An Analysis of the Provision of Services for adult Female Offenders with Substance Misuse Problems in Norfolk

Prepared for:
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by

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1. **Introduction**

The County Strategic Group for Crime Reduction funded the Norfolk Drug and Alcohol Partnership (N-DAP) to commission researchers at Anglia Ruskin University to provide a comprehensive assessment of the complex and multiple needs of adult female offenders in Norfolk.

The research undertaken has sought to obtain this information through a variety of methods to obtain the views of both professionals working in this area and of the offenders themselves. However, priority has been given to the views of the women offenders receiving substance misuse treatment in order to identify their perceptions of gaps in the health, social care and Criminal Justice services.

The final research report identifies a number of key areas for further consideration including the following:

- The importance of flexible and personalised nature of the support provided to female clients.
- The value placed upon a relationship with one clearly identified worker with whom a positive relationship could be built up and sustained over time.
- The needs of offender’s partners should be recognised, with their needs catered for alongside those of the offenders.
- The impact of offender’s substance misuse on dependent children should also be recognised, along with the important role played by Children’s Services in supporting families affected by substance misuse issues. This raises further issues of effective partnership working between agencies.
- The importance of dealing with mental health issues of the offenders alongside the problems of drug use, which again raises further issues of effective partnership working.
- The geographical spread of provision and the subsequent logistical difficulties faced by offenders travelling to these services.
- The importance of early provision of suitable accommodation.
- An increase in reliance on peer groups to provide mutual support and to pass on experience gained by offenders with drug issues who have successfully overcome them.
1.1 Research process and methodology

This research study has used a mixed methods approach which we regard as especially appropriate for this particular issue of problem drug use and offending, as it offered both the breadth and the depth required by the project (Bryman 2004). This would also replicate the approach taken by other work in this area, such as that of Hamilton and Fitzpatrick (2006) who supplemented a quantitative needs assessment with a more qualitative, in-depth interview technique.

The main components of the research were as follows:

1. Literature and policy review

2. Statistical information

It was originally intended to obtain detailed information on the statistical profile of the offender population in Norfolk. However, it proved particularly difficult to obtain comprehensive statistics from the relevant authorities and those which were obtained were limited. This was rather disappointing, and necessitated a rethinking of the overall research design with a refocusing on analysis of the data obtained from the primary research with both practitioners/professionals and offenders (see below). The difficulty in gathering and disseminating/sharing information is one issue which could usefully be addressed as part of any strategy developed as a result of this research.

3. Primary research with practitioners

People working in the field of offenders and problem drug/alcohol use, including probation officers and third sector employees and volunteers were sent a structured questionnaire, which was distributed electronically. These focused on the resources and services available to female offenders in Norfolk, and the implementation of recent policy measures.

To increase response rates, and to ensure that those who did not reply to the original questionnaire were not significantly different in views from the those who did respond, a personal e-mail questionnaire, with a restricted number of questions, was then mailed to a
sample of those who had not replied to the original electronic structured questionnaire. Follow-up telephone interviews were then carried out with a sample of key stakeholders identified through analysis of the structured questionnaire and meetings were arranged where useful to discuss any salient issues.

4. Primary research with service users

Interviews were carried out with a sample of the offender population identified in the initial stage, and based on a reflection of identified offending patterns across Norfolk\(^1\). It was originally anticipated that a proportion of these would be sampled from those currently serving custodial sentences in HMP Peterborough\(^2\). However, access to the prison proved more difficult than originally envisaged, so no currently serving prison inmates are included in the research. However, the sample interviewed did include a number of women who had previously served a sentence in a range of prisons (*including* HMP Peterborough) and were able to comment extensively on services available to women in prison.

Interviews used a combination of structured questions followed by a semi-structured section to allow the fullest exploration of the issues faced by respondents. The first, structured section asked respondents a number of factual questions regarding their offending behaviour, patterns of drug and/or alcohol use, and engagement with services. The second section of the interviews followed a topic guide derived from issues highlighted as relevant in our review of the literature (see section 3). Question schedules in the second part of the interviews did not follow a set order of topics, but the researchers aimed to cover (as a minimum) the following issues:

- **offending history** including onset/progression of offending, perceptions of the links between offending and drug/alcohol use (including offending as a means of funding drug use), and the influence of offending partners/family members/peers
- **patterns of drug and alcohol use** including onset, frequency, influences and consequences
- **other factors impacting on drug/alcohol use** including
  - family relationships, especially with partners and children
  - education
  - (un)employment, low incomes and benefit receipt

\(^{1}\) Interviews were carried out in Norwich, Great Yarmouth, Cromer and Kings Lynn, to obtain as wide a coverage of the region as possible.
- health (particularly mental health)
- housing and homelessness

Researchers also noted down any relevant points about significant life events raised by the women in the initial structured section of the interviews, and used these as prompts or probes in the second stage.

1.2 The national policy context - a new focus on female offenders?

Criticisms of a system which has consistently failed to recognise the specific needs of female offenders and instead ‘shoe-horns’ them into a criminal justice system designed around patterns of male offending, are both long-standing and numerous. However, in recent years policymakers have increasingly begun to recognise the needs of female offenders, and there are signs that the situation is slowly beginning to change. The publication of the Women’s Offending Reduction Programme (WORP) Action Plan in 2004\(^3\) began to recognise these issues and to address the 'common cycles and paths that lead from unmet needs to crisis to offending'\(^4\). The Corston Report (2007)\(^5\) highlighted the multiple and complex needs of female offenders, identifying three key areas of vulnerability: their domestic circumstances (such as experiences of domestic violence or single parenthood), personal circumstances (mental health problems or a history of substance misuse) and socio-economic factors (experiences of poverty, unemployment and isolation). The report also recognised the disproportionate part played by drug addiction in female offending, with high levels of drug use and alcoholism among respondents.

