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Different Needs: Women’s Drug Use and Treatment.

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Abstract

In recent years research has illustrated a growing population of problematic female drug users in the UK. This article explores this drug use and suggests that experiences of female drug users are often very different from their male counterparts. It is argued that women, particularly pregnant, drug users suffer more social stigma than men and often suffer a greater severity of addiction with physical and psychological reactions. The article goes on to explore drug treatment for women. The article argues that given the different experiences women drug users have to men, drug services need to be tailored to meet the needs of women. Finally, despite the view that prisons are ideally placed to deliver drugs treatment, it is argued here, that the prison environment is often inappropriate and harmful for women drug users further supporting the argument that there is a need to develop specialised community treatment facilities.

1 The Advisory Council on the Misuse of Drugs (ACMD) defined problematic drug users as ‘those who experience social, psychological, physical or legal problems related to their drug use’ (ACMD 1982). More broadly, Bennett and Holloway (2005: 8). state that problematic drug denotes drug use that is considered to ‘generate problems, either for the user or for society’
Introduction

In 1998 the UK Government introduced a strategy to tackle drug use in a more integrated way: ‘Tackling Drugs to Build a Better Britain’ (Home Office, 1998). A key objective of the strategy was to increase the participation of problematic drug users, in drug treatment programmes. The Updated Drug Strategy (Home Office, 2002a:10) stated, ‘Treatment works’ and highlighted that people are receiving treatment and support more quickly with the number of people presenting for treatment increasing by approximately 8% from March 1999 to March 2002. According to the updated UK drugs strategy ‘women and minority ethnic drug misusers are particularly under-represented’ in treatment (Home Office, 2002a: 50). Yet by 2005 the NTA argued that there was clear evidence to suggest that women are not under-represented in treatment (Best and Abdulrahim, 2005). Notwithstanding the debate surrounding representation, a further issue concerns the configuration of services that are able to meet the needs of drug using women. Becker and Duffy (2002: 2), for example, argue in their review, that ‘a strong message emerging from the literature was that women problem drug users have specific experiences and complex needs which are not always recognised or met by some existing drugs services’. The updated drug strategy acknowledged that drug users have different needs and identified that Drug Action Teams and the National Treatment Agency were committed to ensuring that all geographical areas of England and Wales have access to an adequate range of services that are ‘tailored’ to meet individual need. ‘Models
of Care’ (NTA, 2002) set out a national framework for the commissioning of adult drug treatment in England ensuring ‘equity, parity and consistency in the commissioning and provision of substance misuse treatment in England’ (ibid: 3).

The focus of this article is to explore whether treatment services are ‘tailored’ to meet the needs of women who use drugs and to critically examine whether treatment is equitable and consistent. Initially the paper will explore recent trends in female drug use and illustrate how women’s experiences of drug use are often very different from their male counterparts. Following this, the article will move on to explore drugs treatment for women, where it is argued that current service provision is lacking in attempts to maintain women in effective treatment and reducing the ‘cycle of harm’ to their children. Finally, the article will examine treatment for women in prison. It will highlight that, despite the perception that prisons are ideal environments for treatment, the current provision does not adequately address drug using women’s needs. Therefore, women are often released from custodial sentences drug dependent or highly likely to reengage in problematic drug use. Methodologically, this paper draws upon an extensive interdisciplinary literature review spanning the social and medical sciences. Although the paper predominantly draws upon UK literature, as the context is England and Wales, the paper also uses international evidence as many of the issues discussed have an international relevance.

