenting, vocational training, physical/sexual abuse, physical security, interpersonal relationships and health care are included in the comprehensive treatment approach. These additional components are viewed as being integral to the well being of the women and therefore essential to the effectiveness of treatment. An holistic approach, such as described above is best managed through multidisciplinary team work whereby those best suited to deliver the specific treatment do so.

In the present study the women themselves pointed to the importance of skills-based programs on topics, such as: parenting; self-esteem; relationships; budgeting; stress; nutrition and relapse prevention. They also indicated a preference for the involvement of 'ex-users' in the provision of treatment. Both these features have been associated with effective outcomes, such as reduced recidivism and reduced drug use in inmates (Wexler et al, 1991; Chaiken, 1989; McLaren, 1992). Further, of those who had experienced prior sexual abuse ¾ were of the opinion that abuse issues should be addressed in drug treatment programs. (It should be noted that just under ½ the women interviewed reported experiencing prior physical/sexual abuse and of these over ½ had not received any treatment in relation to the experience). Some key informants expressed concern with relation to correctional centre-based treatment for prior abuse issues emphasising the importance of a therapeutic, supportive environment and specialised staff.

When those women in the present study with drug-related problems were asked whether drug treatment programs for men and women

should be different, their responses were fairly spread. Just over a ⅓ of the group were of the opinion that programs should be gender-specific. It therefore appears that a program which combines both drug issues and women's issues should be a treatment option.

As men and women are physically separated while in custody it is an opportune time to address gender-based concerns in group work. This option is not always available in mixed-sex community-based programs.

As mentioned in the introduction recent approaches to gender-sensitive programs for women have been based on principles of empowerment, whereby the women perceive they have choices, alternatives and self-control. Notwithstanding this, the restoration of some sense of self-control and some sense of personal power and decision making seems to be at odds with a highly controlling environment such as prison. Therefore, it is more likely to be made possible through skill acquisition and through creating choices within program structure.

According to Reed (1987) drug treatment programs for women are defined as those which:

(i) address women's treatment needs;

(ii) reduce the barriers to recovery from drug problems that are more likely to occur for women;

(iii) are delivered in a way that is compatible with women's communication and learning styles and orientation;

(iv) take into account women's roles, socialisation and relative status within the larger society.

According to Reed, women reportedly are more likely to explain their drug use in terms of a coping strategy than men. Reed reported that material about gender socialisation and its effects and roles has been incorporated into treatment activities to assist women in developing an alternative understanding of their lives. The author contends that such material can help reduce the shame and blame experienced by many women.

The American Correctional Association Task Force on women in prison (1990) concluded that female offenders entering the criminal justice system will continue to have drug abuse problems and a lack of education. Accordingly, they recommended that prison-based programs should not only focus on drug treatment (support groups, counselling, referrals to community-based agencies and follow-up) but also education. It was recommended that fast-paced and reward oriented programs be designed to raise educational levels within a short space of time.

It was further recommended that in-prison industry programs representative of the current job market be made available. Key informants in the present study suggested that training and Works-Release opportunities for women need to be increased and provide greater variety. Generally, women in prison have received training in traditional low paying occupations for women, such as clerical and sales. Training choices should include more creative, marketable options and trades-based opportunities for women which offer higher income.

Evaluation and follow-up of programs

To date most of the evaluations on programs for women appear to be either of descriptive form or have not used randomised control methodology.

Those evaluations which have used systematic methodology, though few in number, have shown positive outcomes in terms of recidivism and pro-social behaviour (Wellisch, Anglin and Prendergast, 1993). One such evaluation is that on the drug treatment program DEUCE. DEUCE was generally described as a self-esteem based program for imprisoned women in California. Reportedly, those who participated in the program were half as likely to be re-arrested within 12 months of release compared to the control group. This program focussed not only on drug treatment, but also on increasing employment. There was also a voluntary post-release 'outmate' support group with probation department staff working with inmates in the design of the program.

Transitional programs and post-release after-care and follow up have been associated with positive outcomes (McLaren, 1992). The D&A Service and other departmental services need to facilitate further development of inmate peer support groups. Inmate support groups offer a cost-effective way of developing and maintaining coping skills for women while imprisoned. In addition, the formation of 'outmate' support groups would provide that ongoing post-release support that has been associated with successful outcomes. Providing such a buffer from life stresses once inmates are released may prove to be an effective way of preventing relapse.