This trend has accelerated further still following publication of the Corston Report, with the recent development of a National Service Framework for female offenders (Ministry of Justice 2008a) intended to underpin service delivery by key agencies. Part of this has been the requirement to implement the gender equality duty, which was one of the key recommendations of the Corston Report. The recently published Offender Management Guide to Working with Female Offenders (Ministry of Justice 2008b) also acknowledged some of the particular issues experienced by female offenders such as their issues around emotional well-being, or the impact

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of their caring responsibilities - and argued that many women may hide or underplay their substance misuse for fear of losing their children. The guide also pointed out that accessibility of services should be a key consideration during the planning stages, with sufficient attention paid to women’s childcare needs and stressed that ‘some women may benefit from a greater outreach type of work rather than an expectation that they attend appointments at a particular service at pre arranged time.’ However despite the apparent increase in recognition of women’s criminogenic needs, a recent evaluation published by the Fawcett Society\(^6\) was critical of the lack of progress, arguing that “more than two years later, while there have been some important steps forward in the policy arena, the movement from policy to practical implementation remains disappointingly slow\(^7\), and that women continue to experience disadvantage within the criminal justice system.

2. The Local Context

2.1 Relevant demographic factors in Norfolk

The County of Norfolk covers over 2,000 square miles and is a relatively sparsely populated, rural county of approximately 833,000 people. It is the fifth largest area of English two tier non-metropolitan counties, with the eighth highest population but the tenth lowest population density. Around 40 per cent of the population live in the three major built up areas of Norwich, Great Yarmouth and King’s Lynn, and a further 18 per cent in the market towns. Another 20 per cent live in villages and settlements of under 1,000 population, indeed 20 per cent of these settlements have less than 300 inhabitants. The county is expected to grow by 12 percent by 2021, faster than the regional and national averages.

Levels of income and deprivation are lower than the average in England, but there are significant areas of deprivation in Great Yarmouth, King’s Lynn and, to a lesser degree, in Norwich. Some districts in Norfolk rank highest in the region for persons who are permanently sick or disabled, with 28% of the population who either have a long-term illness or are generally in poor health.


\(^7\) Fawcett Society (2009: 30)
2.1.1. **Relevance to the current research**

The relevant points from the above information for this research project are that Norfolk is a largely rural county with much of the population having significant distances to travel to reach large sized conurbations where a range of health, social care and Criminal Justice services are likely to be located. Secondly, problem drug use is associated with high levels of deprivation. Although overall Norfolk is not a deprived county, there are significant pockets of deprivation across the county. Finally, population growth above average for England suggests a growing demand for health, social care and Criminal Justice services with an inflow of people moving into the county.

2.2 **Substance abuse in the East of England and Norfolk**

Statistics for problem drug misuse in the East of England and Norfolk are available as a result of two locally-commissioned research projects. It should be noted however that the findings of the two research projects are not directly comparable as they vary according to different methodologies used and they counted different categories of drug users. According to research carried out by The University of Glasgow (2007), the East of England is the region with the *lowest* rate of problem opiates and/or crack cocaine users in England, with rates significantly below that of the national average, as indicated in the chart below.
Research commissioned by Norfolk DAAT in 2006 from the University of East Anglia (UEA) (Holland et al. 2006) concludes that Norfolk has, however, higher levels of overall problem drug use as compared to the national average:

“Our estimate suggests a prevalence of problem drug use of 2% of the population aged 15–54 in Norfolk...... This appears to be a high value when compared with the national estimate of 1.1% of the UK’s population aged 15–54.”

The UEA study uses a definition of problematic drug use that covers all drugs. The Glasgow research uses a definition of problematic drug use that covers only opiates and/or crack cocaine. We note that the NDAP feels confident that they have a good idea of the numbers of substance misusers and that they perceive no conflict between the two sets of figures.

2.2.1. Relevance to the current research

The information above is relevant to this research project in that, although the numbers of problem opiates and/or crack cocaine users is relatively low in the county, the above average
numbers of problem drug users (in total) identified by Holland et al. might suggest that there is a potential for a future increase in the opiates and/or crack cocaine user population. Female offenders with opiates and/or crack cocaine use problems may be in contact with others who are not known to official agencies, and it is widely recognised that continuation of drug use is often linked to membership of social networks of problem drug users (PDUs).

2.3 Numbers in treatment

A second relevant point to note for this report is that only a proportion of problem drug users (PDUs) receive treatment. The work undertaken by Glasgow University points to approximately 60% of problem opiates and/or crack cocaine drug users receiving treatment, whilst that by UEA suggests that the overall figure for problem drug users could be as low as 30% (see fig. 3 below).

**Fig 3. Overall numbers of PDU’s (Opiate and/or crack cocaine) compared to numbers actually in treatment**

![Graph showing numbers of PDU's compared to numbers actually in treatment](ERPHO/Muse (2009) Substance Misuse in the East of England. Cambridge: Eastern Region Public Health Observatory)
In 2007/8, 15446 residents of the East of England received drug treatment, a 10% increase on the previous year. This represents a figure of 4.24 individuals for every 1000 of the population. The figures for Norfolk are significantly higher however, with 5.09 individuals receiving treatment. This is noticeably above the levels for other rural authorities within the Eastern region such as Suffolk, Essex and Cambridgeshire, suggesting that Norfolk is more effective in getting opiate and/or crack cocaine problem drug users into treatment.

2.4 Gender and Age of Female PDUs

Out all East of England residents treated for problem drug use in the region during 2007–2008, 33% were female, with an average (mean) age of 32, corresponding to the national average. The proportion of females receiving treatment appears to be the similar throughout the age range. However, there does appear to be a decline in the numbers of individuals in the 20–24 year age group accessing treatment.

