Effective interventions for drug using women offenders: a narrative literature review

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Abstract: A detailed understanding of the effectiveness of interventions designed to meet drug using women offenders' (DUWOs) complex needs is essential to maximise success. This article reports on a narrative literature review of evaluations of interventions designed to assist DUWOs in their recovery from drug use and in their desistance from offending. It aims to identify gaps in that research and point to possible directions for future studies. It shows that successful interventions are likely to be intensive, of significant duration, multi-dimensional and inter-disciplinary. Evaluations must similarly be designed to take into account all individual and structural factors. Qualitative longitudinal research which incorporates DUWOs' opinions on their needs might best inform the development of interventions tailored to meeting those needs. Evaluation design should acknowledge the importance of progress as well as outcomes and be designed to follow DUWOs through their whole sentence rather than focusing on a single intervention/point in time without the context of what came before and what might or should happen in the future.

Key words: addiction, drug use, offending, substance use, women

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Introduction

The link between drug use and female criminality is very strong (Covington, 2002). Globally, more women are incarcerated for drug offences than for any other crime (Moloney and Moller, 2009). Drug use among women offenders is exceptionally high –higher than among male offenders – and is often the key driver in their offending (Light et al., 2013). Women are more likely than men to report needing help with their drug use on entry to prison (ibid). Many women are reluctant to seek out help for their drug use. However once in treatment, they are more likely than men to engage, stay longer and get better results (NTA, 2010).

The reasons behind women's drug use are more complex than that of men (NTA, 2010) – particularly in terms of the reasons they start using drugs which is often to cope with physical and emotional pain caused by abuse or trauma (Bartlett, 2007). For example, Fedock et al (2013) found a history of trauma in 51% of their sample of 231 women compared to 24% of 494 men. Similarly, Messina et al (2007) found higher rates of childhood adverse events among the women in their comparative sample of male and female inmates – specifically in terms of emotional and physical neglect (20% vs 40%); physical abuse (20% vs 29%); and sexual abuse (9% vs 39%). Butler et al (2011) found higher rates of mental disorder amongst women (61% vs 39%) in their sample of 1478 men and women prisoners as well as higher rates of co-morbidity (46% vs 25%).

It is imperative that a detailed, nuanced understanding of the effectiveness of interventions designed to meet drug using women offenders' (DUWOs) needs is available so that the success of such interventions can be maximised. This article reports on a narrative literature review with three key aims: to review research on the effectiveness of interventions designed to assist DUWOs in their recovery from drug use and desistance from offending; to identify gaps in that research; and to point to possible directions for future studies.

Methodology

A narrative methodology was used incorporating systematic searches of the published literature to draw out findings from primary research. This process allows for the inclusion of many different research methodologies. It is therefore possible to summarise and disseminate as wide as possible a range of research findings and identify gaps in research activity[1]. Searches were conducted of the following databases: Criminal Justice Abstracts, Social Policy and Practice, Social Sciences Citation Index and Scopus. Multiple search terms were used including 'drug' 'substance' 'addict(ion)' which was then combined with 'women', 'female' 'gender' and 'crime/offence/prison/inmate/probation'. Intervention-based terms such as 'program(me)' 'intervention' 'throughcare', 'aftercare', 'support', 'treatment', 'recovery', 'rehabilitation', 'holistic', 'gender responsive/sensitive' and 'what works' were then added to complete the searches. Only English language papers published in peer-reviewed journals were included. 244 article abstracts were read for relevance from which 89 articles were selected that specifically reported findings on interventions with DUWOs. These papers were read, categorized according to the type of intervention evaluated and notes were taken.

Intervention, treatment and programme evaluations

Psychosocial interventions for drug use[2] in Prison

There is evidence to suggest that women respond better to psychosocial interventions in prison than men. Pelissier et al's (2005) found no significant effect of any of the 16 programme interventions for males in that there was neither a higher or lower likelihood of recidivism for participants from any programme. However, one of the four women's programmes evaluated was able to show a significantly reduced likelihood of future arrest ($p=<0.0125$). However another women's intervention showed a significantly increased likelihood of post-release drug use ($p=<0.0125$). The researchers suggest that these differences could be due to less experienced staff and less individual counselling on this latter programme. In addition, the pressure

[1] It should be noted that the only systematic review of this population was able to include only nine studies (Perry, 2014)

[2] Psychosocial interventions vary considerably in terms of intensity and duration but normally centre on drug education and cognitive-behavioural group work focused on criminal lifestyles and pro-social skills building to prevent relapse.

on programme staff to perform correctional duties alongside housing participants with non-participants was also thought to undermine the treatment process.

