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Drugs and Women in Prison

Maureen Miner
Angela Gorta

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DRUGS AND WOMEN IN PRISON

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PREFACE

In 1984, a N.S.W. Government Task Force on Women in Prison was set up to review the management of women prisoners and make recommendations especially about the construction of new prison accommodation for women. The Research and Statistics Division of the N.S.W. Department of Corrective Services carried out a substantial amount of research in support of the Task Force. Some of the results were presented in the Report of the Task Force. Following submission of that Report in 1985, the government set up an Implementation Committee to put into effect those Task Force recommendations which have been adopted.

The research conducted for the Task Force obtained a large amount of new data on women prisoners. Time constraints limited analysis of the data and consideration of the conclusions which could be presented to the Task Force in time for the final Task Force report. Thus, the Corrective Services Commission and the Minister for Corrective Services agreed that further work should be done to produce substantial Research Publications based on further analysis of the data and consideration of relevant literature. This Research Publication is the first of a number which have been prepared in this way.

The views expressed in this report are those of the authors and do not necessarily represent the views or policies of the Minister for Corrective Services or the New South Wales Corrective Services Commission. For example, the authors recommend that methadone 'blockade' be tried with selected offenders. Commission policy has been to use lower 'maintenance' doses in methadone programmes. The permission of the Minister and Commission to publish the report is acknowledged.

Public discussion of correctional policy and practice often is based on assumption, prejudice and general attitudes. Research carried out elsewhere can too easily be ignored, dismissed as irrelevant to local conditions, or misapplied through ignorance of the sometimes substantial differences in social context and correctional systems. I am pleased to be able to present this report which sets out locally obtained data in the context of a critical examination of the results and relevance of research in other societies. The processes of discussion and evaluation of policies can continue with a better factual basis, to which this report makes a useful contribution.

DON PORRITT
Chief Research Officer
August, 1985

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Most of the data upon which this report was based were collected through a team effort. The design of interview schedules and interviews with women prisoners was the work of a research team comprising:

David Alcott, Cath Barrett, Clive Dickens, Anna Dudek, Simon Eyland, Geoff Gordon, Angela Gorta, Julie Graham, Michelle Karas, Maureen Miner, Don Porritt, Craig Tucker, David Tucker and Helene Panaretos.

Preliminary data analysis was performed by members of the research team, with additional assistance from Joyce Athanasopoulos, Ruth Pennington and Dale Waters. The writing of the preliminary reports which provided a profile of women in NSW prisons for the Task Force on Women in Prison was undertaken by Angela Gorta, Michelle Karas and Maureen Miner.

Both David Cairns and Ros Riley assisted with computer analyses of the data.

Contents

INTRODUCTION

Much has been written about drug use and its relationship to crime. A smaller proportion of the literature has been devoted to female criminality and drug use. However there have been very few research studies examining the extent of prior drug use amongst women sentenced to imprisonment and, in particular, the needs of heroin users serving a prison sentence. This study identified women who reported regular, long-term heroin usage prior to their current imprisonment in NSW and, in the same interview situation, explored their perceptions of prison life.

A search of the literature revealed six major issues related to drugs and female criminality:

1. prevalence of heroin use by females;
2. The relationship between female criminality and heroin use;
3. The provision of assessment and treatment programmes for women charged with narcotics offences or women charged on other matters but known to be abusing heroin;
4. The provision of detoxification and treatment programmes for female heroin users sentenced to imprisonment;
5. The provision of treatment programmes and follow-up care for female heroin users after release from prison.
   Finally, there is a broad area of debate which should be addressed in any study of the needs of heroin users, whether male or female:
6. The desirability of methadone maintenance compared with drug-free treatment.

Each of these six issues will be examined in turn as a foundation for the present study. However there are certain methodological problems which apply to studies across most of these areas, and these will be discussed first.

Methodological Problems

The two main approaches to the study of heroin use in selected populations comprise self report and record data analysis. Each has significant limitations.

Since heroin use is illegal in all jurisdictions under study, respondents may understate their heroin involvement for fear of legal action. However, usage may be exaggerated if interviewing occurs in social contexts where drug usage is acceptable, such as certain adolescent sub-cultures. In a discussion of reported use of illicit drugs by high school students in NSW it was stated:

> "The overall impression gained from the administration of the survey in many schools was of a general ignorance as to what these illicit drugs were. It is possible that the exotic nature of such drugs offered the enticement to display a bit of bravado, even if anonymously. In any case, it is necessary that the results for these illicit drugs be treated cautiously" (Homel, Flaherty, Trebilco and Dunoon, 1984, p. 15).

The use of record data such as police files listing arrests or convictions for drug offences in order to identify heroin users is also biased. Since heroin usage is an unreported, victimless crime, detection is very difficult. Furthermore, arrest rates for drug users may fluctuate due to administrative policies affecting policing of drug laws and the intensity of police activity in the area. Often, detection of drug users depends on secondary factors such as suspicion of other crimes. Thus official statistics related to illegal drug usage severely under-represent the level of use in a population and relate only to the most visible offenders. They could also overestimate the association between drug use and other crimes.

From time to time, estimates of the prevalence of heroin use in a population have been made, using extrapolations from perceived community use or using data concerning known availability and consumption of heroin. Dobinson and Ward (1984) illustrated the tenuousness of such endeavours by quoting estimated annual consumption rates for individual heroin users of 16.2 pure weight grams by the Woodward Royal Commission and 51.5 pure weight grams by the Williams Royal Commission 1980. The writers concluded:

> "The fact that two commissions could come to such diverse findings as to the level of consumption illustrates the difficulties in making any precise conclusions about drug related crime of any type" (p. 2).

While self-report, record data and estimating approaches to research in the area of drugs and crime yield different results, comparisons between research studies are also largely affected by definitions of drug and drug user. Differences in definition are often ignored in literature reviews. For example Silverman (1982) reviewed over thirty studies of female drug use and crime, in which the female drug user was variously defined as:

1. an opiate addict with minimum 6 months usage of narcotic drugs and who has experienced Grade II withdrawal (James, Gosho and Wohl, 1979).
2. an addict, with heroin and amphetamine addicts sub-divided (Goldstein, 1979).
3. a regular, occasional or 'ever' user, with drug types of marijuana, cocaine, heroin and hallucinogens sub-divided (Richards, in Silverman, 1982).

Thus type of drug, frequency of use, duration of habit and quantity consumed may all affect the definition of drug user and comparing studies using disparate definitions is a hazardous undertaking.

1. THE PREVALENCE OF HEROIN USE BY FEMALES IN NSW

Although methodological considerations severely limit the usefulness of individual studies in addressing the incidence of female heroin use, consistent findings from a number of studies may suggest a range of possible estimates.

In the Report of the Williams Commission (1980) evidence from nine surveys on drug use strongly

indicated that a higher proportion of males than females used illegal drugs, including heroin, and "generally the male to female ratio was between three to two and two to one" (p. A101). Further, it was noted that 70% of those surveyed in a 1975 study of 635 addicts for whom methadone was authorized were males. If there were approximately 10,000 heroin users in NSW in 1980 (according to the Woodward Royal Commission) then between 3,000 and 4,000 of these would have been women.

However it must be emphasized that these are very loose estimates based on studies carried out between 1972 and 1978. Changes since that period may have greatly affected both the total numbers of heroin users and the proportion of females involved.

2. THE RELATIONSHIP BETWEEN FEMALE CRIMINALITY AND HEROIN USE

There are four ways in which drug use and crime may be related:

a. By possessing or using heroin, which is proscribed by law, a person is committing a crime. Associated offences of importing and selling heroin are crimes for the same reason (crime defined by heroin).
b. A person may commit an offence as the result of an altered state of consciousness induced by heroin (direct pharmacological effect).
c. Criminal or deviant acts such as prostitution, armed robbery or drug dealing may be committed in order to obtain money for the purchase of heroin (income generating crime).
d. Heroin use is an expression of a deviant lifestyle in which crime already figures (crime breeding heroin use).

a. Crime defined by heroin use

While several indicators of officially recognized heroin usage amongst women in NSW will be examined later in this report, overseas data provide a preliminary picture. Silverman (1982) reviewed studies of female criminality in the United States based on Uniform Crime Reports from 1965 to 1977. He noted that arrest rates per 100,000 for narcotics violations rose from 17.7 to 109.9 over the twelve year period. At the same time the arrest rate per 100,000 for male narcotics violations rose from 117.3 to 700.1. Arrests for narcotics offences remained a small percentage of total arrests, although for females narcotics arrests rose from 1.4% to 5.8% of total arrests and the corresponding increase for males was from 1.0% to 6.4%.

Does this change reflect increased use of narcotic drugs, hardened public attitudes towards heroin use or increased police efficiency in apprehending drug offenders? Silverman suggested that all three reasons were applicable:

> "Increases in arrests for both adults and juveniles for drug violations reflect changing patterns of substance abuse among both adult and juvenile populations combined with changing public attitudes and official policies toward the use of these substances" (1982, p. 170).

b. Direct pharmacological effect

While it is a plausible theory, there is little evidence that the effects of heroin produce violent crime, although Sandhu claimed that "use of narcotics and alcohol, alone or in combination, was associated with more than two-thirds of all violent deaths in New York City between 1974 and 1975, according to medical examination data (1981, p. 297)". However Dobinson and Ward (1984) cited research suggesting that violence within the drug dealing situation was increasing.

This may not be true of female users or female users may suffer from different kinds of violence (such as sexual violence) in their negotiations for drugs. Goldstein (1979) reported that 39% of the heroin addicts in his sample had resorted to drug bartering, exchanging sexual favours for drugs. He noted that these women often became prostitutes in order to support increasingly expensive habits. However, he did not examine the question of whether violence occurred in these dealings, nor whether any violence which may have occurred was a direct pharmacological effect of heroin.

c. Income generating crime

James, Gasho and Wohl (1979) interviewed 268 women classified into four groups: addicts, prostitute addicts, prostitutes and female offenders. When data based on 134 addicts and addict-prostitutes, reporting a minimum of 6 months' usage of narcotics, were separated from data based on the two non-addict groups, the following emerged:

1. 69% of addicts' total income was reportedly derived from illegal sources such as drug sales, prostitution or stealing.
2. 66% of their total income was spent on narcotics, both for personal use and for resale.