*Fig 4. East of England profile of individuals in drug treatment, by age and gender*

The Norfolk-specific study undertaken by Holland et al. (2006) suggests that the Norfolk profile is slightly younger than that of the East of England as a whole.
2.4.1. Relevance to the current research

The majority of women with drug problems are of an age where they are most likely to be responsible for children, which can impact on their willingness to engage with drug treatment programmes and their ability to attend.

2.5 How successful were treatment interventions overall?

Over half (51%) of all discharges from drug treatment in the East of England are unsuccessful, with half of these due to the client dropping out or leaving treatment. Referrals drawn from backgrounds linked to offending had lower than average successful discharge, with probation clients achieving average rates of successful discharge. We have no access to figures based on gender, however both the ‘Sex Worker Project’, ‘Arrest Referral/DIP’ categories which are amongst the lowest levels of success would have significant numbers of females. 42% of dropouts from treatment were explained by ‘dropped out/breach of contract/prison’. 
2.5.1. Relevance to the current research

Certain sub-categories of women with problem drug use clearly have higher drop-out rates from treatment programmes. Although, we do not have specific information on exactly who these may be, it has been suggested to us that these are likely to be women sex workers and female prolific offenders.

2.6 Acquisitive crime and problem drug use

The study by Holland et al. (2006) suggests that the minimum proportion of all acquisitive crimes in Norfolk related to problem drug misuse is likely to be in the region of 20-25 %.
2.7 Alcohol abuse in the East of England/Norfolk

National figures indicate that the East of England has the lowest levels of problem alcohol use in England\(^8\). However within this region, Norfolk has the second highest levels of problem alcohol use, with about 4.5 people per 1000 of the population attending treatment, as illustrated in the diagrams below (figs 7 and 8).

**Fig 7. The Position of the East of England in the National Context**

![Graph showing the position of the East of England in the national context](Image)

*Figure 9. Percentage of people in England with an alcohol use disorder by region (see Section 2 for definition).*
*Source: Ref. 3.*

\(^8\) Problem drinking is here defined as drinking above the nationally recommended limits, which are currently 14 units per week for women, and no more than four units in any one day.
2.8 Treatment:

Those attending treatment for alcohol problems tend to have a higher age on average than problem drug user clients. For alcohol treatment the mean age for women was 40 years, almost 10 years older than those undergoing treatment for problem drug use. The proportion of males and females in the treatment population tends to remain constant throughout all the age groups, with females forming about 30% of problem drinkers. Amongst young people however females are increasing significantly in the proportion of those being treated and represent over 40 per cent of those undergoing treatment.
2.9 Relevance to the current research

The available statistics indicate that Norfolk has a relatively high level of problem alcohol use within the East of England, with figures higher than other rural authorities. The age of women entering treatment programmes is noticeably older than the average age of those entering programmes for drug abuse, suggesting that the clients will have different domestic circumstances and life experiences, both of which may impact on treatment.

2.10 Alcohol use and crime

Levels of alcohol-related crime vary greatly across the East of England, reflecting the rural/urban differences. The diagram below indicates this variety, with approximately 60 per cent of the
CDRP’s reporting crime alcohol related crime levels below the national average and 40 per cent reporting levels above it.

Recorded crime attributable to alcohol for 2004/05 in the East of England

![Graph showing recorded crime attributable to alcohol for 2004/05 in the East of England.]

Source: ERPHO (2006)

### 2.11 Statistics of Female Offenders (PDU’s) in the Year March 2008-2009

According to Norfolk Probation Area Offender Assessment System (OASys) figures, during the year preceding April 2009 the numbers of female offenders on orders to Probation totalled 595.

The punishments applied to these women consisted of:

- Community Orders - 420
- Suspended Sentence Orders - 176
- Pre CJA2003 Orders - 21
- Licenses - 78
- Custody - 47

(Note: offenders might receive more than one punishment type)

374 of these offenders had completed assessments by Probation, and of these a total of 296 women were identified as having drug or alcohol issues. Within this figure of 296, 126 had
specific drug problems, 170 had alcohol problems with 58 admitting to both drug and alcohol problems.

Accommodation: 61 women did not live in permanent accommodation.

We were unable to obtain more statistical information than this.

3. **Literature Review**

3.1 **Complexity of female offenders’ needs**

A common theme throughout the literature is the complexity of female offenders’ needs, and the significant challenges this presents in terms of service commissioning and provision. A recent report on community provision for female offenders noted the incidence of these ‘multiple presenting problems’ among their sample, including⁹:

- experiences of domestic violence (39%)
- accommodation needs (33%)
- misuse of drugs (32%)
- misuse of alcohol (24%)

Other factors highlighted include lack of a legitimate income and subsequent experiences of poverty, family breakdown, and mental health issues. Low levels of educational attainment and other related issues such as truancy and exclusions can also be a significant factor¹⁰.

3.1.1. **Poverty, financial exclusion and low incomes**

The lives of many offenders are often ‘defined by poverty’ and financial exclusion¹¹, which can have a negative impact on mental well-being. The recent report published by the Revolving Doors Agency (RDA), *Hand To Mouth* noted the strong links between poverty and offending, citing Home Office evidence which showed that 72% of prisoners had been in receipt of benefits.

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prior to receiving a custodial sentence\textsuperscript{12}. Benefit claims can be slow to process, and these delays can put released prisoners at particular risk of re-offending. Financial welfare has been recognised as a central element of effective resettlement, and is one of the current NOMS pathways, yet research has shown that the problem still exists. As the authors of \textit{Hand to Mouth} argue, ‘Financial crisis can lead an individual to turn to crime and, equally, time in prison and a criminal record can lead to further financial exclusion’\textsuperscript{13}. Gaining and maintaining employment can be particularly problematic for female offenders, particularly where this is compounded by drug or alcohol misuse and ‘chaotic lifestyles with many problems and needs, which would make holding down a job difficult’\textsuperscript{14} - meaning that few have legitimate earning opportunities\textsuperscript{15}.