2 The literature review was conducting using ASSIA and SCOPUS.
Trend in Female Drug Use

Prevalence Estimates

Although it is difficult to estimate the prevalence of drug abuse among women, there are several trends that have been identified in the literature (Geoghegan et al., 1999.) Findings from the 2003/04 British Crime Survey (Chivite-Matthews et al., 2005) identify that males reported higher levels of any illicit drug use than females during the last year, 15.7% against 8.8%, the figures fell to 14.3% and 8.3% for 2004/05 (Roe, 2005) and fell again 2005/06 to 13.7% and 7.4% (Roe and Man, 2006). In 2004/05 4.5% of males reported use of Class A drugs in the past year compared to 1.9% of females (Roe, 2005) and by 2005/06 there was a rise to 4.7% of males whilst it remained stable for women (Roe and Mann, 2006). It is important to note that the British Crime Survey is representative in terms of gender. For example, the 2005/06 survey included ‘47,796 face to face interviews’ (Walker et al., 2006: 24) this included ‘26,351 women’ and ‘21,378’ men (Walker et al., 2006: 186).

The Department of Health Statistical Bulletin (DOH, 2000) identifies from the Regional Drug Misuse Database, a male to female ratio of 3:1. Such figures are broadly consistent with US estimates of women being representative of more than a third of illicit drug users (Greenfield et al., 2003) and also

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3 Class A drugs are those deemed by the UK Government to be most harmful. The Misuse of Drugs Act 1971 (current legislation) categorises drugs into three groups. Class A, B and C. Examples of Class A drugs include heroin, cocaine and Ecstasy.
consistent with Hepburn’s (2002) global estimation of approximately one-third of the 180 million drug users throughout the world being female.

**Demographic Trends**

In relation to regional variations, the 3 to 1 ratio is not universal as in some parts of the UK, women account for half of the drug using population. Hay et al’s (2001) study, for example, identified significant variations in the ratio of female drug users in certain areas of Scotland. In Edinburgh, 54% of the estimated drug-using population were known to be women compared to 26% in South Lanarkshire.

In terms of age, the initiation of substance misuse is progressively taking place at a younger age with the trend being more dramatic in women (Zilberman et al, 2003). Melrose and Brodie’s (2000) study of vulnerable young people in two areas of South-East England identified that out of their sample of 59 young people, the most problematic drug users were young women. Findings within the study suggest that vulnerable young women were more likely to consume licit and illicit substances, start drug use earlier, use a wider range of substances and therefore have a higher degree of problematic drug use than vulnerable young men.

Regarding initiation into drug use, women are more likely to initiate or maintain their drug use in order to develop more intimate relationships (NIDA, 2004). Moreover, drug-using women are more restricted in their choice of
partner as even within drug cultures male drug users prefer non-drug using partners (Wright, 2002). Women with drug using partners often maintain traditional gender role expectations acting as ‘caretakers’ to their partner attempting to limit drug use for both parties or increasing their drug use to ‘match’ their partner (ibid: 20).

Severity of Addiction

Whilst it is evident that women use alcohol and illicit drugs at lower rates than men, the health impact of such use is significant and as Cormier et al (2004) suggests in some cases is greater than that for men. A distinct issue associated with problematic drug use for women is the severity of harm. At treatment entry, despite a shorter progression from first drug use to dependency, female problematic drug users exhibit comparable or greater severity of addiction with physical and psychological reactions, described as ‘telescoping’ (NTA, 2002; Hernandez-Avila et al, 2004; Neale, 2004).

Furthermore, whilst women are less likely to use drugs intravenously they do report higher incidences of sharing injecting equipment than their male counterparts. The National Treatment Outcome Research Study (Gossop 1996), a prospective study of 1,100 drug users accessing treatment services in 1995 found that women reported significantly higher sharing rates than men. Bennett et al’s (2000) study identified a complex pattern of gender relationships with women receiving needles and syringes more often than
men did. The study concluded that due to such patterns of behaviour women were at higher risk of blood-borne viruses.