Further, the D&A Service should provide continued support to the provision of Alcoholics Anonymous and Narcotic Anonymous meetings within the correctional system as linkage with these support groups in the community is then assured.

In addition, present findings indicate that the Department should support the allocation of additional resources to transitional halfway houses and co-operative living arrangements to facilitate inmate reintegration into the community.

Finally, the role of gender needs to be examined more systematically in all aspects of drug dependence treatment programming. It has not been established whether drug treatment programs for women need to be extensively modified or specifically developed. Most of the studies have been descriptive.

Seemingly, a variety of factors such as personal, interpersonal and structural are related to drug use behaviour and criminality in both women and men. It may be found that treatment has not been sufficiently responsive to individual differences.

Endnotes

(1) **Post Traumatic Stress Disorder** - The development of characteristic symptoms following exposure to a traumatic event, such as experiencing or witnessing physical injury or threat to physically injure. The person's response to the event must involve intense fear, helplessness or horror. The person has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling asleep that may be due to recurrent nightmares during which the traumatic event is relived, hypervigilance, and exaggerated startle response. Some people report irritability or outbursts of anger or difficulty concentrating or completing tasks (American Psychiatric Association, 1994).

(2) **Bipolar Disorder** - is a recurrent disorder which involves episodes of mania that may or may not involve major depressive episodes. There are many categories of bipolar disorder (American Psychiatric Association, 1994).

(3) **Schizophrenia** - The characteristic symptoms of Schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioural monitoring, drive, and attention. No

single symptom is pathognomonic of Schizophrenia; the diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning (American Psychiatric Association, 1994).

(4) **Reception meeting** - It is the policy of the Department of Corrective Services that a reception meeting is held within held within 48 hours of an inmate being received. The Reception Committee informs the inmate of programs and daily routines of their institutions. The committee can also make recommendations in relation to the security classification and placement of short-term inmates.

(5) **Users** - the classification of women as regular-heavy users of drugs was based on their patterns of drug use in the 6 months prior to imprisonment, as reported in the first of this 2 part report series. The following criteria were used to classify women as regular-heavy users (users): any individual who drank more than 4 standard glasses of alcohol per day or 28 glasses per week; any individual who used any drug (excluding cannabis) on a weekly to daily basis; and any individual who used cannabis on a daily basis.

(6) **Potential clients** - those individuals who did not use the D&A Service and who fell into any of the following categories: (i) users of drugs; (ii) self-perception of a relationship between their drug use and imprisonment; (iii) self-perception of drug-related problems; (iv) self-perception of drug dependency at reception; (v) self-reported drug withdrawal at reception.

(7) **Split kits** - It is Departmental policy to offer a split kit to all inmates being released to freedom and those participating in day or weekend release programs, immediately prior to their exiting the correctional centre. The kit contains 1 condom, 1 lubricant sachet, plus written information on injecting safely and telephone numbers of the Alcohol and Drug Information Service and the HIV/AIDS Information Line.

(8) **Section 29 (2)(c) of the Prisons Act, 1952** - Any prisoner may, in accordance with a permit granted to the prisoner by the Commissioner, be permitted to be absent from a prison, on such conditions as may be prescribed and such conditions as may be specified in the permit, for a period being: in the case of a female prisoner who is the mother of a young child or young children, for the purpose of enabling the prisoner to serve her sentence with her child or children in an appropriate environment determined by the Commissioner.

(9) **Dual diagnosis** - Concurrent diagnosis of drug/alcohol problem and major psychiatric illness in an individual.

(10) **Motivational interview** - Motivation is conceptualised not as a personality trait but as an interpersonal process. Labelling is de-emphasised and heavy emphasis is placed on individual responsibility and internal attribution of change. Cognitive dissonance is created by contrasting the ongoing problem behaviour with salient awareness of the behaviour's negative consequences. Empathic processes are employed to channel the dissonance toward a behaviour change solution, avoiding the "short circuits" of low self-esteem, low self-efficacy and denial (Miller, 1983).