### 3.1.2 Levels and prevalence of drug and alcohol use among female offenders

Growing numbers of women are being sentenced to custody who misuse either drugs or alcohol, with an increasingly ‘high proportion imprisoned for offences \textit{directly related to problem drug use}’ (added emphasis)\textsuperscript{16}. Recent research\textsuperscript{17} found high levels of reported use of any drug in the twelve months prior to imprisonment, amounting to 77\% of white women surveyed and 63\% of black/mixed race women. When this data was further examined and broken down according to levels of use of different drugs among different groups of women, the researchers found higher levels of heroin use among the sample of white women (59\%), as well as high levels of cannabis use (57\%) and crack use (48\%). Reported levels of tranquilizer use were also significant at 43\% of the sample, 30\% of whom reported using methadone. In comparison, only 19\% of the sample of black/mixed race women reported using heroin. However, the levels of cannabis and crack use were more comparable (at 55\% and 36\% respectively). Significantly, levels of tranquilizer use were also found to be much lower at just 14\% of the black/mixed race women. Differences in levels of amphetamine use between the two samples were also identified; while 25\% of white women surveyed reported using amphetamines, this figure fell to just 5\% of the black/mixed race sample.

\textsuperscript{12} This may mean that women, who often have higher levels of benefit receipt, are particularly vulnerable.
\textsuperscript{13} Pratt and Jones (2009: 34)
\textsuperscript{14} O’Shea et al. (2003) \textit{Snakes and Ladders: Mental Health and Criminal Justice}. London: RDA
\url{http://www.homeoffice.gov.uk/rds/pdfs2/hors267.pdf}
This study also found that not only was use of various drugs widespread, the severity of respondents’ drug use was also particularly high, with 49% of all the women surveyed were dependent on at least one drug. Once again, when this data was disaggregated, significant ethnic differences were identified: 60% of white women were found to be dependent, compared with a much lower figure among black/mixed race women (29%). High rates of heroin dependency were identified (33% overall, but 47% of white women compared with only 10% of black/mixed race women). Overall, 23% of women were dependent on crack and there was no significant ethnic difference between the sample of white women (25%) and black/mixed race women (21%). 31% of respondents reported injecting drugs at some stage, although 45% of white women had injected compared with just 9% of black/mixed race (although the researchers acknowledged that this was likely to be - in part at least - a reflection of the higher levels of heroin use among white women).

Regarding alcohol misuse, 34% of the sample reported ‘harmful or hazardous levels of alcohol consumption’ in the 12 months prior to imprisonment, with ‘no significant association between ethnicity and drinking status’. Co-current problems with drugs and alcohol were also identified among a small but significant proportion of the women (16%) who were found to exhibit both harmful/hazardous levels of drinking and dependency on at least one drug18. Only 3% of the women surveyed reported drinking in prison. However, the study found that ‘there was considerably wider use of other substances’ with 45% of the sample reporting having used an illicit drug, such as heroin (27%), cannabis (21%) and tranquilizers (17%)19.

Significantly, given the high incidence of mental health difficulties among female offenders, women in this study reported that their excessive drinking was a result of their experiences of victimisation and abuse, and that they used alcohol ‘primarily to cope with negative emotions, stress and painful memories’. However, the researchers equally warn against making simplistic assumptions regarding the reasons for women’s drinking, and emphasise that respondents’ alcohol problems ‘were also associated with causing physical harm to others, suggesting that

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18 Other studies have reported much lower proportions of women who have issues with both drugs and alcohol - for example only 2% of respondents in O’Shea et al. (2003) Snakes and Ladders: Mental Health and Criminal Justice. London: RDA

19 The research also investigated various demographic, social and psychological factors associated with substance use such as education/employment (see section 3.1.1), relationships with family/friends and caring responsibilities (see section 3.1.5), experiences of violence and abuse, and mental health problems, including histories of self-harm and suicide attempts (see section 3.1.4).
the association may result from underlying personality or lifestyle characteristics, rather than a causal link between victimisation and substance misuse.’ Furthermore, they found that ‘crack users in particular referred to using alcohol as a sedative - to balance the stimulant effects of the drug’.

While women’s drug use in prison was found to mirror levels among male prisoners, the study clearly identified differences in type of drug use not only between men and women, but between different groups of women - and in reasons for drug/alcohol use, highlighting the complexity of patterns of substance misuse and the consequent difficulty in formulating appropriate policy responses or designing local services. Subsequent studies have broadly replicated the findings of Borrill et al.’s study. For example, research carried out by the RDA in 2005 found that over 51% of remand prisoners and 40% of sentenced prisoners reported some form of drug dependency in the year before they come to prison, with 40% of remand prisoners and 23% of sentenced prisoners dependent on heroin. This study also found that 38% of women had engaged in ‘hazardous’ levels of drinking in the 12 months prior to their imprisonment, rising to 50% of young women (under 25).

3.1.3 Unstable housing and homelessness

Female offenders often have particularly chequered housing histories. Research has shown that when women are released from custody, they face a whole range of housing difficulties: a recent study published by the RDA included found that a person with mental health problems had a 40% chance of losing that tenancy by the time they were released, with 47% being released with no fixed abode. While this research covered both male and female offenders, it is likely that women will be particularly affected by such issues, given the high incidence of mental health needs among female offenders and the fact that they often have sole responsibility for tenancies and are less likely to have a partner who will be able to stay in the family home and maintain the tenancy during their sentence. Similar research with female offenders found that 60% reported previous experiences of unstable housing, while 61% anticipated returning to unstable housing situations on release.