*Psychiatric Co morbidities – Dual Diagnosis*

With particular reference to psychiatric co-morbidity, studies such as Gossop and Marsden’s (2000) identified higher levels of psychiatric problems in females than males. Women drug users often identified recurrent mental health problems such as depression, low self-esteem, self-mutilation, suicide attempts and eating disorders (Fiorentine et al 1997; Marsh et al, 2000; NTA 2002; Becker and Duffy, 2002). Furthermore, females have an increased incidence of co-morbid post-traumatic stress disorder following domestic violence, sexual abuse, emotional abuse as a child, incest, stillbirth or the death of a child (Becker and Duffy, 2002, Department of Health 2003).

**Context of Female Drug Use.**

*Drug Use and Sex Work*

As many as 95% of those working on the street are believed to be problematic drug users, however, such figures do not clarify the number of female sex workers (Home Office, 2004a). As Nuttbrock et al (2004:233) state, ‘Substance use is interwoven into the sex work life-style in multiple respects.’ The type of drugs being used has changed over time, particularly from the use of heroin to crack cocaine (Green et al, 2000, Gilchrist, 2005) and it is clear
that current service provision does not meet the needs of crack (cocaine) users. As acknowledged by the UK Government ‘generic programmes aimed at tackling the problems caused by illegal drugs have not always addressed crack with the weight and vigour that the nature of the drug deserves (Home Office, 2002c: 2). It is beyond the scope of this article to discuss this in detail (for further reading see Home Office, 2002c, Gossop et al, 2003). Drug-using women may resort to sex work to fund their drug use increasing risks (sexual health, violence) for themselves. Both intravenous drug use and sex work place the woman at increased risk of HIV, Hepatitis B and C (NTA, 2002).

**Pregnant Women and Problematic Drug Use**

A further vulnerable group are women who use illicit drugs during pregnancy. They are often portrayed as unfit, in some states of America, for example, they are faced with criminal charges for causing harm to their unborn baby (Charles and Shivas, 2002). It is suggested that society’s state of ignorance and stereotyping of drug using parents reinforces their perceptions of the need to remain hidden preventing researchers from gaining insight into their lives, the problems they face as parents with a dependency and their perceptions of parenting (Klee, 1998). The social stigma and criminalisation of drug use has contributed to the silence of drug using women rarely offering them a legitimate voice in (Ettorre, 1992; Boyd, 1999). Malloch (2004b) hypothesises that media publicity has the potential to reduce the number of women approaching treatment services. It is difficult to document an accurate number of women in the UK who use illicit drugs during pregnancy and one
reason for this is that they may conceal their drug use and not present for treatment (Mountenay, 1997).

A further issue is that a higher proportion of babies being born to drug dependant women and children of drug using parents are taken into care than in the general population (Klee, 1998; Suchman et al, 2004). The recent Inquiry by the Advisory Council on the Misuse of Drugs ‘Hidden Harm’ (ACMD 2003) estimated that there are between 250,000 and 350,000 children of problem drug users in the United Kingdom (2-3% of the population under 16) (ACMD, 2003). This may be an underestimation as the report highlights that not all drug services ask about dependent children and not all drug users may be prepared to give such information for fear of intervention from other agencies.

**Drug Treatment for Women**

During the past decade a number of reports have recommended the commissioning of services that are tailored to meet the needs of women drug users (Powis, 1997; Becker and Duffy, 2002). Becker and Duffy’s (2002) study is commendable in its attempts to identify gaps in service provision and the promotion of a holistic, needs-led approach. Whilst it is acknowledged that there have been a number of changes and improvements by some drug treatment agencies to provide services to women, the overall response has been limited (Osorio et al, 2002).
It has frequently been suggested that women are under-represented in the treatment population (Home Office, 2002a, for example), yet a recent research review of epidemiological evidence undertaken by Best and Abdulrahim (2005) identified that in overall terms women do not appear to be under-represented. The report further suggests that variations in female representation may be contingent on local issues of access for different hidden populations. The report concluded:

women present to services with different problems and characteristics and, while in overall terms do not appear to be under-represented, this is not to suggest that the problems women drug users face are adequately addressed in current treatment configurations (Best and Abdulrahim, 2005:2).