References

American Correctional Association (1990) *The Female Offender: What Does the Future Hold?* Washington, D.C.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)- 4th ed.* Washington, DC.

Bureau of Justice Statistics (1992) *Census of State and Federal Correctional Facilities, 1990.* U.S. Department of Justice.

Carp, S. Schade, L. (1993) Tailoring Facility Programming to Suit Female Offenders' Needs, in American Correctional Association (ed) *Female Offenders. Meeting Needs of a Neglected Population,* United Book Press, Baltimore.

Chaiken, M. (1989) Prison Programs for Drug Involved Offenders. *National Institute of Justice. Research in Action.* U.S. Department of Justice, October.

Coopersmith,S.(1981) *Self-Esteem Inventories.* Consulting Psychologists Press, Inc. Palo Alto, California

Copeland, J. & Hall, W. (1992) A comparison of women seeking drug & alcohol treatment in a specialist women's and two traditional mixed-sex treatment services. *British Journal of Addiction 87,* 1293-1302.

Criswell, T. (1989) A step in the right direction. *Corrections Today*, Aug, pp.200-208.

Darke, S. Ward, J. Hall, W. Heather, N. Wodak, A. (1991) The Opiate Treatment Index (OTI) Manual. *National Drug & Alcohol Research Centre. Technical Report Number 11.* University of New South Wales.

Flannagan, T.J. (1991) "Long-term Prisoners: Their Adaption and Adjustment ", *Federal Prisons Journal, 2(2)*, pp. 45-51.

Goldberg, D. & Williams, P. (1988) A Users's Guide to the General Health Questionnaire. Basingstoke Press Ltd, Basingstoke, Hampshire.

Hattem, T. (1994) The realities of life imprisonment for women convicted of murder. *Forum on Corrections Research, Vol. 6,* No.1, pp. 42-45. Corrections Service of Canada.

Ingram-Fogel, C. (1991) Health Problems and Needs of Incarcerated Women. *Journal of Prison and Jail Health, Vol. 10,* No. 1, Summer, pp. 43-57.

Kevin, M. (1992) Drug and Alcohol Exit Survey. Part one. Drug and Alcohol Background Characteristics of Inmates. *Research and Statistics Unit, Research Publication No. 26,* N.S.W. Department of Corrective Services.

Kevin, M. (1993) Drug and Alcohol Exit Survey. Part Two: Inmate Contact with Drug and Alcohol Services. *Research and Statistics Unit, Research Publication No. 27.*, N.S.W. Department of Corrective Services.

Kevin, M. (1994a) Women in Prison with Drug-Related Problems: Part One. Background characteristics. *Research & Statistics Unit. (in print)* N.S.W. Department of Corrective Services.

Liebling, A. (1994) Suicide Amongst Women Prisoners. *The Howard Journal, Vol. 33,* No.1. pp. 1-9.

Maden, A. Swinton, M. & Gunn, J. (1994) A Criminological And Psychiatric Survey Of Women Serving A Prison Sentence. *British Journal of Criminology, Vol.34,* No.2, pp. 172-190.

McLaren, K. (1992) *Reducing Reoffending: What Works Now.* Penal Division, Department of Justice, New Zealand, May.

Miller, W. (1983) Motivational Interviewing with Problem Drinkers. *Behavioural Psychotherapy, Vol. 11,* pp. 147-172

Miller-Ashton, J. (1993) Canada's New Federal System for Female Offenders, in American Correctional Association (ed) *Female Offenders. Meeting Needs of a Neglected Population,* United Book Press, Baltimore.

Miner, M. & Gorta, A. (1986) Drugs and Women in Prison. *Research and Statistics Division, Research Publication No. 10,* N.S.W. Department of Corrective Services.

Moffat, K. (1991) Creating Choices or Repeating History: Canadian Female Offenders and Female Reform. *Social Justice, Vol. 18.* No.3, pp. 184-203.

Newkirk, C. (1993) Mental Health Needs and Treatment of the Female Offender. Paper presented at the *5th World Conference on Prison Health Care,* Brisbane.

N.S.W. Department of Corrective Services (1994) *Women's Action Plan. A 3 Year Strategy for Female Inmates in N.S.W. Correctional Facilities.* June, 1994.