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21 Revolving Doors Agency 2001
22 Hamilton and Fitzpatrick (2006)
An independent study of what works in service provision for female offenders found that accommodation was a central factor in effective resettlement, and could become the ‘primary factor impacting upon the motivation of women to go on and address other needs’\(^{23}\). However, the study also argued that ‘women often report finding difficulties when attempting to access and retain a stable and affordable living situation’\(^{24}\). Problems in accessing stable, appropriate accommodation can have a disproportionate impact on female offenders who are then faced with the ‘conundrum of being unable to re-establish a family unit without accommodation’\(^{25}\). The recent Fawcett Society report also notes that women’s role as ‘primary carers … creates further difficulties accessing housing. If women do not have a home they will then experience difficulty in getting their children back. However, they will also find it harder to get a home if they are not caring for their children’\(^{26}\). Consequently many women can find themselves trapped in a vicious circle, with no home and unable to regain custody of their children.

### 3.1.4 Mental health problems, victimisation and abuse

Research has repeatedly highlighted the extent of mental health difficulties among female offenders, with depression and anxiety as the most commonly cited problems\(^{27}\). Many women’s offending behaviour and/or substance misuse can arise as a form of response to traumatic life events and experiences of loss, such as bereavement, the sudden death or stillbirth of a child, and family/relationship breakdown\(^{28}\). Many women who become involved in substance misuse and/or offending behaviour have been shown to have extensive histories of victimisation and sexual or physical abuse\(^{29}\). An analysis of OASys data for 2007 indicated that 46% of female offenders had been victims of domestic violence, compared with just 6% of male offenders\(^{30}\). Similarly, recent research with imprisoned woman at HMP Styal found that the majority (62%) of interviewees had been subjected to abuse or severe parental neglect as children, most commonly at a very early age (below 10)\(^{31}\).

\(^{23}\) Clarke (2004: 12)
\(^{24}\) ibid
\(^{25}\) ibid
\(^{26}\) Fawcett Society 2009: 40
\(^{29}\) ibid.
\(^{31}\) Hamilton and Fitzpatrick 2006
Often the mental health needs of women are not routinely met by the services available. In a recent study\(^\text{32}\) it was found that a significant proportion of women were ‘falling through the net’, with 36% of respondents reporting an undiagnosed mental health issue, which often remained unrecognised until they entered the criminal justice system. On the other hand, Hamilton and Fitzpatrick’s report into the needs of women at HMP Styal\(^\text{33}\) noted high levels of diagnosed mental health problems - but low levels of contact and engagement with statutory services.

According to another report published by the RDA\(^\text{34}\), existing mental health difficulties can be further exacerbated by the stress of trial and a subsequent custodial sentence, with high levels of self-harming and suicide attempts in women’s prisons\(^\text{35}\). The mental health of imprisoned mothers was highlighted as a particular cause for concern, because of the risk that it could be ‘further damaged by women’s anxiety over the safety of their children’. 55% of women in this study who were on their first prison sentence displayed symptoms of mental health problems (mostly depression which affected 45% of those surveyed), and 7% had multiple mental health problems. 18% of the prison sample had had no contact with mental health services, while 33% of those surveyed in police stations had never had a mental health diagnosis and 48% had never had any contact with their local CMHTs. A study commissioned by the Home Office\(^\text{36}\) also found high levels of recent self harm (50.5%) and suicide attempts among imprisoned women (47%), while further research also found disproportionate levels of self-harm among female prisoners who, in 2003 accounted for just 6% of the prison population but 46% of all recorded incidents of self-harm in prison\(^\text{37}\). The final report of the Fawcett Society Commission on Women in the Criminal Justice System\(^\text{38}\) recently noted that rates of self-harm among female prisoners had risen since the beginning of their investigation, with levels up 48% between 2003 and 2007. Women who have recently been released from custody are also particularly vulnerable: the National Service Framework for Women Offenders\(^\text{39}\) noted that this group was 36 times more likely to commit suicide or die from a drug-related overdose in the first two weeks

\(^{32}\) O’Shea et al. (2003)
\(^{33}\) Hamilton and Fitzpatrick (2006)
\(^{36}\) Borrill et al. 2001
\(^{38}\) Fawcett Society (2009)
\(^{39}\) Published in 2008 by the Ministry of Justice and National Offender Management Service
after release.

Recent policy developments have given some recognition to the mental health issues faced by female offenders. For example, the *Offender Management Guide to Working with Female Offenders*\(^\text{40}\) noted that women were more likely than men to have high levels of mental health needs, problems with low self-esteem and emotional well-being, as well as poor coping responses to stressful life events. Previous research has also noted a high incidence of dual diagnoses among female offenders\(^\text{41}\). The importance of meeting the needs of this particular group of women has also been recognised and identified as a key area for action in the Corston Report, which noted that there is a widespread lack of expertise in dual diagnosis in service provision. Several of the women interviewed for this study had experienced significant mental health issues, and talked about the difficulty they experienced in accessing appropriate integrated provision\(^\text{42}\).

### 3.1.5 Family relationships and parenting responsibilities

Many women who misuse drugs also have a partner with similar problems\(^\text{43}\), and services also need to account for the needs of couples as well as single women. For example, a recently published evaluation of the Drug Treatment Outcomes Research Study (DTORS) found that 61% of drug-using women with a partner had a partner who was also a drug-user. The disruption to family life and parental responsibilities caused by women’s drug use and imprisonment is another key theme throughout the literature. The DTORS research found that 75% of parents surveyed were living apart from all of their children aged under 16 years, and that this was most common where drug use was more serious and involved class A drugs - for example among crack users, 92% of whom had lost custody of their children compared with 74% of heroin users (and 60% of those using other primary drugs).