Those who do present for treatment, often find the provision to be inadequate and/or inappropriate (Marsh et al, 2000) as most treatment facilities are designed to accommodate the white, opiate using male under the age of 35 (NTA, 2002). Male-orientated treatment services appear to ignore the influencing factors of women’s drug use (Wright, 2002). Hepburn (1999) further comments that poor compliance with services is a reflection of the inappropriate nature of the services that fails to recognise the woman’s lifestyle and her wide range of problems. O’Mara (2005) questions the overuse of methadone dispensing and urine testing and the lack of service provision that offers vulnerable women the support they need, for example.
Over 90% of female drug users presenting to treatment services are of childbearing age (Clarke and Formby, 2000). Pregnancy should bring the woman into contact with the health care system and may provide a ‘window of opportunity’ to engage the vulnerable and ‘high risk’ woman into essential health care (Nair et al, 1997). Many women with problematic drug use first come to the attention of treatment services when they seek care during pregnancy (Corse and Smith, 1998).

The ACMD (2003) report, ‘Hidden Harm,’ identified that on average 1% of babies born in maternity units were to problem drug users and a similar number to problem drinkers. Significantly, 82% of the maternity units said there had been an increase in the number of pregnant drug users in the past five years. The Northern and Yorkshire Public Health Observatory (2002) estimated that 9.3 drug users per 1000 deliveries used antenatal services within their region.

Despite fears that their baby (children) may be taken into care and despite the fear of disapproval, women may contact treatment services as they are concerned about the potential impact of their drug use (Powis et al, 2000). Avoidance of antenatal care may be due to practical reasons regarding locality or childcare issues. Effective antenatal care can be provided in the community through specialist multi-disciplinary teams (ACMD, 2003). As Klee
(2002) highlights however, by far the most significant reason for failure or reluctance to seek antenatal care are concerns regarding judgemental and hostile attitudes of staff. The Government Green Paper ‘Every Child Matters’ (DfES 2003) identifies that the most vulnerable and disadvantaged women, such as women drug users, are likely to delay seeking care when pregnant and to fail to attend clinics regularly. The National Service Framework (DOH 2004) further supports this view identifying markers of ‘good practice’ being the provision of services for women with more complex pregnancies who may require multi-disciplinary or multi-agency care. Services that do not meet identified needs will not be accessed because women are unwilling or unable to use them (ibid: 482). When pregnant drug users are provided with services that acknowledge their views and their needs, however, research has shown that they do attend regularly (Hepburn, 1996).

Service Provision for Women with Childcare Responsibilities

The availability of childcare services for mothers who are accessing or plan to enter drug treatment has been identified as one of the most important factors in improving treatment attendance. (Nelson-Zlupko et al, 1996; Marsh et al, 2000). Women in treatment are more likely than men to have primary responsibility for their children (Henderson 1998). The ‘Hidden Harm’ (ACMD 2003) report identifies that mothers were far more likely (64%) than fathers (37%) to live with their children. EATA’s (2004) research of service users identified that negative experiences centred around the lack of crèche facilities and child friendly or family-specialist services. The ACMD (2003)
also identified that few community based treatment services had childcare facilities with gaps being due partly to the expense of providing good quality facilities, as well as a lack of suitable space and additional staff required. The report recommends that drug and alcohol agencies have a responsibility towards the children of their clients and therefore should aim to provide effective and accessible support, either directly or via links with other agencies. Ultimately, however, treatment services must become family-focused and child-friendly (ibid: 90). Whilst the capacity to develop such a service requires additional resources and is perceived to be a long-term project, government programmes such as SureStart\(^4\) may provide acceptable support for the woman (family). This service, however, should not replace the necessity of developing family-friendly treatment services.