They concluded that there was a significant link between female criminal activity and female drug involvement with drug sales and prostitution the major means of support for heroin addicts.

Two further studies of prisoners will be examined for evidence linking crime with support of a drug habit. Weitzel and Blount (1982) interviewed 176 female prisoners, a random 38% sample of the only women's prison in Florida. They found that 48% of the women used a wide range of drugs at least weekly or a single drug daily, while 27% were daily polydrug users. Only 42% of women in the latter category reported that the offence resulting in their present incarceration was drug motivated, while 24% of lighter drug users reported a drug related instant offence. However the researchers did not distinguish between types of drugs used. They concluded that future studies should at least separate users of alcohol from other drug users in trying to establish patterns of behaviour related to drug use. It would seem appropriate to distinguish heroin users also, since James et al (1979) found that

"only heroin appeared to be closely associated with crime committed to purchase drugs" (p. 225). Other drugs used recreationally such as cocaine, marijuana and hallucinogens, or habitually such as stimulants and sedatives usually lack the narcotics' "physical imperative for use" (p. 227).

The most recent study of the relationship between drug use and property crime in NSW was conducted by Dobinson and Ward (1984). They used self report data from 225 prisoners, including 15 females, convicted of property offences and carefully distinguished between types of drug and levels of usage. Most of their reported data related to 78 daily heroin users who had consumed a minimum of one weight gram of street pure heroin per week during the six months' period prior to their arrest. The heroin users comprised 88% of reported drug users and 40% of the prisoners interviewed.

Major findings relating to the heroin users were:

a. 92% obtained drugs by cash purchase;
b. 55% sold heroin, with profits largely converted to drugs for personal use;
c. 90% stated that their current offence was motivated by the need for cash to buy heroin;
d. 78% reported that their main source of income was property crime.

All of these studies suggest that for heroin users identified as criminal through contacts with police, courts or prisons, money for their drug habit was regularly obtained through crime. Female users reported patterns of prostitution, drug sales and some larceny as sources of income whereas male users were more likely to commit burglaries, armed robberies and frauds.

d. Crime breeding heroin use

Although it is clear that heroin users often commit crimes in order to obtain money for drugs, it has been argued that criminality usually precedes regular heroin use. Thus, it is held, heroin addiction intensifies an existing pattern of deviancy rather than motivating criminal behaviour in otherwise law abiding people. If it is generally true that people committed to a criminal lifestyle become heroin users, then treatment for drug addiction may not eliminate criminal behaviour, and intervention from various parts of the criminal justice system may be required.

Data supporting the contention that heroin use is an outgrowth of criminality come from various sources but must be carefully evaluated with reference to methodology. In the study previously cited by James et al (1979) it was found that:

a. 43% of the addicts were regular users of drugs as juveniles;
b. 51% of the addicts reported juvenile arrests;
c. 32% cited drug involvement in their juvenile arrests;
d. there was a temporal sequence from first drug use to first narcotic use to addiction and then to first adult arrest.

Drug use was not a factor in most juvenile arrests, they suggested, nor was it causally related to juvenile crime. Moreover the types of crimes committed as adults largely depended on the women's experiences and skills, with criminality extended to support their drug habit.

While this was a well-defined, thorough study it was nonetheless based on females located through their involvement in the criminal justice system. The results may be generalized to other women with criminal records but not necessarily to street addicts. This is particularly true of inferences about cause-effect relationships between heroin use and criminality, as Potteiger's (1981) study of 942 heroin addicts suggested that "captive" addicts were more likely to have been involved in crime before drug addiction than non-incarcerated addicts.

Studies of criminality amongst female street addicts are rarely reported. Inciardi and Chambers (1972) found in a study of 52 female New York addicts undergoing treatment that forty-five reported past illegal acts other than drug purchase or use. Again, this indicates a very strong link between narcotics use and criminality. Yet methodological factors limit the generality of their findings. As Dobinson and Ward (1984) pointed out, the treatment facility surveyed in this study (NACC) dealt largely with convicted persons remanded for treatment, so it was very likely that subjects would have a record of involvement with the criminal justice system.

Yet Hawks studied British addicts who were given regular legal prescriptions for heroin and not a sample derived from the criminal justice system. He found:

> "A significant proportion (approximately 50 per cent) of notified addicts have criminal records which pre-date their drug use and a significant proportion (again approximately 50 per cent) contrive to engage in illegal pursuits of a kind not closely related to their drug dependence though they are at the time in receipt of a prescription" (1976, pp. 170-171).

Australian research into the criminal records of narcotics users has largely focused on samples already located through convictions or imprisonments. Dobinson and Ward (1984) studied incarcerated property offenders who were regular heroin users. They found that 71% reported committing property crime before first using heroin and the majority committed regular crimes with or after their first or regular use of heroin. In a records study of male and female narcotics offenders, Wardlaw (1981) found that a large proportion of crime committed was an extension of their previous criminal histories. Narcotics users also had more serious criminal histories than cannabis users.

It appears that criminality may well precede regular heroin use for samples identified through their involvement with the criminal justice system. This may also be true of about half of the "street addict" samples receiving regular legal prescriptions of heroin in Britain. However these samples are unlikely to be representative of the total population of heroin users in Australia and hence the findings should not be used to support broad policies assuming that most addicts are

criminally deviant.

3. THE PROVISION OF ASSESSMENT AND TREATMENT PROGRAMMES FOR WOMEN HEROIN USERS CHARGED WITH NARCOTICS OFFENCES OR OTHER MATTERS IN NSW

A comprehensive review of assessment and diversionary programmes for females arrested on drug charges in NSW can be found in the Report of the NSW Task Force on Women in Prison (1985). A brief summary of their material and findings will be given.

In 1977 a drug diversionary programme was established in an attempt to direct drug offenders into helpful programmes other than traditional criminal sanctions. After a review of this scheme in 1979, the Drug and Alcohol Court Assessment Programme (DACAP) was established with the major aim of providing magistrates with information that would assist them in the sentencing of drug offenders. The service operates in central Sydney, northern Sydney (Chatswood) and a western area (Westmead). It was suggested that DACAP has resulted in better understanding and liaison between courts, probation and parole officers and health services dealing with drug users and the extension of DACAP to all courts dealing with drug offenders in NSW was recommended.

If a non-penal sanction is considered appropriate, the sentencer may place the offender on a bond, on the condition that she undertake specific treatment. The Task Force Report commented:

> "At present, the only facilities exclusively available to women are "Women's Place" (a crisis centre located at Kings Cross which refers women to detoxification programmes) and Kamira Farm (a residential therapeutic community in Wyong). Other programmes have acknowledged the particular needs of women by introducing women's groups; for example, WHOS, Odyssey House, Selah Farm (a residential therapeutic community at Berkeley Vale run by the Salvation Army as part of its William Booth Institute Programme) and Grantham House (a residential programme for Aboriginal women at Burwood)".

Some difficulties in obtaining suitable assistance for women included the location of most services in the Sydney area, with little available in country regions and the lack of provision for children or couples in therapeutic communities, especially for women who are the sole providers for dependent children.

The Task Force recommended that all court-ordered treatment should be based on independent assessment, modelled on the DACAP system. Further, it was strongly argued that sentences should not "intrude into the area of treatment" but rather bond the offender to the Probation and Parole Service on condition that she follows a course of treatment.

It was noted that, in contrast to presentencing assessment and diversion programmes, preliminary pre-trial diversion was operating in northern Sydney (Manly) and involving magistrates, police and the drug referral centre. The Task Force recommended that the South Australian pre-trial diversion system be considered for adoption in NSW with due regard to possible infringements of the offender's civil liberties.

4. THE PROVISION OF DETOXIFICATION AND TREATMENT PROGRAMMES FOR FEMALE HEROIN USERS IN PRISON

Although there is considerable information relating to treatment for male drug users in prison, very few studies refer to female addicts. As well as a dearth of research data there is also much debate as to whether treatment for drug abuse should be provided in a prison setting. This section will examine the arguments concerning the provision of drug treatment programmes in prison, outline the major approaches to drug programmes for inmates of both sexes and discuss research findings in the area.

It has been argued that it is futile to attempt to treat imprisoned drug addicts. Newman (1977) summarized this position, which attacks the provision of psychological therapies for addicted prisoners. He pointed out that these 'clients' were not mentally ill and thus not in need of psychotherapy; that involuntary treatments had failed in the past; that there was potential for abuse of staff-client relationships because of the power of treatment personnel over captive clients; that therapists were unable to maintain independence from gaol administration, precluding the establishment of genuine therapeutic relationships and that resources required for gaol treatment programmes should be spent elsewhere.

Instead of gaol-based drug treatment Newman (1977) advocated adequate detoxification, humane custody, inmate education and vocational training and referral to relevant community services. However his main concern was that the possession and use of drugs should be decriminalized.

The basis, then, of arguments against treatment for addicts in prison is that addiction is not a psychological disorder but rather has its roots in external social factors. Ramsay (1977) elaborated this theme in her discussion of programmes for imprisoned female addicts. She argued that drug taking was a means of coping with a woman's powerlessness in society. Overcoming the problem required, not changing the offender, but changing social structures to give women more power.

A secondary argument against prison-based treatment holds that even if treatment of perceived psychological problems is commenced, it is doomed to fail because of the conflict between prison security requirements and the ethics of therapy. For example, treatment staff usually lack autonomy and control over treatment factors, while confidentiality may be subordinated to disseminated information to enhance security (Smith, Beamish and Page, 1979).

Nonetheless, opponents of drug programmes in prison advocate humane detoxification procedures for people under the effects of drugs on reception.

Proponents of prison-based treatment generally adhere to a psychological model of drug abuse: they hold that changes to an individual's attitudes, beliefs and values can change relationships, lifestyles and drug taking behaviour. Some may emphasize both psychological and social changes for an individual by advocating additional follow-up programmes to assist with housing, employment and family relationships (e.g. Garner, 1978).

Many different kinds of treatment have been implemented in prisons: drug education, counselling, vocational training, work programmes, self-help groups, marathon groups and therapeutic communities. Most have been described in the literature but few have been rigorously evaluated.