Recent figures published by the Fawcett Society showed that an estimated 17,700 children per year are separated from their mothers due to imprisonment, but that only 5% of those children

\(^{40}\) Published in 2008 by the Ministry of Justice

\(^{41}\) for example Malloch (2004)

\(^{42}\) For example, one interviewee talked about how she could only access mental health treatment once her drug use had been resolved, despite the fact that for her the two issues were clearly interlinked.

stay in their own homes while their mother is in custody. Women are more likely to have taken on the role of primary carer for their children, particularly where they are a single parent, and recognising and accommodating these particular responsibilities is essential to the successful delivery of services. Motherhood has been shown to be a ‘powerfully motivating force’ for female offenders, who frequently emphasise the importance of fighting for their children and maintaining an image of themselves as a ‘good’ mother. As already mentioned above, the harmful effects of imprisonment can be further heightened by anxiety about the well-being of dependent children. Women often feel ‘frustrated and marginalised’ by constant surveillance from social service departments, and ‘foiled’ in their efforts to improve their lives by narrow sets of rules. For many women, the threat of having the children removed from their care is seen as a ‘constant source of fear’. Becoming a new mother can also act as an important catalyst for changing offending behaviour, or reducing/desisting from substance misuse.

### 3.1.6 Implications for service provision

The distinctive nature of female offenders’ needs has direct implications for service provision, and the ‘complexity of factors relating to women’s pathways into crime points to the need for broadly-based provision that can be individually tailored’. Research has highlighted the importance of delivering support and services as flexibly as possible, and access is not restricted by the application of narrow eligibility criteria. Informal, broad-based support is seen as key to engaging effectively with women, which quite often will mean simply ‘having someone to talk to’. Effective partnership working is also seen as vital to achieving positive outcomes, and successfully addressing clients’ multiple, complex and overlapping needs.

There is a growing recognition that it may be more appropriate to provide women-only services wherever possible, as women’s past experiences of abuse or domestic violence can make them reluctant to engage in group work where a high number of male offenders are present, or to work with a male worker: ‘The physical, sexual or emotional abuse women problem drug users

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44 Fawcett Society (2009: 33)
47 Reid et al. 2008: 224
48 Gelsthorpe et al. 2007: 7
(PDUs) have frequently suffered, can lead to fear of male staff. However, the nature of the treatment offered and how it is delivered to women may be more important than employing female drugs workers\textsuperscript{50}. Women-only services should be made available where there is the need, but should not be prioritised at the expense of quality of service provision.

Suggestions from the literature for improving engagement with services include\textsuperscript{51}:

- fast response or immediate access
- varying opening times
- providing or facilitating childcare
- additional outreach work to contact ‘hidden populations’ of women
- stronger links with key partners, such as mental health agencies and housing providers

4. Primary Research

4.1 Practitioner and provider survey/telephone interviews

A cross-section of practitioners, (local authority/state/third sector) involved with female offenders were e-mailed a questionnaire on the shortcomings of services provided. A personalised follow-up asked a smaller group specific questions drawn from the fuller questionnaire. Separately, a sample of practitioners was interviewed by telephone and in person. Responses to the e-survey, the personalised e-mail questions and the interviews raised a number of important points which bear out the themes raised in the literature (see above). Because of the nature of the questionnaire and the discursive nature of the responses, it is not possible to provide a quantitative analysis. We have therefore indicated the salient points raised by practitioners from across the spectrum. Where particular comments can be linked to specific agencies we have done so.

Before we set out the responses to the questionnaires and interviews, it is worth noting that the definition of ‘successful engagement with clients’ was defined in a variety of ways, both within agencies and across them. Rather than signifying ‘absolute success’ or abstinence or desistance from drug/alcohol use, successful outcomes included:

\textsuperscript{50} Becker and Duffy 2002: 3
\textsuperscript{51} Becker and Duffy (2002)
• desistance from drug/alcohol use
• maintaining levels of drug/alcohol use
• desistance from offending or a change in patterns of offending (i.e. to less serious offences)
• greater levels of family stability
• housing needs met
• behaviour stabilised (e.g. reduction in complaints by/problems with other agencies and local residents)
• raised self-confidence, emotional well-being and improved health outcomes
• simply attending the services on offer - ‘getting through the door’

This suggests to us that practitioners may, in fact, be working towards slightly differently nuanced goals with their clients and therefore asking them for their views on gaps in provision will be influenced by what they see as the aim of the service they provide. These differences in perspectives partially explain the surprisingly wide variety of responses we received.

However, bearing this wide variety in mind, the two most commonly mentioned issues centred around housing and mental health provision. These twin concerns were expressed in the majority of both questionnaires and interviews.

Professionals from a number of agencies raised the issue of mental health provision, which has already been highlighted as a significant issue in the lives of female offenders (see above), and an important factor in their effective resettlement. Gaps were identified in current levels of provision, such as the availability of anger management support. Eligibility criteria were seen as unnecessarily rigid: for example, often offenders were unable to access services until they were no longer using alcohol or drugs. It was also felt that there were problems in achieving the necessary quality of partnership working between drug agencies and mental health services.

Concerns were also raised about variations in the geographical spread of provision and the availability of services. While Norwich seems to be reasonably well covered, services were less comprehensive in areas such as Cromer or Yarmouth, which lack facilities such as drop-in centres (which have already been proven to work well in Norwich) or wet centres (dedicated premises where homeless people/alcohol dependent people can drink at anytime). The fact that women often had to travel some distance to access the necessary support was seen as
particularly problematic, and a major barrier to their successful engagement with services. While transport issues are particularly acute in rural areas of Norfolk, the difficulties caused by the overall lack of reliable and affordable public transport has been highlighted as a problem across the county. For instance, recent research carried out by Norfolk TIF\textsuperscript{52} reported widespread criticisms of the infrequency and unreliability of public transport, with prohibitively high costs and a particular lack of links between rural villages, and the major market towns as well as Norwich. For service users, who may not only be on low incomes but also have additional priorities such as arranging childcare, the importance of reliable and affordable transport options is a key factor in engaging with services.

Related to this, one voluntary agency practitioner suggested that the children of female service users received poor provision. By ensuring the children were more comfortable in the environment of the agency (whilst the mother attended a group or individual session), the mother would be more likely to attend and to be positively engaged.