Reed, B. (1987) Developing Women-sensitive Drug Dependence Treatment Services: Why So Difficult? *Journal of Psychoactive Drugs. Vol.19* (2) pp. 151-164.

Shaw, M. (1994) Women in Prison: A literature review. *Forum On Corrections Research, Vol. 6,* No. 1, pp. 13-18. Correctional Service Canada.

Wellisch, J. Anglin, D. & Prendergast, M. (1993) Treatment Strategies for Drug-Abusing Women Offenders, in J. Inciardi (ed) *Drug Treatment and Criminal Justice.* Sage Publications, Newbury Park, California.

Wexler, H. Blackmore, J. & Lipton, D. (1991) Project Reform: Developing a Drug Abuse Treatment Strategy for Corrections. *The Journal of Drug Issues, 21(2)*, pp. 469-490.

Appendix A: RECOMMENDATIONS (taken from Miner & Gorta, "Drugs and Women in Prison", Department of Corrective Services Research Publication, 1986, p.24)

1. Detoxification

1) That separate detoxification facilities be provided for women undergoing drug withdrawal.

2) That the detoxification facility contain adequate facilities for inmates to wash themselves and access to warm baths for the alleviation of withdrawal symptoms.

3) That the detoxification unit be staffed by personnel with experience in detoxification outside a prison setting.

4) That the range and dosages of medication provided during detoxification be comparable with community standards.

2. Treatment

1) That an assessment program be established to identify heroin users and obtain background information which would clarify bases for treatment choices (e.g., drug history, treatments experienced in the past, etc).

2) That at the conclusion of the assessment phase, each identified heroin user be fully briefed about the treatment programs available in prison.

3) That a methadone treatment program be established for women who wish to be stabilised on a blockade dose prior to release.

4) That care be taken to ensure fully informed, voluntary consent from those who wish to be enrolled in a methadone program.

5) That a segregated facility be provided with adequate control over the storage and administration of methadone.

6) That close liaison be established with community methadone programs to ensure immediate transfer and hence continuity of blockade on release.

7) In addition to a methadone program, a therapeutic community should be established in a separate facility of the gaol.

8) The program should include some or all of the following components: group counselling, group behaviour therapy, drug education, life skills course, unit management.

9) The unit should be staffed by specialists with experience of broad programs for drug users and prison officers who volunteer for duties in the unit.

10) That initial and continuing staff training be provided.

11) That ongoing evaluative research be conducted into all drug treatment programs.

3. Pre-release

That a welfare worker be appointed specifically to assist heroin users on release by:

a) co-ordinating information on community resources available to drug users;

b) co-ordinating visits by representatives of drug, employment and accommodation groups in the community;

c) establishing a "best friend" scheme for women in prison.

Appendix B:

Table 19: Incidence of reported assault between July 1993 - October 1993

(Rate per 100 inmates according to institution)

Centre	Av. inmate pop.	Assaults on inmates	Rate	Assaults on officers	Rate	**Total assaults as a rate**
Bathurst	309	21	7	4	1	8
Berrima	60	1	2	-	-	2
Broken Hill	37	3	8	2	5	13
Cessnock	443	6	1	6	1	3
Cooma	161	-	-	-	-	-
Emu Plains	144	3	2	-	-	2
Glen Innes	138	2	2	-	-	2
Goulburn	558	35	6	10	2	8
Grafton	173	1	1	-	-	1
John Morony	220	6	3	5	2	5
Kirkconnell	188	-	-	-	-	-
Lithgow	277	4	1	4	0	3
Long Bay Complex Reception & Industrial	412	13	3	6	2	5
Training	279	6	2	2	1	3
Remand	345	8	2	12	3	6
Special Care Unit	22	1	5	2	9	14
Crisis Support Unit	9	-	-	-	-	-
Lifestyles Unit	5	-	-	-	-	-
Special Purpose	43	-	-	-	-	-
Long Bay Hospital	104	12	12	4	4	15
Prince Henry Hospital	6	-	-	-	-	-
Maitland	138	4	3	7	5	8
Mannus	139	1	1	1	1	1
Mulawa	229	21	9	12	5	14
Norma Parker	74	1	1	-	-	1
Oberon	62	2	3	-	-	3
Parklea	259	11	4	2	1	5
Parramatta	400	24	6	7	2	8
Silverwater	345	1	0	-	-	0
St Heliers	235	8	3	-	-	3
Tamworth	56	7	13	9	16	28
Junee	579	20	4	6	1	5
TOTAL	6449	222	3	101	2	5

Notes:

1. Rate per 100 based upon the average inmate population of the institution between July 1993 and October 1993.
2. It should be noted that differences between correctional centres on assault rates are partly determined by the reporting practices of correctional centres.