Becker and Duffy (2002) also identify outreach work as an approach that offers services to women who are unable to access centre-based services, particularly pregnant women and those with children. They identified five different types of outreach:

- Home visiting particularly targeted at women looking after children and pregnant women
- Pre-care and after-care schemes chiefly for women with places for themselves and their children in residential services;
- Services aimed at sex-workers
- Detached work using the premises of other community services mainly for pregnant women
- Services aimed at women involved in court proceedings (2002: 25-26)

\(^4\) Sure Start is a Government programme which aims to achieve better outcomes for children, parents and communities through the provision of childcare, improving health and emotional development for young children and supporting parents as parents and in their aspirations towards employment. It is beyond the scope of this article to discuss the effectiveness of this programme, see NESS (2005) for a national evaluation.
It is beyond the scope of this article to discuss these different types in detail. Overall, it is clear that outreach work is a way of delivering services to women who will not or who are unable to access agency based treatment. What is less clear is whether drug treatment agencies have the resources to effectively maintain such a service.

_Service Provision for Women with Co-morbidity_

Significant differences between women and men have been identified in their patterns of psychiatric co-morbidity and substance misuse including, as previously discussed. The National Treatment Outcome Research Study (Marsden et al, 2000) identified higher levels of psychiatric problems in females than males. The most common co-morbid diagnoses are affective disorders, such as acute or chronic depression and anxiety disorders (phobias and panic attacks) (Berkowitz, et al, 1998) Furthermore, women are more likely to present to primary care services or mental health units for psychological difficulties therefore, unless effectively assessed, drug use may be more difficult to detect (ibid:19). Dual diagnosis is associated with a higher relapse rate, more non-compliance and a poorer prognosis therefore the clinical and social outcomes for the client are worse (Crawford et al, 2003). The severity and complexity of need amongst women with a dual diagnosis requires the development of an appropriate and integrated service that is relevant to their specific needs, flexible and attractive to women. Recently the women’s mental health strategy, ‘Mainstreaming Gender and Women’s
Mental Health’ (DoH, 2003) has been implemented emphasising the need for integrated care. Whilst there are identified aims and outcomes for many aspects of women’s mental health within the implementation guidance there is no clarification of aims and outcomes for dual diagnosis. Furthermore as Keene (2005) identifies care is fragmented with services only providing care for a small proportion of the population ‘in need’ (males and females). Keane further argues that improvements in the treatment and care of clients with dual diagnosis may be facilitated when a single NHS Trust encompasses both mental health and drug treatment services. It is unclear how many NHS Trust undertake such a function and the effectiveness of engagement and retention in treatment therefore this is identified as an area where further research is required.

_Service Provision for Women who have experience Abuse._

Studies examining gender differences in substance misusing populations have often identified that women compared to men as having a greater likelihood of sexual and physical abuse. Previous research undertaken by Chiavaoli (1992), for example, has shown that when drug users do not receive treatment to address past history of abuse outcomes of treatment are less positive. McKeganey et al’s (2005) research within drug treatment services in Scotland identified that nearly two-thirds (61.9%) of females had been physically abused and more than a third (35.5%) had been sexually abused. Among male users just under a quarter (22.3%) reported being physically abused and 6.9% sexually abused. The research further identified that women
drug users experience a high level of repeat victimisation (women experiencing childhood abuse subsequently experiencing violence in adult relationships). The authors conclude that there is a need to ensure that staff working in drug treatment services are either trained to provide such support or are experienced in recognising possible abuse and refer individuals to appropriate support agencies. This also raises questions about the appropriateness of mixed gender groups on orders such as Drug Rehabilitation Requirements. Furthermore as Griffiths et al (2004:17) state:

If child sexual abuse is not integrated into the work at each stage, it is likely that, at best, victims of abuse will be able to achieve lasting change. At worst, deprived of a vital coping strategy (substance use) they may be exposed to memories or feelings which they fear are intolerable and therefore be at significantly higher risk of suicide

Whilst it is acknowledged that professionals working within agencies may have professional qualifications in nursing or social work it is unclear what experience or training they have received to address such influencing factors on women’s drug use. We would argue that such an issue warrants further consideration and action from treatment providers.