Schmidt, Burchiel and Meyers (1977) reported on a drug education programme at San Quentin State Prison, California. This was a formal, 17 week undergraduate level course on the pharmacology of drug abuse. From an analysis of the assignments and exam papers of fourteen students who completed the course, the researchers concluded that subjects' attitudes towards drugs had changed in a positive direction. However this was not a controlled research programme and did not examine the effect of presumed attitude change upon behaviour.

A drug education programme operating in a federal maximum security prison at Edmonton, Canada, was described by Pagliaro (1983). Key activities comprised lectures and discussions on drug abuse, with emphasis on pharmacology, individual counselling and updating library facilities. Pre- and post-test measures of drug usage (past and projected future use) knowledge and attitudes indicated significant positive changes, although the author commented on the dubious reliability and validity of the drug usage measures. Again, the crucial relationship between attitudes to drug usage and actual behaviour was not tested in this study.

In Hong Kong drug treatment programmes were established by statute in 1969 for persons sentenced to detention for a period between 6 months and 18 months in addiction treatment centres (Garner, 1978). Regular work, especially of a physical nature, involvement in community projects and strengthening of family relationships were considered central components of the programme which included a twelve-month after care component. Success on the programme was defined in terms of the offender being drug free, in stable employment, with good family relationships and no further offences on record. A three year follow-up study found a 39% success rate for males, with insufficient numbers of women completing the three-year period for firm results. An obvious weakness was the descriptive nature of this report: there were no comparisons with either a control group or expected recidivism figures for the treatment group.

The Special Narcotics Addiction Programme (SNAP) is a voluntary, self-help group for prisoners in Massachusetts similar in concept to Alcoholics Anonymous. In a twelve month follow-up of 84 SNAP participants and 46 mixed drug users who did not join the programme Callahan (1971) found no significant differences in recidivism rates. However when a sub group aged 18 or more at time of first arrest was examined it was found that SNAP recidivism rates (23%) were significantly lower than those of the control group (55%). The author concluded that the SNAP programme was effective for those not too deeply involved in drugs or criminal behaviour. However the findings must be treated with caution since the control group tended to be older than the SNAP group and to have experienced more arrests for drunkenness.

The four studies examined above dealt with education, work and self help in structured programmes which were not rigorously evaluated. The next three projects to be discussed all dealt with intensive counselling and therapy provided by professionals within a prison setting. Most were descriptive, and where research was attempted it evidenced serious methodological problems.

Page, Smith and Beamish (1977) described an unstructured therapeutic community for drug users in the Florida Women's Prison. The aims were for residents to solve personal problems contributing to drug abuse and to improve interpersonal relationships. Programme activities included house meetings, drug education, art, yoga, meditation and a range of therapies: group counselling, reality therapy, Gestalt therapy and, on a bimonthly basis, marathon groups. Although no comprehensive evaluation was undertaken, the writers reported that programme staff felt that residents had learned to relate more effectively with each other.

Page (1980) described in detail processes taking place in a series of 16 hour marathon groups which he conducted as part of the drug therapy. The aim was to develop less manipulative lifestyles. Open-ended questionnaire responses indicated that participants reported acceptance and security in expressing themselves honestly, but long term effects of intensive group sessions could not be assessed.

Therapeutic communities have been established for drug users in Swedish prisons, with little emphasis on psychotherapy (Edholm and Bishop, 1983). Key features of programmes operating in prisons for males and females were a formal contract in which the inmate agrees to abstain from drugs and accept frequent urine tests, personal responsibility within the unit, training in social life skills and graded release including weekend leave and work release. Although the first unit was established in 1978, no formal evaluation has been published. However Grunewald (1984) noted that "only one of 25 inmates released during the last year has relapsed" and this rate was "considerably lower than that of traditional prisons" (p. 41).

The most thoroughly researched study of a therapeutic community for heroin addicts in prison, reviewed for this project, described the Wharton Tract Narcotics Treatment Programme and analysed data on 1600 inmates experiencing the programme of over the period 1970-1977 (Platt, Perry and Metzger, 1980). Male addicts, aged 19 years and over, participated in

group therapy (guided group interaction and interpersonal problem solving group therapy), took personal responsibility within the unit, made self evaluations, experienced peer review and graded release.

Psychological change was measured by pre- and post-test questionnaires. Compared with a control group of subjects meeting all admission criteria for the programme but not experiencing treatment, participants showed greater resistance to conformity, more personal control and decreased sensation seeking. A two year follow-up on parole revealed that participants had significantly fewer arrests, a lower re-commitment rate, slightly higher use of community drug treatments and lower use of heroin, as perceived by parole officers, than control subjects.

These are promising findings, but methodological problems raise some doubts about their usefulness. The control group was not randomly assigned and selection biases may have been operating to make participants "better risks" for the programme and for release. Although 1600 inmates experienced the programme, only 48 participants and 18 control subjects completed the psychological questionnaire and it appears that only 10% of the sample was assessed on parole. No indication was given of the representativeness of these samples. Finally, it should be noted that all evaluations of new programmes may be biased by the "Hawthorne effect", reflecting the optimism, energy and commitment common to the initial stages of any venture.

It can be concluded that all of the programmes reviewed above - educational, vocational, self help and therapeutic community - appear to have some beneficial impact on drug users in prison. With multi-faceted therapies such as the community approach it is impossible to isolate those features which contribute most to positive change. In all of these areas rigorous evaluative research is essential for substantiating and clarifying initial favourable claims.

5. THE PROVISION OF TREATMENT PROGRAMMES AND FOLLOW-UP CARE FOR FEMALE HEROIN USERS AFTER RELEASE FROM PRISON

There is little emphasis in the literature on the needs of women drug users after release from prison. The Women in Prison Task Force noted lack of money, unemployment and high housing costs as major problems for women wishing to break away from drug involvement. Half way houses offering supportive staff and information were advocated, as well as accommodation for women with children.

Similarly Garner (1978) emphasised after care in his discussion of Hong Kong programmes. Both half way houses and social clubs for leisure activities were available to drug users on release from prison.

6. THE METHADONE VS TREATMENT CONTROVERSY

Methadone, a synthetic narcotic, was first used for the treatment of heroin addiction in 1964 (Dole, Nyswander and Warner, 1968). Currently, there are three ways of using methadone: withdrawal, in which the patient receives a dosage of 40mg daily, decreasing to nil over a 4 to 8 week period; maintenance, where the daily dose varies between 30mg and 80mg and blockade in which the daily dose exceeds 100mg (Dalton and Duncan, undated a).

In essence, the latter procedures involve establishing tolerance to the drug by gradually increasing doses of methadone until the desired daily dosage level is reached. A constant oral dose then eliminates narcotic drug hunger "presumably by maintaining a blockade of the sites of narcotic drug action" (Dole et al, 1968, p. 2709). However in a review of the physiological action of narcotic drugs (including methadone), Helmer pointed out in 1977 that the exact biochemical mechanisms underlying tolerance and addiction were still unknown.

During withdrawal from heroin, daily or more frequent doses of methadone given over a 7-10 day period can reduce the severity of the primary withdrawal syndrome which is characterized by restlessness, irritability, opiate craving, sweating, muscle spasms, nausea, insomnia and "gooseflesh". However secondary withdrawal, comprising high blood pressure and body temperature together with anxiety may continue for another 2 or 3 weeks and a terminal withdrawal stage marked by lowered blood pressure and body temperature may be present for up to 30 weeks (Sandhu, 1981). It appears that chemically assisted detoxification programmes, of themselves, have had little success in overcoming long term narcotic addiction, but they have a major role to play in crisis intervention and referral to both social service and drug treatment agencies (Sandhu, 1981).

While there is some controversy over the desirability of using methadone for slower, less intense withdrawal in contrast to 'cold turkey' or symptomatic treatment only, there is heated argument over the use of methadone as a long term treatment agent. Thus methadone treatment programmes will be described and evaluated in some detail followed by a review of two major studies comparing methadone and therapeutic community programmes.

a. Characteristics of methadone treatment programmes

The distinction between methadone maintenance and blockade has been linked to an underlying orientation of change versus adaptation. In maintenance programmes addicts are given lower daily doses and structured therapy with the aim of eventual unsupervised, drug free life in the community. Blockade programmes, on the other hand, use higher doses of methadone with counselling and support services designed to assist the addict live a heroin and drug-free life while receiving methadone indefinitely. Both types of programmes are referred to as "methadone maintenance treatment" in the literature.

While details of admission criteria and programme features vary it is common for selection to be:

1. voluntary (not a condition of a court order);
2. based on narcotic addiction of at least two years;
3. restricted to adults (at least 18 years of age) with no major medical complications;
4. preferred for those who had previously participated in other treatment programmes without long term success.

The programme itself is usually conducted on an outpatient basis. After a thorough medical examination, patients are gradually brought to tolerance through increasing daily doses of methadone administered orally. Urinalysis must be undertaken on specified visits to the clinic. In most programmes patients are permitted to take home weekend doses of methadone after a qualifying period, with contact tapering to twice weekly visits following sustained progress over one or two years.

Common side effects of the treatment are constipation and reduced libido in males, usually disappearing after a few months. Short term effects also include analgesia and respiratory depression. Persistent side effects for up to 10% of patients comprise excessive sweating and drowsiness, although the latter may be relieved by reduction in dosage (Dole, 1971). On a positive note it has been found that patients given maintenance doses do not differ from the general population in cognitive functioning and intelligence. In summary, results of twenty years of clinical observation and research indicate that methadone is relatively safe and without serious side effects (Sandhu, 1981). By 1976 about one-third of drug users in treatment in the U.S were on methadone maintenance (Sandhu, 1981).

b. Research on methadone programmes

The outcome of methadone programmes can be evaluated at a number of levels. Specifically, success may be measured by:

1. retention on the programme over a defined period;
2. abstinence from other narcotic drugs while on the programme;
3. improved social functioning indicated by employment stability and better social relationships;
4. reduction in criminal behaviour;
5. abstinence from all drugs including methadone, a criterion applicable to change oriented programmes only (Dalton and Duncan, 1976).

Retention rates for methadone programmes vary according to the period of study and whether a population or sample of traceable cases is used. According to Sandhu (1981) a two-year retention rate for the New York methadone programme was similar to rates achieved by other programmes studied before 1974. However he suggested that later figures were somewhat lower. A study of 50 addicts placed on methadone blockade in NSW under the Wistaria pilot project found that 65% of patients traced (56% of the population) remained on the programme for the recommended three years (Dalton and Duncan, undated b). However not all programme dropouts are necessarily failures since one study of 112 dropouts found that 65% were either drug free or on methadone at another programme one year later (Boudouris, quoted by Sandhu 1981).