Other barriers which were highlighted, particularly by Probation Staff, included the complex processes and number of questions asked of clients at the initial assessment stage, and the amount of paperwork to complete, which can make it difficult to build up the necessary rapport and trust with clients, many of whom will have problems trusting authority figures. Spending the time engaging with clients in a flexible way, and building up that rapport was seen as more important.

The need for more flexible support was stressed in a both questionnaire replies and in interviews. What this meant for different respondents in terms of practical policies varied, with suggestions for improvement including more out of hours and out of office/outreach support; a more personalised approach to problems; a more relaxed environment for sessions; and a drop-in centre in Kings Lynn. Practitioners mentioned that formal settings (such as main project offices) could discourage clients from engaging with services, and also emphasised the need for flexible appointments which also accounted for women’s childcare responsibilities.

In interviews, several instances were mentioned where clients who missed appointments had been told to put themselves back on the waiting list. While the difficulties missed appointments could cause for agencies were understood and fully acknowledged, it was also felt that a greater

\textsuperscript{52} Norfolk TIF (2007)
understanding was sometimes needed of the difficulties female offenders/substance users can face in making their appointments (such as child-care responsibilities, or interference from male partners).

Despite the developments at national level, and the growing recognition of female offenders’ needs, services continue to be biased towards the majority of offenders who are male and aged between 19 and 24 - and women continue to be disadvantaged. It was frequently mentioned in interviews that many female clients can find group situations (where the majority of clients are often male) intimidating, and suggested that a women-only group would benefit those for whom mixed settings were not appropriate. It was also widely felt that providing female support workers where necessary should be a priority.

One personalised questionnaire response mentioned the usefulness of strategies to maximise access such as providing mobile phone or SIM cards on a loan system for service users.

4.2 Service user interviews

The women we spoke to shared a number of the characteristics and experiences highlighted in the literature as common to female offenders and/or substance mis-users. For example, few of the women we talked to had any consistent history of stable employment, and the majority were in receipt of benefits. Those who had been employed often took jobs which fitted in with their caring responsibilities, but were often insecure and low-paid jobs:

“Because of the children, I’d do it in some period when my mum could have the children, or when they were at school, sort of peeling jobs when they were at school, just anything really I could do. “ (N01, Great Yarmouth)

I: What sort of jobs have you done in the past?
R: [laughs] Care and cleaning. I’ve worked in old people’s homes, doing washing up, little bit of waitressing … So I’ve done that. Worked in factories, cleaning chalets, that’s it. (N02, Great Yarmouth)

“Yes, I’ve had jobs … I think at sixteen … my memory’s not very good … I worked, I done
like cleaning jobs in the sports park at UEA, done factory work. In the chocolate factories. Didn’t last very long. But I still done it.” (N06, Norwich)

4.2.1. Housing

Interviewees’ housing histories were characterised by instability and insecurity, with multiple moves and extensive periods of homelessness:

“If I could then I’d sofa surf, as they call it. But if I couldn’t I’d stay on anyone’s sofa then I’d sleep on the streets. Which was probably about three times a week, four times a week.” (N08, Great Yarmouth)

Many of the women reported difficulties in maintaining a tenancy, due to a combination of low income, drug dependency and a chaotic lifestyle:

“Just broke down. I just weren’t able to cope with a flat. Everything was … you know, everything was on top of me. And I weren’t able to cope with running a flat, paying the bills and everything else that came with it.” (N06, Norwich)

Homelessness left many of the women extremely vulnerable to further victimisation and abuse, often at the hands of much older men, who encouraged them further into drug use. One woman, who had been homeless as a teenager talked about how she had been sexually assaulted by someone who she had relied on as a friend:

“Some friends that I had, some friends that had happened to me … this friend … this is to do with drugs like … he’s just, he’s just like a proper Scottish bloke and he’s proper into banging up base, and he’d get really good stuff. He said come round, and they tied me up and I didn’t realise, I thought it was just him there … and they tied me up. And … he went out of the room, and I didn’t realise but [speaks quietly] his friend came in and … [shakes head] … I could always find a floor to sleep on, it was rare that I couldn’t find a floor to sleep on, but some of the places were dodgy. I just felt that the only reason they want me there was to use me.” (N03, Great Yarmouth)

Several of the women had been released from custody without any housing arrangements in
place, leaving them homeless and more likely to slip back into the cycle of drug use and acquisitive offending:

Well, you come out, and you think you want to stay clean, and … but you’re homeless, so … you haven’t got no food, money for food because that runs out … your social, that takes about four weeks to get all sorted out because you’ve been in prison. That takes a long time to sort out, about four weeks … no money. So I found myself committing crime again, stealing food and using because I was just homeless … because I was homeless, I was trying to get in people’s to stay, and you … you’re living with users, so I was getting back in to it all again, and … all the old, sort of, the same circle again.
(N01, Great Yarmouth)

Losing custody of children, because of their drug use, could also leave women homeless:

“I got kicked out of a couple of places because I kept stealing the meters, very embarrassing … Stealing the money out of the meters. Because I was on the drugs then. Pound meters. Put the pounds in. And obviously I did steal some, and I got kicked out … and I’ve been moved so many times. Moved to a mate’s, got thrown out of there. The last place I was, was Kent Square - that’s another B&B hotel place, and, er … I had to move out of there eventually because I lost ______ and that was the reason I was there. Because of ______.” (N02, Great Yarmouth)

“Well, I lost the house because of drugs and everything, and … that’s why my mum had to have my kids. And … so, I lost that house. I just went. When the kids got took, that’s it. I just thought fuck that house. But I lost everything, I didn’t have no proof of id, nothing.” (N03, Great Yarmouth)

Conversely, the initial stability provided by accessing accommodation could give women an important incentive to change their lives, and was seen by several as key to getting their lives back on track.