Those that provide services for women who are drug dependent and involved in prostitution need to acknowledge the impact and particular nature of their involvement in prostitution (Hester and Westmarland, 2004). Outreach services and evening opening hours are particularly valuable aspects of treatment for prostitutes linking a highly addicted group with much needed treatment and support (May et al, 1999; Nuttbrock et al, 2004). Many treatment services, however, do not tailor their service to meet such a hard to
reach group. Furthermore, Pitcher and Avis (2003) highlight a lack of awareness among drug agency staff in relation to the issues and needs concerning women sex workers who are drug users. Thus there is an identified need for treatment agencies to have a greater understanding of the range of problems sex workers encounter and to address such needs of a vulnerable group.

The NTA (2002: 14) notes that ‘in planning the overall range of care provision for drug misusers, commissioners need to take account of the high level of need that drug misusers present with, particularly in relation to physical and psychiatric co-morbidity and social care needs.’ The ‘Models of care’ framework (NTA, 2002) identifies 4 tiers of services with Tier 4 services aimed at individuals with ‘high levels of presenting need’. Many women drug users may be perceived as having ‘a high level of need’. Killeen and Brady (2000) study of residential settings suggests that ‘substantial gains’ can be made in child development by providing a stable and enriched environment. Furthermore, their study argues that such a treatment option may be cost-effective by saving on repeated detoxifications, incarcerations, foster care placement, special educational needs for children and hospital admissions. Whilst residential treatment may be an option for some, the ACMD (2003) report identified that residential agencies were less likely than community based services to offer services for pregnant drug users and those with children. Findings supported by Best et al (2005) highlighting that one of the groups most likely to be under-represented within Tier 4 treatment services include women with children (particularly those with children under 9 months).
Furthermore, service users within EATA’s (2004) study identified a lack of appropriate facilities for women with children and families.

Best et al (2005) findings also highlighted that provision of Tier 4 services varies sharply in regional availability. Placing women who attend residential services, without their children, in a similar position to those in prison where travel costs and time may limit the amount of contact with their children. It is perceived that such stressors may impact on the woman’s ability to remain in a residential setting to complete treatment and rehabilitation. Richards (2005) suggests that whilst residential treatment services that accommodate women and children need to be increased, improved access may be facilitated by a single funding source for both mother and child(ren) placements. Alternatively improvement in treatment provision may be possible through shared care arrangements and a more flexible use of specialist services (Best et al, 2005).

**Women, Drugs and Imprisonment**

Illicit drug use has been identified as a key concern within the criminal justice system and has been seen as particularly significant for female offenders (Malloch, 2004c). Women comprise a small proportion of the overall prison population; however, they are imprisoned disproportionately for drug-related crimes compared to their male counterparts. In the ten year period between 1992 and 2002 there was a staggering 414% increase in the number of females being imprisoned after drug offence convictions (Home Office,
Borrill et al’s (2003) study identified that almost two-thirds of women in prison have a drug problem, whilst the Prison Reform Trust (2004) suggest that in some prisons 70-80% are dependent. Ramsey et al (2005) found that Crack and heroin use was more prevalent in female prison populations and they argue that:

significantly more women identified themselves as having a ‘problem staying off drugs’ in the twelve months before their imprisonment (60% as opposed to 39% for the men). Similarly, significantly more women were assessed as having ‘acutely problematic’ levels of use during this same period (65% as opposed to 46% for the men (2005: 273)

These results may be indicative of greater levels of problem drug use amongst female drug users, however, Newcombe’s (2007) review of prevalence literature found that ‘about three quarters of problem drug users were usually male’. Therefore, what this appears to be more indicative of is either greater problematic drug use by females amongst criminal active populations or that problematic drug using women are more likely to be incarcerated than their male counterparts. Clearly, further research is needed to explore this area.