Table 20: Incidence of reported deliberate self-harm between July 1993 - October 1993

(Rate per 100 inmates according to institution)

Centre	Av. inmate pop.	Self-harm frequency	Rate
Bathurst	309	12	4
Berrima	60	-	-
Broken Hill	37	-	-
Cessnock	443	3	1
Cooma	161	-	-
Emu Plains	144	-	-
Glen Innes	138	-	-
Goulburn	558	17	3
Grafton	173	4	2
John Morony	220	3	1
Kirkconnell	188	1	1
Lithgow	277	10	4
Long Bay Complex Reception & Industrial	412	14	3
Training	279	3	1
Remand	345	7	2
Special Care Unit	22	1	5
Crisis Support Unit	9	1	11
Lifestyles Unit	5	-	-
Special Purpose	43	-	-
Long Bay Hospital	104	9	9
Prince Henry Hospital	6	-	-
Maitland	138	1	1
Mannus	139	-	-
Mulawa	229	24	11
Norma Parker	74	-	-
Oberon	62	-	-
Parklea	259	5	2
Parramatta	400	4	1
Silverwater	345	-	-
St Heliers	235	-	-
Tamworth	56	1	2
Junee	579	3	1
TOTAL	6449	123	2

Notes:

1. Rate per 100 based upon the average inmate population of the institution between July 1993 and October 1993.
2. It should be noted that differences between correctional centres on self-harm rates are partly determined by the reporting practices of correctional centres.

Table 21(a): Incidence of prison offences between July 1993 - October 1993

(Rate per 100 inmates according to institution)

Centre	Av. Pop.	Abuse Freq.	Abuse Rate	Fighting Freq.	Fighting Rate	Order Freq.	Order rate	Stealing Freq	Stealing rate	Property Freq.	Property Rate	Failure to attend muster Freq.	Failure to attend muster Rate
Bathurst	309	40	13	25	8	39	13	26	8	26	8	22	7
Berrima	60	1	2	-	-	4	7	-	-	-	-	7	12
Broken Hill	37	2	5	-	-	1	3	-	-	3	8	-	-
Cessnock	443	53	12	35	8	57	13	23	5	16	4	91	21
Cooma	161	-	-	2	1	-	-	-	-	2	1	-	-
Emu Plains	144	2	1	2	1	8	6	6	4	5	4	40	28
Glen Innes	138	2	1	-	-	5	4	2	1	2	1	13	9
Goulburn	558	22	4	30	5	99	18	18	3	22	4	10	2
Grafton	173	6	4	10	6	22	13	4	2	11	6	18	10
John Morony	220	40	18	17	8	11	5	8	4	5	2	2	1
Kirkconnell	188	3	2	-	-	12	6	8	4	5	3	7	4
Lithgow	277	46	17	12	4	37	13	10	4	11	4	29	11
Long Bay Complex													
Reception & Industrial	412	28	7	6	2	20	5	9	2	-	-	1	0
Training	279	20	7	9	3	31	11	11	4	2	1	1	0
Remand	345	13	4	21	6	23	7	21	6	7	2	-	-
Special Care Unit	22	-	-	1	5	2	9	1	5	5	23	-	-
Crisis Support Unit	9	-	-	-	-	-	-	-	-	-	-	-	-
Lifestyles Unit	5	-	-	-	-	-	-	-	-	-	-	-	-
Special Purpose	43	1	2	2	5	4	9	1	2	-	-	-	-
Long Bay Hospital	104	28	27	26	25	8	8	4	4	20	19	1	-
Prince Henry Hospital	6	-	-	-	-	-	-	-	-	-	-	-	-
Maitland	138	37	27	18	13	50	36	5	4	11	8	1	1
Mannus	139	7	5	2	1	4	3	2	1	6	4	20	14
Mulawa	229	56	25	24	10	152	66	70	31	26	11	36	16
Norma Parker	74	7	10	-	-	16	22	3	4	4	5	3	4
Oberon	62	1	2	-	-	8	13	-	-	-	-	9	15
Parklea	259	9	4	21	8	11	4	18	7	11	4	2	1
Parramatta	400	35	9	34	9	54	14	23	6	13	3	-	-
Silverwater	345	10	3	-	-	15	4	6	2	-	-	1	0
St Heliers	235	14	6	3	1	23	10	6	3	3	1	62	26
Tamworth	56	19	34	16	29	11	20	4	7	3	5	1	2
Junee	579	29	5	8	1	57	10	13	2	14	2	23	4
TOTAL	6449	531	8	324	5	784	12	302	5	233	4	400	6