There have been attempts to combine psychosocial interventions in prison with treatment for mental health issues. One such study randomly allocated women to either an interpersonal psychotherapy group (IPT-G) in combination with the standard intervention or to treatment as usual alone (TAU) (Johnson and Zlotnick, 2008 & 2012). The intention was to treat major depressive disorder alongside substance misuse with a view to lowering depression and reducing relapse. 73% of the women (n=16) who completed the IPT-G programme no longer met the criteria for any depressive disorder at follow up (p=<0.001). However, there was less of an impact on relapse with 6/19 of the IPT group and 9/19 of the TAU group relapsing after release.

Opiate Substitution Therapy

There are very few studies on Opiate Substitution Therapy (OST) in prisons. Those that do exist suggest that the use of OST appears to have an impact on future offending. Lind et al (2005) found that for every 100 females under 30yrs on an OST programme for one year there was a reduction of 44 charges overall (with 27 for women over 30 yrs and 10 for men) (p=<0.0001). Less positive results were found by Cropsey et al (2011 & 2013). Whilst DUWOs receiving buprenorphine to aid relapse prevention participated in and completed treatment at a significantly higher rate than the placebo group (p=<0.0001); on 3 month follow up there were no difference with 83% of both groups having a positive urine opiate screen. These findings suggest that for OST to succeed its use may need to be continued post-release (Farrell-MacDonald et al 2014).

Therapeutic communities

Therapeutic Communities (TCs[3]) have become the preferred treatment option in US prisons over the past decade though they are far less frequently available elsewhere (Calhoun et al, 2010). Some DUWOs participate in standard TCs which are non-gender specific whereas other programmes have been adapted to be more relevant to women's specific treatment needs. There is evidence that that participation in a prison TC benefits both male and female prisoners – particularly those with the most severe needs. However the key factor in this success appears to be length of time in treatment and uninterrupted continuity of care on release (Burdon et al, 2007; see also McDonald, 2009 and Rowan-Szal et al, 2009).

Sacks et al (2008) compared outcomes for DUWOs participating in a gender-responsive prison TC to those in a cognitive-behavioural therapy (CBT) intervention and found significant improvements in terms of depression and post-traumatic stress disorder (PTSD) in the TC group ($p=<0.001$) as well as significantly greater reductions in self-reported criminality other than parole violations ($p=<0.05$). The greater treatment effects in terms of both illegal drug use and criminal activity were also maintained at the 12 month follow up point (Sacks et al, 2012). However, additional support in terms of employment, education and housing on release are needed if these gains are to be maintained in the presence of other drug users (Scott et al, 2014).

Colley and Blackwell-Young (2012) question the appropriateness of the prison environment to the facilitation of expressing emotion required in a TC. Other barriers to successful TCs in prison include lack of time to cover issues; large group size; competing priorities such as staff shortages or lockdowns; the poor attitudes of some staff; and the lack of control TC staff have over who is sent to the programme (Calhoun et al, 2010). Mosher and Phillips (2006) found that white, older women recruited to established programmes are most likely to be successful. They report that only 13% of the TC group were reconvicted compared to 30% of the control group in the follow up period. However, this effect did not sustain beyond 24 months – again suggested the need for comprehensive aftercare even after TC involvement. Messina et al (2006) found significant differences in the 6 month return to custody rate between TC-only participants (21%)

[3] Therapeutic communities involve participation in an intensive treatment programme where offenders are housed separately from the general prison population in a pro-social community.

compared to TC plus aftercare (6%). Indeed, they calculate that for each additional day spent in aftercare, the odds of a return to custody within 12 months were reduced by 1% (p=<0.001).

Drug courts

Drug courts (DCs) are a key way to engage DUWOs in treatment in the community and research findings suggest that they can be successful in helping women recover from substance misuse and avoid incarceration whilst maintaining family ties and employment (Shaffer et al, 2009). Hartman et al (2007) found that, whilst their sample of 151 DC women participants (who were methamphetamine users) reported higher rates of mental illness, prior sexual and physical abuse and daily methamphetamine use than the 153 men in the sample, they were less likely to be charged with a new crime (32.6% vs 45.3%; p=0.021). Shaffer et al (2009) found probationers were 8 times more likely to re-offend than DC participants due to the provision of wraparound services with a wide range of providers and types of support (p=0.001). The DC process was also more accommodating of relapse and provided prosocial models and reinforcement for readiness for change. In contrast, in the probation group, relapse was often treated simply as a violation of probation (see also Begun et al 2012). Brown (2011) found DC participation was associated with a significantly longer time to recidivism (p=0.028) (compared to a matched sample of non-DC offenders) even amongst offenders with a serious criminal record.