The consistent use of heroin, detected by urinalysis, is viewed as a programme failure for patients undertaking methadone maintenance. Wilmarth and Goldstein (quoted in Sandhu, 1981) reported a decline in heroin use to 18% of initial use by people admitted to the Californian methadone programme. However the total proportion of heroin free patients was not recorded. From the Wistaria project Dalton and Duncan (undated b) reported that 75% of the patients traced (54% of the population) were drug free, apart from prescribed methadone, after three years. Yet caution must be exercised in interpreting these figures since there is a high error rate with urinalysis for determining heroin use.

The measure of social functioning is even more difficult. Some researchers use global definitions, such as "leading reasonably happy and productive lives". At an eight year follow up 70% of the Wistaria project group traced (60% of the population) fulfilled this criterion (Dalton and Duncan, undated b). Others use some measure of increased employment, with widely different results depending on the methodology (e.g. Bloch, 1977).

The impact of methadone programmes on criminality is usually assessed by changes in arrests or convictions following treatment. Dole et al (1968) reported a 90% reduction in crime by patients in methadone treatment, while Dalton and Duncan (undated b) stated that 65% of their traced sample had recorded no new criminal convictions. After a review of U.S. research Sandhu concluded that "the results unanimously indicate a favourable impact on criminality by methadone maintenance treatment though the magnitude of this impact is a matter of dispute" (1981 p. 318).

Many methadone programmes aim for adaption of the user to a drug free life whilst taking methadone by prescription. Programmes which aim for eventual withdrawal from methadone hold that a completely drug free life is possible although difficult. Dole's initial study did not incorporate a long term phase of complete drug withdrawal, while Dalton and Duncan (undated b) reported that only 28% of her traced sample were free from all drugs at the eight year follow-up. Other studies give relatively low rates of success in achieving drug-free living. Stimmel (1977) found that only 35% of patients were narcotic free after varying periods of up to 6 years, but success largely correlated with reason for termination, with those completing as a mutual staff patient decision having over 80% chance of success.

This very brief review of some of the research evaluating methadone programmes suggests that promising results may be achieved during programme participation and that, for those who complete a change-oriented maintenance programme satisfactorily, successful drug-free living is highly probable. However these can only be tentative conclusions because of methodological differences between studies and lack of rigour in defining and measuring key variables.

c. Research comparing methadone maintenance with therapeutic communities

Some of the difficulties in comparing different therapeutic community programmes and different methadone programmes have already been noted. Where comparisons between different types of treatment are made, the problems are confounded by initial differences between the types of individuals selecting each programme mode, discrepant treatment aims and varying emphases (Bale et al, 1980). However it is important to review comparative data, whilst acknowledging these very real difficulties.

Sandhu (1981) drew several conclusions from his analysis of comparative research:

1. Length of stay and treatment completion correlated highly with successful outcomes in both programme types.
2. Favourable performance during treatment was highly correlated with favourable pre-treatment history (including criminal record).
3. Methadone patients had treatments of longer duration.
4. Methadone patients had greater improvement in criminal behaviour than those in therapeutic communities.
5. Those in therapeutic communities were more likely to achieve drug abstinence than those on methadone.

In an attempt to minimize uncertainty due to inadequate methodology Bale et al (1980) designed a prospective, controlled study of methadone maintenance and therapeutic communites, measuring the five major indices of success listed above for methadone with a total sample of 585 people. Random assignment of subjects to different treatments after detoxification was compromised by unwillingness of some subjects to experience treatment (22% of original sample), failure to qualify for methadone maintenance under FDA guidelines (47% of "willing" group), failure of 54% of the "willing" group actually to enter treatment and the fact that only 24% of those expressing a desire for treatment entered the programme to which they had been randomly assigned. However in terms of personal and drug histories, members of the different treatment groups were very similar. Major findings comparing methadone with therapy will be noted under key headings for ease of reference.

Retention

The retention rate over 1 year for methadone maintenance was at least two-thirds whereas only 3 subjects remained in a therapeutic community after 12 months.

Drug use

There were no significant differences between the two groups in their use of heroin and other drugs in the month prior to the twelve month follow up.

Social functioning

The two groups did not differ significantly in their participation in work or education at follow up.

Criminal behaviour

The two groups did not differ in rates of arrests or convictions over the year.

Length of treatment

For all subjects, time in treatment was strongly related to outcome. In particular those who spent more than seven weeks in a therapeutic community or who were in methadone treatment were more likely to be employed or in a course and less likely to be in gaol, arrested, convicted or using drugs. Moreover long term therapeutic community subjects (empirically divided at 50 days as the median length of treatment) performed better than the methadone group across all variables, but those who spent less than 50 days in therapeutic community treatment performed no better than subjects in a "no treatment" group.

In short, this study suggested that length of treatment was the key factor in overcoming heroin addiction. Methadone maintenance programmes tended to retain subjects for long periods, whereas therapeutic communities had high attrition rates. Those who managed to stay in therapy performed well, but short exposure to therapeutic community treatment had very little effect. However the effects of different kinds of therapeutic communities (confrontation style, staffed by ex-addicts, group versus individual counselling) or different types of addicts was not addressed in this report and the combining of different approaches into "short term" and "long term" categories depending on retention may have masked important programme variables and interactions between types of programme and retention levels.

Conclusion

This section has examined methodological problems and six major issues related to drugs and female criminality. It has been argued that the usefulness of research findings has been seriously limited by weaknesses inherent in the available strategies and lack of comparability between studies. However some tentative conclusions may be drawn.

Prevalence

In 1980 there were possibly several thousand female heroin users in NSW, but numbers may have increased over the last five years.

Heroin-crime relationships

It is reasonably clear that the relationship occurs by definition of heroin use as illegal and because the high cost of heroin results in crime to support the habit. It is possible that crime may have been committed before the regular use of heroin, so that heroin use represents an extension of an already deviant lifestyle, at least for those processed by the criminal justice system.

Diversion

There is limited pre-sentence diversion for female drug users and a pilot pre-trial diversion programme is operating in NSW.

Prison treatment

It has been argued that prison treatment for heroin use is both inappropriate, since the roots of addiction are social rather than psychological, and doomed to failure because of insuperable administrative difficulties. However there are some promising findings from research into prison-based educational and psychological treatments, although these must be considered tentative through lack of rigorous evaluation.

Follow-up

Researchers have virtually ignored the issue of follow-up and treatment for female heroin users released from prison.

Methadone compared with therapeutic communities

While both approaches have strong supporters and critics, it appears that each has its place in the range of treatments for heroin users. Methadone, which requires careful administration, appears to be a relatively safe drug which is suited especially for those who wish to reduce their criminal behaviour without necessarily aiming for abstinence from drugs. Therapeutic communities appear to be a valuable option for those willing and able to remain in treatment for several months, aiming for total abstinence. The relative merits of these approaches for imprisoned female heroin users will be discussed later.

AIMS

This report developed from a wide-ranging interview study of the backgrounds and experiences of a population of women prisoners in NSW. The specific objectives of this report covered three major areas.

1. To compare record characteristics of heroin users in prison with those of non-users, with reference to prevalence and the heroin-crime relationship.
2. To contrast the experiences of imprisoned heroin users with non-users.
3. To assess the needs of heroin users in gaol, including needs for diversion, detoxification, treatment and follow-up.

METHODOLOGY

Published record data were used to depict trends in the conviction and imprisonment of females for illegal drug offences. However these do not reflect all drug users in prison, since many are received for non-drug offences. The police records of all women in prison under sentence on 30 June 1984 were examined to identify those women with any indication of drug use in their histories: those with any past drug conviction were compared with women having no record of drug offending on the variables age, current offence, sentence and past convictions.

Interview data were used in the assessment of the needs and experiences of female heroin users in gaol. Their responses represented a re-analysis of information obtained for the NSW Women in Prison Task Force. In a comprehensive study of women in NSW prisons, 90 interviews were completed with female prisoners serving sentences at the two prisons accommodating women offenders in August 1984. Those interviewed comprised an 84% sample of the total population of sentenced women in prison. The remainder declined to be interviewed or left the prison before interviews could be completed.

Within the interview schedule a series of questions related to drug use and attendance at treatment centres. Eighty-nine women answered these questions. Other areas covered in the interview and related to the current imprisonment were: accommodation, food, clothing, medical services, counselling, discipline, general conditions, alternatives to prison, effects of imprisonment, care of children, courses, work, sports and recreation and a demographic section including migrant status, languages spoken, schooling, occupation, marital status, housing and income prior to imprisonment.

1. Court statistics on drug offences in NSW

Males and females convicted of drug offences at NSW Courts of Petty Sessions

Year	Females	% of Total Drug Conv.	Males	% of Total Drug Conv.	Total
1976	555	11.8	4152	88.2	4707
1977	588	13.4	3841	87.7	4379
1978 (a)	575	15.0	3263	85.0	3838
1979	597	14.2	3613	85.8	4210
1980	664	14.0	4085	86.0	4749
1981	880	14.7	5111	85.3	5991
1982	871	13.6	5547	86.4	6418
1983	955	13.7	6008	86.3	6963

Source: Court Statistics, Published by the Department of Attorney General and of Justice, NSW Bureau of Crime Statistics and Research.

(a) Prior to 1978 figures refer to distinct persons convicted. From 1978 onwards figures refer to total convictions.

RESULTS

A. DRUG ABUSE AMONGST WOMEN PRISONERS: THE SIZE OF THE PROBLEM

Since 1976 total convictions for drug offences increased by 48%. Although the increase in females convicted of drug offences over this period was 72%, it appears that the dramatic rise in convictions is due to the relatively low base rate of female convictions in 1976 compared with male drug convictions. In fact, female drug convictions as a proportion of total drug convictions remained relatively stable, varying only between 12% and 15% over the period.

While total receptions into prison under sentence declined from 11,538 in 1970-71 to 7,738 in 1979-80, a decrease of 33%, the number of people received into prison under sentence for drug offences more than tripled over the same period.

However receptions of female drug offenders under sentence increased fivefold over the decade. By 1980 female drug offenders comprised 17% of the total number of female receptions under sentence, representing the third largest offence grouping after property offenders (25% of receptions) and driving offenders (22% of receptions).