Ramsay (2003) identifies that treatment to address drug misuse can be effective in reducing re-offending particularly when it is of adequate length, meets an individual’s needs and is followed through by aftercare (as within community services). It is also argued by Inciardi (1996) and Ramsay (2003) that prisons are ‘ideally placed’ to deliver target treatment interventions providing health benefits and reducing crime because of the substantial
number of problematic drug users that exist within it. Furthermore, as the Joint Prison Service and National Health Service Executive Working Group stated (1999:1) ‘Good healthcare and health promotion in prisons should help enable individuals to function to their maximum potential on release, which may assist in reducing offending’. It is suggested, however, that women drug users often do not receive healthcare appropriate to their needs and therefore are not ‘functioning at their maximum potential’ on release (ibid).

The Prison Service Drug Strategy (HM Prison Service Drug Strategy Unit, 2003) forms part of the National Drug Strategy, which aims to reduce the rates of drug misuse during and after custody and to reduce the likelihood of drug-related re-offending. Previously the primary focus was on the reduction of supply and detection of drug use; the emphasis is now on expanding drug treatment provision within the prison setting. Ramsay’s study (2003) of prisoners’ drug use and treatment concluded that whilst there is a high level of need for treatment there are some variations both between and within different prisoner groups. Furthermore, Kothari et al (2002) identify a further ‘stumbling block’ for treatment within the criminal justice system (CJS) is the adequacy and funding of treatment. To improve prison-based treatment provision the Updated Drug Strategy (Home Office, 2002a) reported increased allocation of funding for an additional 2,000 treatment places and new low intensity programmes to be introduced providing 17,000 places for those serving short sentences. Furthermore, the strategy aims to improve the throughcare aspect of the system by further development to ensure continuity of care on release from custody. An indicative needs analysis undertaken by
Her Majesty’s (HM) Prison Service Drug Strategy Unit (2003) estimated that approximately 18,000 drug-misusing prisoners would benefit from intensive treatment each year, however; the service will provide only 7,600 places by 2006 with a significant gap in unmet need. Unfortunately, it is unclear what proportion of low intensity or intensive treatment places women have access to.

A Thematic Review undertaken by HM Inspectorate of Prisons in 1997 (Home Office, 1997) recommended that there should be a central strategy for women substance misusers with much greater co-ordination of drugs treatment policy so that the provision of treatment and counselling addressed the needs of the female prison (drug using) population. A follow up to the review in 2001 (Home Office, 2001) identified that actions to address the recommendation were ‘ongoing’. The key elements of effective treatment are the same within the criminal justice setting as they are within the community setting (Turning Point, 2004). Like community-based treatment services, however, almost all prison-based drug treatment programmes have been developed to address the needs of white opiate using males (Langan and Pelissier, 2001), ‘shoe-horning’ a minority population into a system that is not designed for them (Fawcett Society, 2003). Moreover, overcrowding within the prison estate can only serve to exacerbate these problems.

The Prison Service Drug Strategy (HM Prison Service Drug Strategy, 2003) identifies that the range of drug interventions offered addresses the needs of ‘low, moderate and severe drug-misusing prisoners’. However, The Social
Exclusion Unit (2002) identified that the availability of drug treatment generally increases in line with the category of risk and further argues that this approach is the ‘wrong way round’ as lower risk prisoners account for the majority of offences (often committed to buy drugs). Ramsay et al (2005) highlights that sentence length influences the level of service take up with significantly more, longer serving inmates (serving four years or more) receiving assistance in custody than those serving short sentences (less than a year). Ramsay further reflects that such practice is despite the finding that the severity of respondents pre-prison drug use is likely to correlate with their treatment needs. Women in prison may be viewed as a transient population with 71% receiving a sentence of less than twelve months and 59% of those on remand not receiving a custodial sentence when tried in court (Social Exclusion Unit, 2002; Home Office, 2003c).