Findings from qualitative studies of DC programmes emphasise the quality of support DUWOs received as essential to their successful engagement. Fischer et al's (2007) sample of 11 DC female participants reported feeling supported by people who cared for them and, in particular, singled out the judge as empathetic, professional and knowledgeable about recovery. The women stressed the importance of an individualised treatment programme involving their views, concerns and preferences. They also wanted services that moved them toward independence through financial help, skills acquisition and vocational training. They were in favour of one-to-one therapy with female ex-addicts whose judgement they could trust (see also Roberts & Wolfer 2011). However, women on another DC programme spoke about being overwhelmed by the demands of the DC programme and argued for more emphasis on practical help with transportation, sick

children and domestic violence and for a greater focus on housing, health and childcare needs (Morse, et al, 2014).

Specialist approaches in probation, parole, community supervision and aftercare

Chan et al (2005) define probation case management (PCM) approaches as allowing more frequent and intensive engagement with clients including more gender-specific education about addiction, more counselling and referrals to other agencies. Guydish et al (2011) found no advantage of PCM over standard probation because the intensity of engagement was no better with only 54% of women reporting face-to-face contact with their probation case manager in 6 months (see also Johnson et al, 2011). A number of research studies examined the benefits of a recovery management check-up programme for women offenders (RMC-WO). Scott and Dennis (2012) found that women in the RMC group were significantly more like to return to treatment sooner and to participate in treatment overall (p=<0.5) but RMC was not significantly linked with increased abstinence or reduced recidivism suggesting that longer term support is needed to cope with a number of relapses over time (see also McCollister et al, 2014).

McDonald and Arlinghaus (2014) evaluated an *intensive* case management (Female Offender Re-entry Project) and compared women who had participated in the programme prior to release ('pre-only') to those who had participated both prior to and after release ('pre and post'). The 'pre and post' group were more likely to be working (40% vs 30%); to be residing in a halfway house or sober living (49%/35%); to be participating in substance misuse treatment (55%/47%) and mental health treatment (53%/28%); and were also less likely to commit a new crime (22%/30%). Increasing time in treatment was associated with decreasing risk of a return to custody as was previous participation in in-custody treatment. Another study showed that the women who participated in and completed the FOTEP programme[4] were 80% less likely to return to prison than non-completers (Grella and Rodriguez, 2011).

[4] Female Offender Treatment and Employment which comprised 6-15 months residential drug treatment, case management, vocational services and parenting-related services.

Alcoholics Anonymous (AA), Narcotics Anonymous (NA), self help, peer support and mentoring

A lack of social support is a key issue for DUWOs leaving prison. Interventions which attempt to improve DUWO's social networks can plug this gap and offer longer term support after substance misuse and thus prevent relapse. Brown and Ross' study (2010) of mentoring in Australia suggest that peer mentoring can provide a cost-effective form of support. The study was able to show that the relational, non-judgemental support offered by the mentor was able to improve the social capital of some DUWOs. However, mentoring was less successful in engaging women with extensive drug and alcohol problems who found their issues so overwhelming that mentoring seemed irrelevant. This suggests that mentoring might only work with DUWOs if other supportive services are also in place. Nevertheless, identifying with someone who has recovered can serve as a powerful motivator to women who doubt their own chance of living life without drugs (Sowards et al, 2006). Thus, linking a new client with a more senior participant doing well in a programme may be a useful strategy for encouraging motivation and engagement (see also Warner-Robbins and Parsons, 2010).

One of the most common forms of peer support is AA/NA. However, Sered and Norton-Hawk (2011) express concern about the appropriateness of this form of peer support for DUWOs particularly if it is through mandated attendance. The demands for daily AA/NA meetings in addition to regular urine testing and meetings with probation officers can make managing other issues, including holding down a job, near impossible. A key issue is the lack of focus on structural issues faced by the women with the emphasis firmly on individual responsibility to change. It is suggested that this insistence on taking personal responsibility for one's own addiction ignores or trivialises DUWOs' experiences of homelessness, abuse, violence and neglect. The mixed-gender AA/NA meetings also present considerable risks for DUWOs in terms of constant drug talk; unwanted sexual encounters with men; and their stories being trivialised or ignored. In addition, women do not appreciate the hierarchical and over-controlling nature of their relationships with sponsors.