During the three census years the numbers of prisoners whose most serious offence was drug related remained steady at around 390, comprising 11% of the total population of prisoners on 30th June. However the proportion of female drug offenders decreased from 33% to 22% over this period. It appears that this decline was largely balanced by an increase in the proportion of female property offenders, from 28% in 1982 to 43% in 1984.

Using Past Record Data To Distinguish Drug Offenders

While it appears that about 17% of female receptions under sentence and 26% of all female prisoners in gaol on any day are serving a sentence with drug-related crimes as their major offence, these figures do not indicate the total level of drug offences amongst women in prison. It is necessary to include all drug offences in the analysis, not just those drug offences resulting in the longest sentence and thus defined as the most serious offence.

2. Receptions into prison under sentence for drug offences 1970-1980

Note These are prisoners whose most serious offence was a drug offence. The figures do not include persons convicted of a drug offence in addition to a more serious offence.

Year	Females		Males		Total
	Number	% of total receptions	Number	% of total receptions	
1970-71	13	1.7	134	1.2	147
1971-72	13	1.6	142	1.2	155
1972-73	13	1.8	167	1.6	180
1973-74	8	1.9	198	2.4	206
1974-75	13	3.1	300	3.8	313
1975-76	35	8.0	445	5.6	480
1976-77	49	12.3	459	6.0	508
1977-78	a	a	a	a	a
1978-79	77	14.1	528	6.2	605
1979-80	65	16.8	429	5.8	494

Source: *Court Statistics* published by the Australian Bureau of Statistics
a. Figures not available.
Note: No data were available after 1980.

3. Prisoners in custody on 30th June with drug offence as most serious conviction

Year	Females		Males		Total	
	No.	% of prisoners	No.	% of prisoners	No.	% of prisoners
1982	45	32.8	344	9.6	389	10.5
1983	46	25.3	346	9.7	392	10.5
1984	36	21.7	351	11.0	387	11.5

Source: National Prison Census

Note: These figures include both sentenced and unsentenced persons in custody.

For the population of 103 women in prison under sentence on 30th June 1984 it was found that 28 women (27%) had current convictions for drug offences. For 11 women drug-related activities comprised their only offence while another 17 women had committed both drug and non-drug offences for which they were serving a term of imprisonment. Moreover 62 women (60%) had a record of drug offending when both current convictions, leading to imprisonment on 30th June 1984, and past convictions, resulting in a sentence prior to the current episode, were considered.

Of these 62 women, sixteen (26%) had both past and current drug convictions, twelve (19%) had current drug convictions only and thirty-four (55%) had had only previous convictions. It is possible that some of the women with past drug offences only could have been convicted of a property offence in their current episode, motivated by the need to obtain money for drugs. While record data cannot elucidate this problem interview data can provide further information. This issue will be raised later in a discussion of data obtained from women in prison in August 1984 admitting to a regular heroin habit prior to their imprisonment.

When past and current record data were considered together it was found that only six women were homogeneous drug offenders with drug offences only on their records. The 56 "mixed" offenders largely committed property crimes such as break, enter and steal, stealing, forgery, robbery in addition to drug offences (51 cases) or had committed additional prostitution offences (15 cases, most of whom had also committed property crimes).

In an attempt to examine whether drug dependency leads to a criminal lifestyle or whether the other criminal behaviour precedes drug dependency, the conviction sequences of the 62 women who had received any past or current drug offence were examined. Almost half (44% or 27 women) had been convicted of drug offences prior to any other conviction, if any, while 35 women (56%) had been convicted of other offences before any drug convictions appeared on their records.

B. AGE AND CRIMINAL RECORD DATA RELATING TO DRUG OFFENDERS

Both census data and past record data were examined to determine whether women with past or current convictions for drug offences differed from women with no record of any drug offending. Sixty-two women (60%) had one or more drug-related conviction.

a. Age

Table 1 Age category by any drug conviction

Age	No drug convictions	Any drug convictions	Total
Under 25	14	24	38
25-29	9	25	34
30 and over	18	13	31
	41	62	103

$x^2 = 6.9722$ df = 2 p< .05

There was a slight tendency for drug offenders to be over-represented in the 25-29 years age group and under represented in the 30 years and over age group.

b. Most serious offence (M.S.O.)

Table 2 Most serious current offence by any drug conviction (excludes drug offences as MSO)

Most Serious Offence	No drug convictions	Any drug convictions	Total
Homicides, assaults etc	13	3	16
Robbery	6	10	16
Fraud	6	10	16
BES	5	10	15
Steal and minor offences	11	13	24
Total	41	46	87

$X^2 = 9.829$ d.f. = 4 p< .05

Sixteen women had been convicted of a drug offence as their most serious current offence and were excluded from this table. The MSOs of 46 women who had past drug convictions or current drug convictions resulting in shorter sentences than another current conviction were compared with the non-drug offenders. Drug offenders were more likely to have committed robbery, fraud or BES as their MSO whereas non-drug offenders were more likely to have committed homicides or assaults.

c. Aggregate sentence by any drug conviction

There was no significant difference in sentence lengths for drug and non-drug offenders.

d. Number of past convictions

Drug offenders were more likely to have had at least one prior conviction than non-drug offenders.

Table 3 Past convictions by any drug conviction

Past convictions	No drug convictions	Any drug convictions	Total
Nil	13	8	21
One or more	28	54	82
Total	41	62	103

$X^2 = 4.2802$ df = 1 p< .05

e. Length of criminal career

There was no significant difference in length of criminal career (excluding first offenders) for drug and non-drug offenders.

In addition to comparing drug offenders as a group with non-drug offenders, some analyses were performed on sub-groups of drug offenders: those who had been imprisoned in the past for drug offences ('serious' group) and those who had been given

non-penal sanctions in the past for drug offences ('mild' group). Sixteen women were identified as 'serious' drug offenders and 46 women as 'mild' drug offenders.

There were no significant differences between 'serious' and 'mild' drug offenders in birthplace, marital status or aboriginality. However there was a slight tendency for the 'serious' drug offenders to be older than the 'mild' drug offenders and for 'serious' drug offenders to have had a criminal career spanning 6 years or more while 'mild' drug offenders were evenly divided between shorter (up to 5 years) and longer careers. (With small numbers it was not possible to establish the significance of these differences.)

C. OTHER DEMOGRAPHIC CHARACTERISTICS OF HEROIN USERS AND NON-USERS IN PRISON

Data in this section were derived from interviews conducted with female prisoners in August 1984.

a. Education

Table 4 Last year of schooling completed

	Non-users		Heroin users		Total	
	No.	%	No.	%	No.	%
Primary	3	9.7	-		3	3.3
Junior High (years 7-9)	17	54.8	30	50.8	47	52.3
Senior High (years 10-12)	11	35.5	29	49.2	40	44.4
TOTAL	31	100.0	59	100.0	90	100.0

There was a slight, but non-significant tendency for heroin users to have reached a higher level of schooling than non-users as Table 4 indicates.

b. Employment at arrest

The majority of women in the survey (79%) stated that they were unemployed when arrested. Unemployment was more common amongst heroin users (85%) than non-users (68%) but these differences are not statistically significant. The eight heroin users who gave employment details, worked as cooks (2), in massage parlours (2), acting (1), doing factory work (1), selling handcrafts (1) and "for a newspaper" (1).

c. Marital Status

Table 5 Prior and current marital status (%)

	Non-users No.=31	Heroin users No.=59	Total No.=90
Never married			
- prior to gaol	32.3	42.4	38.9
- while in gaol	38.7	49.2	45.6
Married or de facto			
- prior to gaol	48.4	45.8	46.6
- while in gaol	35.5	32.2	33.4
Divorced, separated or widowed			
- prior to gaol	19.1	11.9	14.4
- while in gaol	25.8	18.6	21.1

Differences in marital status between the two groups were slight. Before entering gaol, almost one half of the women (47%) were married or living in a de facto relationship, whereas only one-third of the women gave their current marital status, at the time of the prison study, as married or de facto. Details may be seen in Table 5.

d. Housing

Almost three-quarters of the women were living in rented accommodation prior to their imprisonment. Only about one third of the women stated that they would be able and willing to return to their former accommodation. Differences between heroin users and non-users were slight as the folowing tables illustrate.

Table 6 Accommodation prior to imprisonment (%)

	Non-users No.=31	Heroin users No.=59	Total No.=90
Caravan, no fixed abode	6.5	3.4	4.4
Live with friends, relatives	32	10.2	7.8
Rented room, flat, house	71.0	71.2	71.1
Owned flat, house	19.4	15.2	16.7
TOTAL	100.0	100.0	10.0

Table 7 Potential for return to former accommodation (%)

	Non-users No.=31	Heroin users No.=59	Total No.=90
Yes, able and willing to return	45.2	32.2	36.7
No, unable, unwilling or unsure	54.8	67.8	63.3
TOTAL	100.0	100.0	100.0

e. Sources of income prior to imprisonment

Although the majority of women (61 out of 90 respondents) disclosed one source of income prior to their imprisonment, 23 women gave two sources and 6 women specified three sources of income. Table 8 below analyses the 125 sources of income specified by heroin users and non-users.

A little under half the income sources were social service benefits (43%) while in almost one-quarter of cases an illegal or fringe activity such as prostitution, drug dealing or stealing was given as a means of financial support.

Heroin users were more likely to cite illegal activities as an income source (32%) than non-users (5%) while non-users were more likely to supplement

their incomes by part-time work or be supported by a partner.

Table 8 Sources of income (multiple responses)

	Non-users		Heroin users		Total	
	No.	%	No.	%	No.	%
Full-time work	8	19.5	12	14.3	20	16.0
Part-time work	6	14.6	2	2.4	8	6.4
SocialService benefits	19	46.3	35	41.7	54	43.2
Spouse, de facto	5	12.2	5	5.9	10	8.0
Illegal activities	2	4.9	27	32.1	29	23.2
Other (e.g. Savings)	1	2.5	3	7.6	4	3.2
Total sources	41	100.0	84	100.0	125	100.0

D. PATTERNS OF DRUG USE AND TREATMENT PRIOR TO CURRENT IMPRISONMENT

Answers to a series of questions related to prior drug use and attendance at treatment centres from 90 women interviewed in August 1984 comprised the basis for the following discussion.

a. Types of drugs used

Over three-quarters of the women interviewed (79%) reported prior drug usage. As can be seen from Table 9, heroin was the drug most commonly reported being used, with two-thirds of the women claiming to have used heroin alone or in conjunction with other drugs. Only 10% of the women reported a regular use of alcohol, while 21% denied using drugs or alcohol.