Notes:

1. Rate per 100 based upon the average inmate population of the institution between July 1993 and October 1993.
2. Charging an inmate with a prison offence is only one of the tools available to officers for maintaining discipline in correctional centres. Thus the number of misconduct charges dealt with does not necessarily indicate the state of discipline in the correctional centre, although monitoring trends in the number of charges over time may be a valuable management tool.

Table 21(b): Incidence of prison offences between July 1993 - October 1993

(Rate per 100 inmates according to institution)

Centre	Av. Pop.	Ref. Urine Freq.	Ref. Urine Rate	Drugs Freq.	Drugs Rate	Alcohol Freq.	Alcohol rate	TOTAL NO. MISCONDUCTS OF CENTRE	TOTAL MISCONDUCT RATE
Bathurst	309	-	-	18	6	-	-	196	63
Berrima	60	-	-	2	3	-	-	14	23
Broken Hill	37	-	-	3	8	-	-	9	24
Cessnock	443	-	-	8	2	-	-	283	64
Cooma	161	-	-	-	-	-	-	4	3
Emu Plains	144	8	6	16	11	5	3	92	64
Glen Innes	138	-	-	13	9	-	-	37	27
Goulburn	558	7	1	16	3	-	-	224	40
Grafton	173	4	2	6	4	-	-	81	47
John Morony	220	1	0	12	5	-	-	96	44
Kirkconnell	188	-	-	14	7	-	-	49	26
Lithgow	277	-	-	12	4	-	-	157	57
Long Bay Complex									
Reception & Industrial	412	-	-	6	2	-	-	70	17
Training	279	-	-	12	4	1	0	87	31
Remand	345	4	1	26	8	-	-	115	33
Special Care Unit	22	2	1	3	14	-	-	14	6
Crisis Support Unit	9	-	-	-	-	-	-	-	-
Lifestyles Unit	5	-	-	-	-	-	-	-	-
Special Purpose	43	2	5	2	5	-	-	12	28
Long Bay Hospital	104	1	1	3	3	-	-	91	87
Prince Henry Hospital	6	-	-	-	-	-	-	-	-
Maitland	138	1	1	4	3	-	-	127	92
Mannus	139	-	-	14	10	3	2	58	42
Mulawa	229	28	12	20	9	-	-	412	179
Norma Parker	74	2	3	3	4	-	-	38	51
Oberon	62	-	-	1	2	-	-	19	31
Parklea	259	1	0	33	13	-	-	106	41
Parramatta	400	-	-	16	4	1	0	176	44
Silverwater	345	3	1	3	1	-	-	38	11
St Heliers	235	1	0	20	9	-	-	132	56
Tamworth	56	-	-	-	-	-	-	54	96
Junee	579	6	1	14	2	17	3	181	31
TOTAL	6449	71	1	300	5	27	0	2972	46

Notes:

1. Rate per 100 based upon the average inmate population of the institution between July 1993 and October 1993.
2. Charging an inmate with a prison offence is only one of the tools available to officers for maintaining discipline in correctional centres. Thus the number of misconduct charges dealt with does not necessarily indicate the state of discipline in the correctional centre, although monitoring trends in the number of charges over time may be a valuable management tool.