Gender-responsive programmes

A body of research focussing on programmes specifically designed for women have indicated that they are better at addressing a history of trauma and mental health issues in combination with substance misuse. Covington et al (2008) in an evaluation of two combined gender-responsive programmes *Helping Women Recover* and *Beyond Trauma* argue that this combination is particularly effective in improving both trauma and depressive symptoms and that this process provides a safe environment to facilitate DUWOs' healing process. A similar programme *Seeking Safety*, which is a CBT-based intervention for women with PTSD and substance misuse dependency, showed a similar impact in terms of significantly decreased symptoms of depression ($p=0.002$), improved interpersonal functioning ($p=0.036$) and decreased maladaptive coping ($p=0.028$) (Lynch et al, 2012; see also Wolf et al, 2012; Zlotnick et al, 2009; Messina et al, 2014). However, all interventions must be appropriate to an individual woman's needs. An evaluation of a prison-based programme again using *Helping Women Recover* and *Beyond Trauma* found excellent results for those women who had experienced physical and sexual abuse but less success in reducing depression and substance misuse in those women who had not (Saxena et al, 2014).

The importance of comprehensive aftercare following a prison-based intervention is also emphasised in research findings on gender-responsive programmes. Twaddle et al (2006) found that a specialist support and residential treatment programme for DUWOs in a prison in Guam was highly successful in helping women recover from past traumas; in addressing their underlying causes of addiction; in developing a sense of community; and in managing the stresses of prison life. However, they recommend that prison interventions are followed up with aftercare providing transitional housing and residential treatment in the community so that women can avoid returning to abusive relationships and can work to reunite with their children (see also Messina et al, 2009).

Messina et al (2012) compared Drug Court (DC) interventions with a gender-responsive element to those working with mixed gender groups. They found that the DUWOs involved in the gender-responsive programme were less likely to receive sanctions, less likely to be remanded to jail and significantly less

likely to be terminated from treatment for unsatisfactory progress in the first 6 months (p=<0.05). Both the gender-responsive and mixed-gender participants showed improved alcohol and drug scores and psychological functioning over time. However, the reduction in a current PTSD diagnosis was twice that in the gender-responsive group than in the mixed-gender group. Nevertheless, there were no differences in overall arrest rates, with 33% of the total sample being arrested at least once during the 18 month post-treatment follow up period. This suggests that more intensive and longer treatment engagement might be required. In addition, Messina et al (2014) acknowledge that integrated and gender-responsive treatment that addresses both PSTD and substance misuse is going to be expensive and will require highly trained staff able to address both issues effectively.

Not all research findings are as positive about gender-responsive programmes. Some research suggests that, like AA/NA, these interventions also over-emphasise DUWOs' individual responsibility for changing their behaviour and taking control over their lives whilst ignoring the structural disadvantages and adverse circumstances they face. The risk with this is that failure to succeed is also placed solely on the women (Hackett, 2013). Thus if gender-responsive programmes do not take into account women's wider social and material needs they risk constructing their vulnerabilities as lying with themselves rather than within wider issues such as social disadvantage and stigmatisation (McKim, 2014).

Discussion

There is a strong emphasis throughout the research findings on the need for good long-term aftercare in order to sustain any treatment gains from prison (Lynch et al, 2014; Taylor, 2008). This also reduces the risk that even if women make progress in prison that progress is undone by a lack of support and/or treatment on release (Johnson et al, 2013). Research findings also highlight the need for comprehensive pre-release planning so that the transition to effective aftercare in the community is successful (Belenko and Houser, 2012; Van Olphen et al, 2006). Good coordination between prison and the community is essential in this process (Green et al, 2005). This allows for quick access to treatment on release and reintegration planning including effective linkage to suitable, good quality aftercare (Doherty et al, 2014; Van Olphen et al, 2009).

This requires effective communication between criminal justice staff in both the prison and the community and information-sharing – including with the DUWOs themselves - in order to fully assess what their needs will be on release (Doherty et al, 2014; Magaletta et al, 2014). These processes should ensure that community programmes reinforce and build upon work done in prison (Monster and Micucci, 2005).