Table 9 Reported prior drug use

Type of drug	No.	%
Heroin only	23	25.6
Herion and others	36	40.0
Others only (not alcohol)	2	2.2
Alcohol and others	2	2.2
Alcohol only	7	7.8
Don't use	20	21.2
TOTAL	90	10.0

Drugs commonly reported being used in addition to heroin included: cannabis (reported by 24 women), serapax (11), cocaine (8), alcohol (5), "pills" unspecified (5), speed (4), barbiturates (3) and mandrax (3).

b. Length and frequency of use

The majority of women who reported drug usage admitted long term habits with daily usage. Frequency of use was related to "the month around the time of the offence" in order to avoid biases introduced by subsequent court action and custody.

Those who used heroin only had an average usage period of 4 years 5 months with a range of 3 months to 10 years. The majority reported at least daily use during the month around the time of the offence (87%): eight (35%) reported using three or more times per day, three (13%) twice a day, nine (39%) daily and the other three (13%) once every two days.

The 36 women who used heroin in conjunction with other drugs had habits of longer duration: they reported heroin usage for an average period of 7 years 4 months, with a range of 2 months to 16 years. Moreover 94% of these "mixed heroin" users reported at least daily use in the criterion month: nineteen (53%) reported using three or more times per day, four (11%) twice a day, eleven (31%) daily and the other two (6%) twice a week.

Seven women reported using alcohol, but no other drugs. All said that they drank daily and had been doing so from between 3 and 15 years. Since the interview study comprised a broad survey of women prisoners it was not possible to probe deeply into alcohol use and try to distinguish between social drinking and alcoholism, for example.

It was decided to analyse in detail the relationship between heroin use and issues related both to past treatment and current imprisonment. The following data, therefore, are based on replies from the 58 women who reported regular usage of heroin only or heroin and other drugs, and who answered the questions (one woman declined).

c. Prior experience of rehabilitation programmes

Of the regular heroin users who answered these questions, 40 (69%) stated that they had at least started some form of drug rehabilitation programme in the community. Types of programmes experienced, together with percentages of heroin users who had commenced each programme, are presented below.

While detoxification may be completed within a week (that is, the first stage) other programmes may require a longer commitment. Lengths of participation in the various programmes are listed below.

From these two tables it appears that the most commonly used treatment programme was a therapeutic community, experienced by half the heroin users. However just under half of these thirty women left the community within one month of entry and only five women (17%) remained in the community for more than six months. If there is little chance of rehabilitation with participation of less than several months (Bale et al, 1980) then it is clear that most of these women did not have a full opportunity to experience the benefits of a therapeutic community in the past.

Other programmes show a similar pattern. A little under one-third of the users had undergone formal detoxification, but the majority left the centre within seven days. Less than one-fifth of the women had entered a counselling programme and, again, the majority left the programme within one week. Fewer than 10% of the heroin users had been involved in a methadone programme or in Narcotics Anonymous.

Table 10: Type of Rehabilitation Programme Commenced in Community

Programme	Number	% of Heroin Users
Therapeutic Community e.g., West Mount, WHOS, Odyssey House, The Buttery, William Booth Institute, John Knight Centre	30	51.7
Detoxification e.g., Wistaria House, Langton Clinic, McKinnon Unit	17	29.3
Counselling e.g., DC-24, Bourke Street Drug Advisory Centre, Caritas Centre, Kangaroo Valley Rectory	11	19.0
Methadone maintenance/blockade	5	8.6
Narcotics Anonymous (NA)	4	6.9
Other e.g., Eversham Clinic, Riverwood	5	8.6

With small numbers it is difficult to comment on the length of treatment experienced.

In short, almost one-third of the heroin users had not experienced any drug treatment programme. Those who entered a programme were most likely to leave it within a month (61%) while only one in eight remained in treatment for more than six months.

The women who had tried some rehabilitation programmes seemed to fall into two groups: those who had only tried one programme and decided to try no others versus those who had sampled four or more. Among them the women had tried a wide variety of programs. There was a great deal of variability in the length of time different women participated in individual programmes, with a number of the women trying the programmes for only very short periods.

When asked about the longest period of treatment, three-quarters said that they had entered the programme voluntarily. Another 15% entered treatment as part of a sentence or a bail condition, while the remainder stated that friends had motivated them or gave other reasons.

The majority (72%) said that they did not complete the programme. Although these 28 women gave a variety of reasons for leaving the programmes, most frequently these reasons related to specific aspects of the programmes such as being locked up, or being separated from children or boyfriend (20%). Typical comments were:

> "...wasn't what I expected, after being locked up in prison going out for a month and then going somewhere else and being locked up ... just was not what I wanted";
>
> "would have liked to have completed, (they) took child off me, so I left";
>
> "left, I fell in love. Lover came and got me out. Impossible to carry on relationship while in programme because of segregation involved".

Some others said they left because they didn't like the attitudes of the other junkies or ex-junkies there (13%), for example:

> "Too hard to do it with other junkies because they didn't really want to get off it - so I began to follow their lead";
>
> "Run by ex-junkies and couldn't stand being told I was a degrading animal for using drugs by people who had used drugs themselves";
>
> "Lots of people there full of bullshit - run by ex-junkie staff who get stoned while off duty - as well as other people in the treatment programme".

Others simply stated that: they weren't interested or didn't think they were getting anything out of it (17%); couldn't handle being without dope (20%); left because they thought they were straight and had beaten their problem (3%); or came back to gaol (10%). One woman left because she felt she was becoming dependent on the programme. She stated that she:

> "Became dependent on the programme. (We) became programmed robots.

Table 11: Period of time spent in each rehabilitation programme experienced

Programme	Participation Time				
	Under 7 days	7d to 1m	1m to 6m	6m+	Total
Therapeutic community	6	8	11	5	30
Methadone	-	2	2	1	5
Detoxification	9	7	1	-	17
Counselling	6	1	3	1	11
NA	2	-	1	1	4
Other	3	-	1	1	5
Total	26	18	19	9	72
Column %	36.1	25.0	26.4	12.5	100%

Programme is a substitute for drugs. Finish progamme, go back to using. (It's) a form of brainwashing, not enough individuality".

When asked to describe what they considered to be the effects of treatment on their drug use and activities, the majority stated that the "treatment had no effect at all" (33%) or had had only a temporary effect, i.e., "stopped me while I was there, when I left I got back into it" (25%). On a more positive note two said that they had just about terminated their hard drug use, one said that it had helped decrease drug use and stopped her stealing and forging money, and nine (23%) said it made them think about why they use.

Only seven inmates who had tried rehabilitation programmes (12%) thought that the programmes for female users should be different from those for male users. Reasons given included: women generally have children with them; men are often more hardened criminals; women have more emotional problems; drug programmes should not be so hard for them and that women need more support because drug use affects their self image more than it does for men.

d. Experience of Drug and Alcohol Court Assessment Programme (DACAP)

Twenty inmates (34% of those who admitted prior heroin use) reported having been sent to one of the DACAP centres before they were sentenced. When asked what they thought the centre was trying to do there was some confusion. Only about one-quarter (24%) of those who had been referred there knew that DACAP was solely concerned with assessment rather than treatment.

e. Treatment programmes immediately preceding current imprisonment

Seven of the women (12% of those who admitted prior heroin use) were on treatment programmes immediately prior to being taken into custody. These comprised: William Booth Institute, DC-24, methadone treatment and counselling at Bourke Street Drug Advisory Centre, West Mount Co-operative Society Ltd, We Help Ourselves (WHOs) and counselling from a voluntary rehabilitation officer employed by a government agency (the inmate did not know the name of the agency).

None of these women continued treatment in gaol. Three women stated that stopping the treatment had no effect on them. However one said specifically that stopping the methadone programme had affected her badly, while another stated that her inability to participate on the WHOs programme had prevented her from progressing to level 2 as her peers had done.

f. Rehabilitation programmes as an alternative to gaol

Over half of those who had admitted prior heroin use (54%) said that either their solicitor or probation officer had suggested that a drug treatment programme could have been an alternative to imprisonment in their case.

Opinion was overwhelming that gaol is NOT a way of helping addicts overcome their addiction. About half argued either that no treatment was provided in gaol (34%) or that drugs were available in gaol (9%) while 10% gave both of these reasons. The remainder gave a wide range of other reasons in submitting that gaol did not help addicts including:

"Gaol only makes you more bitter";

"While you're in gaol you're not around people who support you or care what happens to you after you get out";

"(Gaol) dehumanises you - dope gives you back confidence"; and

"learn about how to commit crimes while in gaol - gaol doesn't help addicts".

E. ACTUAL AND PROPOSED TREATMENT IN GAOL

a. Detoxification

On arrival at Mulawa, the principal reception prison for women in NSW, female prisoners are interviewed by a nursing sister who decides whether admission to the eight bed hospital annex is required for detoxification. Criteria for admission comprise the woman's report of addiction or presence of physical withdrawal symptoms. Two showers are available for the use of women in the annex. Other women who are ill or pregnant may also be accommodated in the annex.

While undergoing withdrawal from heroin, women often experience cramps, vomiting, dehydration and agitation. These symptoms may be relieved by a hemineurins programme, megavitamins and warm baths. Prisoners withdrawing from barbiturates require hospital observation and anti-convulsant treatment.

Of the 59 women who reported regular heroin usage, 55 had encountered gaol detoxification procedures and only one claimed that these procedures were satisfactory. Over half (53%) suggested that the detoxification procedures could be improved by employing more and better medication and not simply relying on hemineurins, for example:

"By medication especially - definitely not enough and what is given is no good. What is given (hemineurins) cannot be taken by some girls, and there are no alternatives";

"medication should be stronger, hemineurins used mainly for alcoholics";

"give more medication to come down slowly";

"should be able to have methadone, even if only for a few days. This cold turkey business is ridiculous. Someone is going to die".