Whilst Borrill et al (2003) study highlighted that imprisoned women have a strong interest in treatment the Fawcett Society (2003) identify there is limited prison-based service provision for women on short sentences. Taylor (2004) and the Social Exclusion Unit (2002) conclude that the gap in provision of drug treatment services means that the majority of female prisoners serving short sentences are unable to benefit from intensive treatment programmes that include Cognitive Behaviour Therapy, 12-Step Approach and Therapeutic Communities. Furthermore, as the Social Exclusion Unit (2002:121) state:

The overall value of short prison sentences is doubtful in many cases, as the disruption they cause to support networks and
protective factors can outweigh the limited opportunity they present to do positive work. This is particularly the case for offenders whose behaviour is driven by drug use.

Kothari et al (2002:426) state, ‘One issue that has become apparent is the conflict between the viewpoint of CJS staff and that of the medical professionals’. Malloch (2000a) argues that the two areas often create contradictory responses within penal policy and highlights the debate between the issue of ‘care’ and the maintenance of ‘control’ within prisons. However, when two distinct policy directives are intended to operate concurrently Malloch (2000b) argues that greater emphasis will be given to one element, furthermore, when resources are limited certain objectives will be prioritised. The Fawcett Society (2003) highlight the fact that women pose minimal security risk, unlike male prisoners who often externalise their ‘disturbances’, further concluding that it would be more appropriate to allocate more funding on rehabilitative and therapeutic support for women rather than excessive resources for security.

*Throughcare and Aftercare*

Clearly it is important to deliver effective drug treatment to prisoners but there is also a need to back up with effective aftercare particularly on release from prison (Taylor, 2004; Ramsay et al, 2005). The Social Exclusion Unit (2002) identify that few prisoners are able to continue drug treatment and support following release or have to join long waiting lists because there is a lack of
provision in the community. Drugscope (2005) identify the need for every woman leaving prison to have access to a dedicated throughcare worker with local supervision and rehabilitation centres for female offenders to address offending behaviour along with educational, psychiatric, financial, training and employment problems. A central issue within Fox et al’s (2005) study, however, was that large populations and a high turnover of female prisoners made it difficult to link prisoners up with aftercare agencies. Furthermore, as Harman and Paylor (2005) identify one of the major difficulties with current throughcare provision is that responsibility is often shared across a number of agencies with resulting fragmented service and little continuity of care (Social Exclusion Unit, 2002). As recently noted by Lord Phillips, the Lord Chief Justice of England and Wales:

We need much better drug rehabilitation facilities in the community. It should not be necessary to commit an offence in order to get drug treatment. I am afraid the reality in many parts of the country is that it is (cited in Allison, 2006)

The creation of National Offender Management Service (NOMS) and The Women’s Offending Reduction Programme (WORP) (Home Office, 2004b) which is a multi-agency strategic approach to respond to the variety of factors which influence women’s offending (poor housing, problematic drug use, mental health issues, abuse, childcare, education and employment) may go someway to addressing some of these issues (see NOMS, 2005) but clearly there is much to do.
Conclusion

Problematic drug use affects women in different ways to their male counterparts, as they face greater social problems, amplified by greater social stigma. Despite growing research illustrating these issues, gender specific services are limited. Pregnant drug using women in particular are often reluctant to seek antenatal care because of negative, judgemental and hostile attitudes of staff, further demonstrating the need for specialist services. Despite claims that prisons are ideally placed to deliver drugs treatment, it is clear that the prison environment is often inappropriate and harmful for women drug users. Greater emphasis needs to be placed on treatment outside of the CJS with more emphasis being placed on outreach work for women and childcare provision within treatment services.

Since the birth of Tackling Drugs Together in 1995 there has been much commendable work in the area of drugs treatment. Despite the growing emphasis on treatment, however, gender specific services are notable by their absence.

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