Community services coming into the prison to engage with and contribute to pre-release planning can aid successful reintegration (Farkas et al, 2007; Fries, 2014; Luther et al, 2011). This also allows a therapeutic relationship to be established with community service agents prior to release. Ideally the same practitioners will build on these relationships to provide good continuity of care in the community (Laux et al, 2008). This also prevents community practitioners having to arrange treatment for a DUWO with limited information and just a few days notification of her release date (Keil and Samele, 2009). It also ensures immediate connection with support services on release – something many studies cite as essential (see for example Johnson et al, 2013; Johnson et al, 2014). However, Kellett and Willding (2011) argue that such coordination is currently lacking and that the need for immediate treatment on release is largely unmet (see also Keil and Samele, 2009; Kinner, 2006; Houser et al, 2014). In Laux et al's (2008) study women complained that they often had to start again with a new treatment paradigm and new practitioners once released.

Successful treatment and aftercare also requires greater integration of medical, psychiatric and substance use treatment to meet the complex needs of DUWOs (Best et al, 2008; Derkzen et al, 2013; Farkas et al, 2007; Fedock et al, 2013; Grella and Greenwell, 2007; Hall et al 2013; Peltan and Cellucci, 2011; Plourde et al, 2012; Walters and Magaletta, 2015). The separation of such services either in prison or in the community does not give sufficient weight to the inter-related nature of women's needs – for example mental health services and drug services may not fully appreciate the impact of co-morbidity on both conditions and may attempt to tackle them one at a time or through medication without psychosocial support (Carlson et al, 2010; Grella and Greenwell, 2007; Salisbury and Van Voorhis, 2009). This issue is exacerbated if the personnel in the service lack the appropriate skills – for example drug service providers lacking the skills to

identify and treat mental health issues (Nowotny et al, 2014). If interventions only address one or two needs whilst ignoring other compelling issues they are unlikely to be successful (O'Brien and Young, 2006). If treatment is predominantly provided within the criminal justice system connection with wider services outside of the system will be necessary in order to meet DUWOs' wide range of needs (Carmichael et al, 2007).

Hall et al (2013) also emphasise that treatment must be of sufficient intensity and duration given the particularly entrenched and complex issues DUWOs face and their high risk of relapse and re-offending. They recommend 5-11 months as a suitable time (see also Kellett and Willding, 2011; Proctor, 2012; Scott et al, 2014; Walters and Magaletta, 2015). In addition, treatment needs to be flexible and sensitive to the other significant pressures on DUWOs during the challenging transition back into the community – for example by providing childcare, transportation (particularly in rural areas) and by offering out of hours support (Moore, 2011; Staton-Tindall et al,2007; Staton-Tindall et al, 2011; Zurhold et al, 2011).

Interventions should combine meeting treatment needs with provision of more practical help with education, employment and housing services that DUWOs will also need to re-integrate effectively (Allen et al, 2010; Colbert et al, 2013; Doherty et al, 2014; Fedock et al, 2013; Fries, 2014; Grella and Greenwell, 2007; Oser et al, 2009; Salem et al, 2013). This approach acknowledges the very real constraints DUWOs face on re-entry (Allen et al, 2010) and prioritises the most pressing of their needs (Bergseth et al, 2011). In addition, parenting support will help women re-unite and care for their children (Few-demo and Arditti, 2013; Hanlon et al, 2005) and a focus on developing pro-social networks will ensure longer-term support (Bui and Morash, 2010).

An over-focus on personal responsibility for recovery evident in some treatment paradigms risks women being blamed for their 'failure' when they face significant structural barriers. By neglecting these wider structural issues, evaluations may not able show significant intervention effect because they do not take into account the impact of those wider challenges beyond drug treatment. Qualitative longitudinal research which

incorporates DUWOs' opinions on their needs could help inform the development of interventions better tailored to meeting those needs and able to prioritise the most pressing (Johnson et al, 2013). Successful interventions are likely to be intensive; of significant duration; multi-dimensional; and inter-disciplinary in order to address DUWOs' complex needs. Evaluations of those interventions must similarly be designed to take into account all individual and structural factors past and present.

Most evaluations are focused on final outcomes, and in particular recidivism rates, whilst progress made is not always taken into account. This flies in the face of what we know about the complexity of drug addiction and recovery which often involves relapses along the way. Acknowledgement of steps made in the right direction is important for maintaining motivation and should be incorporated into any research design. Interventions need to encompass DUWOs' whole sentence - both in prison and/or in the community - building on continual assessment and progress through intensive and long-term aftercare. Research studies therefore should also be designed to follow DUWOs through their whole sentence rather than focusing on a single intervention/point in time without the context of what came before and what might or should happen in the future.

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