Some (17%) said that the facilities should be improved, for example:

"(need) better facilities. If you are really sick you want to have a shower, sometimes you have to wait till morning. (There are) not enough toilets";

"(need) more showers. Shouldn't be locked up as much, should be allowed in the sun more";

"should have baths rather than showers";

"should separate pregnant women from those who are withdrawing because it is very disturbing for pregnant women".

It was suggested by some inmates (12%) that counselling could be helpful. Others discussed staffing. Some suggested that more caring people who have been trained in detoxification procedures were needed (9%):

"Have someone who is trained in detoxification - prisoners should be detoxified by ex-addicts".

"Qualified junkies to look after the junkies. Help 24 hours a day for junkies, somebody who is a good listener (maybe ex-addict). More concern and understanding";

"You're really sick, (there is) only one nurse. You're not being taken care of like a sick person. If you're sick you have to clean yourself up".

When discussing staffing, some suggested that prisoners should be able to see a doctor rather than a nurse on admission (7%).

A variety of suggestions were made by other inmates (20%) including:

"There's a place at Katoomba that's supposed to have good detoxification. They should find out how somewhere like that does it";

"(need) proper treatment, proper education, better hospital facilities, more caring people, more sensitive people - a proper detox.";

(Let) addicts have their own section (of the gaol) - till they come down."

Two of the women (3%) said that they did not know how the present detoxification procedures could be improved. (N.B. Percentages in this section add to more than 100% because some prisoners made more than one suggestion.)

b. Treatment

Only three women (5%) stated that they were receiving treatment for their drug abuse at the time of the interview. They claimed to be taking hemineurins (for withdrawal), unspecified medication and methadone plus counselling.

Most of the heroin users stated that they were not being given any treatment (70%) or did not require any (24%). Two women stated that they were taking multi-vitamin tablets.

c. Suggested treatment in gaol

Over one-quarter of the prisoners said that there were no treatment programmes which would be helpful in gaol. This was either because they thought that nothing would work in the gaol setting (17%) or because no programme could work unless they had made up their mind to stop (12%). The most frequently suggested treatment was a methadone programme (21%) or methadone combined with counselling (8%). Others suggested counselling and group sessions (14%) or that it should be like some specific programme in the community (6%). Those who suggested the programme in gaol be like specific programmes in the community differed in the programmes they mentioned: one said it should be like the detox at West Mount, one said it should be like W.H.O.s or GROW, another that it should be like Narcotics Anonymous and the other said that the counselling should be like that at Bourke Street. A range of other suggestions were made by single individuals (12%) including:

"(there should be) compulsory films showing the damage it does to you, show you really bad pictures of people who have overdosed to shock you out of it, have lectures etc";

"something that makes you sleep through it";

"have rehab. on a farm with work, courses and counselling".

Approximately one in ten of the women (11%) said that they did not know what sort of programme could help while they were in gaol. One woman pinpointed some of the problems of running treatment programmes in gaol when she said:

"Any programme would be hard to run because most prisoners want to take drugs inside (gaol) to have a 'day out' i.e. to escape mentally".

When those who suggested programmes were asked who would be the best people to run these, the majority suggested personnel from outside of the Department of Corrective Services, i.e.: ex-junkies (35%), drug counsellors (12%), Narcotics Anonymous staff (11%), outside personnel where they couldn't specify who (6%), or a range of other personnel (13%) such as "Stella Dalton or similar". Others didn't mind who the staff were as long as the people cared (13%). Still others (16%) stated that they didn't know who should run them.

The inmates were divided as to whether they thought such programmes should be run as soon as prisoners are received in gaol (32%), or throughout the entire sentence (29%). A minority thought the programmes should be run towards the end of the prisoner's sentence (6%). Others (32%) said that timing depended on the individual prisoner or should be run as prisoners felt they needed it.

F. HEROIN USERS' PERCEPTIONS OF IMPRISONMENT

a. Accommodation

There was no significant difference between former heroin users and non-users in accommodation, although there was a slight tendency for non-users to

reside at the less secure Norma Parker Centre (45%, compared with 24% of heroin users).

Lack of privacy was considered a problem by over one-third of all respondents (38%). However, there was a greater tendency for heroin users (46%) to see lack of privacy as a problem than non-users (23%).

b. Medical Treatment

Exactly 60% of the women stated that they had experienced problems with medical treatment in prison, but similar views were held by both user and non-user groups.

Heroin users were more likely to describe the attitudes of doctors as rude, uninterested, ignoring complaints and expressing disbelief, or claim that treatment was ineffective because of delays or wrong diagnosis. The non-users were more likely to complain that they were unable to get any treatment. However, these slight differences were not statistically significant.

c. Disciplinary Action

Heroin users were no more likely than other women to have admitted breaches of prison discipline. However, of eight drug-related breaches, seven were reported by heroin users.

d. Prison relationships

Two-thirds of heroin users and 55% of non-users commented on problems between prisoners. Specifically seven users mentioned drug-related problems and thirteen stated that gossip and petty clashes created problems between inmates. In contrast, non-users were more likely to mention stealing (6 women) or other miscellaneous sources of friction. Numbers were too small to test the significance of these differences.

Similarly, 85% of heroin users and 61% of non-users acknowledged problems between inmates and officers. Both groups mentioned attitudes of officers most frequently as a source of problems, followed by the petty application of rules and favouritism or inconsistency shown by officers.

e. Family relationships during imprisonment

Almost half the women in the study (46%) were mothers. However, only 37% of heroin users, compared with 61% of non-users stated that they had children. Half the mothers in each group had been raising their children as single parents prior to their imprisonment while another 18% cared for dependent children in relationship with a husband or de facto.

Arrangements made for the care of dependent children during the mother's imprisonment differed for the two groups. Heroin users tended to place their children with the child's grand-parents (56% of children, compared with 25% for non-users). Only 11% of heroin users' children, but 38% of non-users' children, were placed with the child's father. Friends were infrequently used as caregivers, accounting for less than 10% of placements for both groups combined.

Three-quarters of the women reported that they received regular visits from family or friends. A slightly higher proportion of heroin users than non-users were visited regularly but the difference was not statistically significant.

f. Prison activities

Over half the women (58%) stated that they were doing a course in prison at the time of the survey. No differences were found between heroin users and non-users. Exactly 90% of the women interviewed were employed in prison: again no differences between the groups were found in the types of prison jobs held.

Almost two-thirds of the women (61%) reported that they participated in sports or organised exercise in prison. There was a slight, but not significant, tendency for a higher proportion of heroin users to be involved in prison sports.

G. HEROIN USE, WORK AND TREATMENT ON RELEASE

a. Relationship between prior drug use and current imprisonment

Over nine out of every ten prisoners (92%) who admitted using heroin prior to coming to gaol said that their being in gaol was a direct result of their drug use. This represents 60% of all the sentenced prisoners interviewed. Half of those in prison as a direct result of heroin usage admitted committing armed robberies, property offences or fraud to obtain money for drugs (53%). Others said that they were in gaol for possessing or using drugs (24%) or for dealing (10%). This self reported information on the relationship between prior drug use and current imprisonment closely resembles the information on actual drug-related offences obtained from records. According to the record data, thirty-two of eighty-nine respondents (36%) were in gaol for offences including using, dealing, or cultivating drugs.

b. Projected future use

Three-quarters said that they did not want to continue using when they were released. Six of these 44 prisoners added that although they did not want to continue using, they knew that they would. Eighteen women said that they knew of existing programmes in the community which could help them. Among the programmes mentioned (together with the number of prisoners mentioning them) were: methadone programme (7), the Buttery (3) W.H.O.s (2) Odyssey House (2), Cyrenian House (1), Bourke Street (1) West Mount (1) and a Brisbane clinic (1).

c. Employment plans on release

Three-quarters of the heroin users stated that they intended to look for a job or commence self employment on release.

This proportion is almost identical to that of non-users intending to seek employment after release from prison.

However, only three users proposed to enter a rehab. programme on release as an alternative to seeking a job.

d. Suggestions for community programmes

The prisoners were given the opportunity to describe their ideal community rehab. programme. About one-third had no ideas to offer, while the remainder gave a wide variety of suggestions.

Some commended existing programmes such as West Mount and the Buttery while others replied that the ideal would differ from existing programmes such as Odyssey House or N.A.

Specific features of the ideal programme, where mentioned by the women included: it should be on a farm where one can eat good healthy food; every junkie should be put on methadone; there should be more counselling or group therapy. Finally, some women gave more complex suggestions, such as:

> "Earn their trust. Earn respect from others. Give them a job, a purpose. (Have) medical staff, counsellors, group sessions, people to talk to, a project book of activities. (Let them) see progress, sense of achievement, self awareness. Not too much work. Have time for yourself".

SUMMARY AND DISCUSSION

The major objective of this study was to assess the needs of female heroin users in prison. However, it was necessary to describe the characteristics of imprisoned women heroin users and their perceptions of their drug histories and prison life in order to put their needs in perspective.

Before summarising and commenting on findings it is important to raise a methodological issue namely, that record data grossly underestimated the incidence of drug addiction amongst women in prison. A census of prisoners on 30 June 1984 revealed that 22% of all female prisoners had a drug charge as their most serious current offence. However, police data relating to these women indicated that 60% had at least one drug offence in their criminal records (including current offence).

From interviews with a sample that approached the total population of sentenced women prisoners on a day in August 1984 it was found that 78% were drug users and 66% were heroin users with long term, largely daily, habits. Thus it would seem that self-report methodologies would be most successful in identifying drug users particularly when the use of particular drugs is to be distinguished.

1. HEROIN USERS AND CRIMINALITY

Overseas studies (e.g., James et al, 1979) found that for heroin users identified through the criminal justice system, money for drugs was regularly obtained through crime. Similarly, this study presented evidence that the expense of a drug habit motivated crime for 75% of female heroin users, who also volunteered that one-third of their sources of income comprised illegal or fringe activities such as prostitution, drug dealing and property crimes.

Evidence for the "crime breeding heroin use" hypothesis was less clear cut. Studies using samples derived from the criminal justice system (e.g., Dobinson and Ward, 1984) reported that crime preceded narcotics use in at least half the cases. Findings from this study were similar: half the women with drug convictions had been convicted of other offences before their first drug conviction. While these findings may not be generalisable to the "street" heroin user, it would be reasonable to conclude that crime was not simply a response to the costs of heroin for women sentenced to imprisonment, but part of their pre-addiction lifestyle in up to half the regular heroin users.

It would seem that female drug users in prison can be divided into two, roughly equal, groups: those whose criminality should cease once drug usage was terminated and those whose criminality would be likely to re-emerge in times of financial or emotional need. Thus, efforts to modify heroin abuse by women in prison would have as a secondary goal the halving of recidivism for these women.

2. DIVERSION PROGRAMMES

Approximately half the heroin users interviewed in this study believed that a drug treatment programme could have been an alternative to imprisonment in their case. Moreover about one-third of these women stated that they had never participated in any drug rehab. progamme in the community. There were wide differences in opinion concerning a preferred or ideal type of rehab. programme.

Considering these views, it appears that flexible diversion programmes would be best to meet the individual needs and preferences of female drug users. This approach endorses recommendations of the NSW Women in Prison Task force, that sentencers should, wherever possible, bond a drug offender to the Probation and Parole Service on condition that she follows a course of treatment. Such a provision would allow different treatment programmes to be considered by the woman in conjunction with her Probation and Parole Officer.

3. CHARACTERISTICS OF FEMALE HEROIN USERS IN PRISON

The drug users tended to be younger than non-drug offenders. They were more likely to have committed drug or property offences and to have experienced at least one prior conviction than non-drug offenders. Thus they appear to comprise a young recidivist sub-group.

When heroin users were analysed separately from both non-users and users of other drugs only, there was a slight tendency for the heroin users to be better educated than the other women, with half completing schooling at Year 10 or beyond. While this could be related to their being younger than other prisoners (with

greater expectations of and opportunities for education than older women) it does indicate that most could cope with courses or information pitched at secondary school level.

Hardly surprisingly, most of the women prisoners appeared to be living in relatively unstable conditions prior to their imprisonment, with few differences between heroin users and non-users in the areas studied. Less than half the women were living in married or defacto relationships; only 17% owned (singly or jointly) their accommodation and only 16% derived income from full-time work. However, heroin users were more likely than others to derive income from illegal or fringe activities. The instability of their arrangements prior to imprisonment does not offer confidence for living stability after the major disruption of imprisonment.

It was illuminating that almost one-third of the heroin users had not been involved in any drug treatment programme in the past. Those who had been in treatment tended to have tried therapeutic communities, detoxification and counselling for short periods. Most programmes were not completed. Only one treatment in eight was experienced for more than six months. Reasons for leaving drug programmes were varied and seem to reflect problems within programmes as well as the attitudes and circumstances of the users. Most felt that treatments experienced had, at best, a temporary effect. These findings suggest that the possibilities for rehab. would not have been exhausted.

4. TREATMENT FOR HEROIN USERS IN GAOL

a. Detoxification

Although most of the regular heroin users had experienced gaol detoxification, they strongly criticized the procedures. It is strongly recommended that separate detoxification facilities be provided for women undergoing drug withdrawal. Inmates undergoing detoxification should have adequate access to facilities for washing themselves and, if considered appropriate, to warm baths for alleviation of withdrawal symptoms. This unit should staffed by a nurse with experience in detoxification units outside a prison setting.

Medical supervision is especially important for the barbiturate users who may suffer severe reactions during withdrawal. Medication supplied to the women during detoxification should be similar in range and frequency of doses to medication available in community detoxification facilities: the women prisoners should not be given reason to feel that they are being punished by undergoing unassisted withdrawal because they have been imprisoned.

b. Treatment

Three-quarters of the women stated that some kind of treatment programme should be run in prison. According to a staff survey conducted for the Women in Prison Task Force, 82% of prison officers, and all executive and professional staff recommended that assistance should be offered to women who wanted to stop using drugs (unpublished report by Godfrey and Morison). Thus there was strong agreement that some form of treatment should be available to drug users in prison. It was strongly emphasised that drug withdrawal and treatment should be provided in a separate unit fully staffed by trained personnel.

It has been argued (Newman, 1977) that attempts to treat drug addicts in prison are futile because of the constraints of a security setting. However, counsellors who have made such attempts, while acknowledging problems, have outlined strategies for working within the exigencies of a prison environment (e.g. Smith, Beamish and Page, 1979). Such strategies emphasise openness, well-developed lines of communication between the drug unit and other sections of the prison and a carefully established administrative structure.

What kinds of treatment should be offered in gaol? A methadone programme was advocated by one-third of the women prisoners, 10% of prison officers and psychologists at both of the prisons for women. Research into community-based methadone programmes indicates that it is a safe treatment which retains its clients and can effectively reduce criminality. However, no report has been found in the literature on the operation of a methadone programme for women prisoners in order to build up to a blockade dose prior to release.

It is stressed in community methadone programmes that participation should be voluntary and not as the result of a specific court order, since the programme involves the use of an addictive drug with minor side effects. It would be necessary to control all external pressures towards participation in a prison setting, such as the notion that co-operation would result in a more favourable pre-release report, and to ensure fully informed consent. Thus strict voluntarism could not be met. Further, the storage and administration of doses of methadone would require careful supervision to ensure that supplies were not bartered or otherwise abused. A strictly segregated facility would be essential to prevent the latter problem. Thus it is recommended that a methadone blockade programme be established in prisons, only if a carefully controlled, segregated facility were available, having close liaison with a community methadone programme to which the woman could be transferred immediately on release. However its use on release for women making an informed choice is strongy supported and information about community methadone programmes should also be provided to women in prison.

Therapeutic communities have achieved promising results both inside (Platt et al, 1980) and outside prison (Bale et al, 1980). However, length of programme participation appears crucial.

While this has been established by research (Bale et al, 1980) experiences of the women heroin users in prison add confirmation. Two-thirds participated in some form of rehabilitation, while 52% entered a therapeutic community. However, half left within a month and only 17% remained for at least six months. Thus the majority of women drug users in prison had little or no experience of long term therapy.

If a therapeutic community were established for drug users in prison, would the women have sufficiently long sentences to enable them to derive some benefit from participation? In order to answer this question, the prison records of 58 heroin users were analysed. For those who had been released at the time of the analysis (June 1985), actual days spent in gaol were calculated. For those still in prison, earliest dates of release were estimated using remission and parole data, and total days comprising the current sentence were calculated. It was found, by combining actual and estimated gaol days, that the median period in custody was 262.5 days. That is, half the women would have spent at least 8.75 months in gaol. Further details are presented below.

Actual or estimated time spent in gaol on current sentence by heroin users:

Less than 1 month	1
1 month and less than 3 months	4
3 months - - 6 months	14
6 months - - 12 months	21
12 months - - 2 years	11
2 years and over	7
	58

Thus if a programme of about six months had been established, then two-thirds of these heroin addicts would have had sentences sufficiently long to allow participation.

The specific features of a therapeutic community for heroin users in prison require careful consideration. It appears that the women rejected coercive, confrontationist and dishonest approaches. In contrast, therapies that included flexibility, together with respect, consideration and maximum autonomy for the client have been advocated (e.g. Krivanek, 1982). From studies of intensive counselling and therapies conducted in prison and cited earlier it appears that single features cannot be isolated, but rather the total direction of a programme should be based on the needs of those involved. Thus components such as group counselling, group behaviour therapies, drug education, life skills courses and unit management may all be utilised in a comprehensive approach. However, it is strongly recommended that continuing evaluative research be included in the design of the treatment programme. Such a programme should be run in a separate facility within the prison and should be staffed by specialists with experience of broad programmes for drug users, together with prison officers who volunteer for duties within the unit. Ongoing staff training and development would also be essential.

If it is decided that a separate unit for a drug treatment programme cannot be established in the near future, then a drug education programme should be started within the general prison. Such a course should include specific pharmacological data on drugs as well as comprehensive information about drug treatment facilities in the community. From an examination of the educational backgrounds of drug users it appears that most of these women would be able to cope with a detailed and thorough course, providing that they were not under the influence of drugs or withdrawal at the time.

5. PRE- AND POST-RELEASE RESOURCES

When questioned about release plans the women tended to be vague and unrealistic. Three-quarters intended to look for work on release, despite the fact that 85% of the heroin users were unemployed at the time of their arrest. Only three women planned to enter a drug rehabilitation programme on release.

It would appear from their unstable living conditions prior to imprisonment, that on release most of the heroin users would be unemployed, obtaining money from social services and illegal activities, looking for rented accommodation and having no stable, supportive relationships.

These predictions were largely supported by a study of women released from prison, prepared for the Women in Prison Task Force by Jill Thomson. She interviewed 26 women at two weeks to some months after release questioning them about the first 2 to 3 weeks after release. Major findings included:

1) Prior to release most of the women would have preferred assistance with money, remaining drug-free, jobs and accommodation.
2) 34% were living with parents, in situations often characterised by "dependency, isolation and deception". (p. 14).
3) 27% were living in hostels or half way houses.
4) 46% were looking for work.
5) 81% had less than $50 in hand on release, while very few had very little after 4 days, despite social service assistance.
6) Only 2 women were helped by staff in prison; the rest relied on family, friends or managed alone.

Three major recommendations emerged from this study. It was suggested that more access to relevant information should be given before release, through allowing representatives of refuges, CYSS schemes, rehab. groups etc. to visit groups in prison and supply written information. In addition more formal information about gratuities and social services entitlements was advocated.

Secondly, a "best friend" scheme was recommended, in which community volunteers would relate to women on an individual basis both before and after release to provide support and advice.

Thirdly, expanded funding for supported accommodation such as short term housing, medium term group homes and longer term units available through the Women's Housing Company should be provided. This recommendation was also supported by the Women in Prison Task Force and its value must be emphasised.

While accommodation needs on release must be met, information and assistance should be available before release. It is recommended that a welfare worker be appointed with the specific role of co-ordinating information and community assistance to be provided before release, but possibly extending after release through a "best friend" scheme.

RECOMMENDATIONS

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 programme 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 programmes available in prison.
3) That a methadone treatment programme be established for women who wish to be stabilized 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 programme.
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 programmes to ensure immediate transfer and hence continuity of blockade on release.
7) In addition to a methadone programme, a therapeutic community should be established in a separate facility of the gaol.
8) The programme 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 programmes 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 programmes.

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 and employment and accommodation groups in the community;
c) establishing a "best friend" scheme for women in prison.

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