4.2.2. Mental health issues

Several of the women we interviewed reported experiencing significant mental health problems
such as anxiety and depression, many of which started in childhood or adolescence. A history of self-harming, and eating disorders such as anorexia was also common. One of the women had also experienced severe post-natal depression:

I: You said your problems really started after you had your middle child. You had post-natal depression?
R: Yes …
I: And had you had depression in the past? Was it diagnosed as depression?
R: Yes .. I really, I didn’t want to pick the baby up, I was crying all the time, and everything just … I just lost control of everything. I just got lazy, I just couldn’t be bothered with anything.
(N01, Great Yarmouth)

Loss was a common experience among the women we spoke to:

“I’ve lost a lot in my life” (N03, Great Yarmouth)

Several of the interviewees had started using drugs and/or alcohol as a way of responding to these losses and to a range of traumatic life events and experiences such as a relationship breakdown, bereavement, and the sudden death or stillbirth of a child. Several of the interviewees also reported being abused (both physically and sexually) as children, as well as suffering from parental neglect. Substance misuse became a form of self-medication to deal with the resulting emotional problems:

“We split up, and I wasn’t coping very well, so I got on the base and amphetamines, and that sort of like helped me [laughs] … and just didn’t realise how deep I was getting into it really. (N03, Great Yarmouth)

“I’d just come out of hospital, because I tried to take my own life, and then someone offered me it and I took it, and it just made me feel ... I don’t know ... really ... like there weren’t no pain.” (N01, Great Yarmouth)

“I liked the way it made me feel, the way I didn’t feel anything, I didn’t cry. And that was really important to me, that I weren’t feeling any pain. So I used it so I didn’t feel any
Another woman talked about how she liked the feeling drugs gave her of making all her problems ‘disappear’, and said that her heroin use had escalated quickly “when I realised what it could do for me”. (N04, Cromer)

Many of the women we spoke to had not had any contact with mental health services, or their mental health issues had only been recognised while they had been in prison. Several of those who had had contact with mental health services reported very negative experiences, and felt that there was little help available to them in this area. What help was available to them was seen as poorly targeted, and chronically under-resourced.

4.2.3. Children

A significant number of interviewees were mothers, several of whose children were either in foster care or had been adopted. Offending and/or substance misuse could often escalate in response to the loss of children. One woman, discussed the effect of the time her mother had fought her for custody of her first baby, born when she was only 15 years old:

R: Well, I was just … like, I was screwed up from what my mum did to me. I’d be blitzed most of the time, because I didn’t want to think about it. People think, oh take her kid of her, you know, then she’ll sort herself out, but you don’t.
I: … and that’ll teach her a lesson?
R: Yes, and … but it don’t sort you out, it makes you worse. Anybody who’s been through the same thing will probably say the same thing. It makes you worse, it don’t make you no better having your kids took off you. They should offer you help …
(N03 Great Yarmouth)

Other interviewees shared her feelings of distress and frustration at what were often lengthy court proceedings:

“No matter what I did, nothing made a difference, so you just think well why should I bother changing, you know. Nothing’s going to … nothing’s there to help me.” (N03, Great Yarmouth)
Interviewees were frequently very critical of social services involvement, and complained about unfair treatment and the difficulty of complying with their conditions and requirements. Often they were angry at the thought that they were being stereotyped by social workers, and seen as bad mothers because of their drug use:

“If you’re a drug user, they think you’re going to live in shit and squalor … they think you’re low. Well I’m not” (N05, Cromer)

Social services were widely criticised for prolonging child welfare cases apparently without reason, despite mothers’ compliance with their requirements, and for a consistent lack of follow-up support. However, other women saw social services’ involvement as generally reasonable and something they needed to comply with, even though they may not like it:

“Well, sometimes I wish they’d leave me alone, but I just have to look at it as a good thing really. They’re there to help me, and … at the end of the day, you hear of social services and you think shit, they’re going to take the baby away because of our past. But then, we’ve just said from day one, I’ll go along with whatever and my partner’ll go along with whatever, anything to prove ourselves. It’s a small price to pay, having them around every day … [inaudible] as long as I’ve got him. I just look at it as a good thing. They’re there for help, you know. They’re there to help us.” (N08, Great Yarmouth)

Becoming a mother seen as a turning point:

R: He’ll be moving in with me. On his last chance [laughs], which I mean this time. Because I’ve got little ‘un to look after.
I: Have you said that to him before?
R: Yeah, I have before. But … he knows it, I mean it now because I’ve got ______ so, at the end of the day I’m not going to risk anything, losing him.

4.2.4. Partners and peers

Partners were often cited as an influence on women’s drug taking, with several reporting feeling pressured into taking drugs by their partners. However, not all women had felt pressured into drug use. Several had started taking drugs to keep a partner company:
“In the end I thought, if I can’t beat him I’ll join him … I’d be lying if I said I was forced into it.” (N06, Cromer)

One woman argued that in the beginning of their relationship her partner had concealed his drug use from her and had not initially pressured her into taking drugs, but that when she later tried to stop taking drugs he encouraged her to use again - seemingly as a result of his insecurity:

I: You don’t really feel that he encouraged you to get involved with drugs?
R: No, not really … but before, I have cleaned my act up before, and …. got really clean, put weight on, really feeling good … but he wasn’t, he was still using really, really heavily, and then he used to put it in front of my face, and he did even admit to me he thought he was scared of losing me because I was sorting my act out, so … but he hadn’t. So he admitted to me he even tried to get me hooked again, because he was scared of losing me, and he wanted me to be, sort of, on heroin, back with him. And I did end up going back on it …

(N01, Great Yarmouth)

Several of the women had been in extremely violent relationships, often with other substance users:

“It was the drugs that made us argue, and one time it just went a bit far. Plus I had my child with me at the time, when he grabbed me from behind … like, he was violent, and then that’s when I left him.” (N02, Great Yarmouth)

The same woman talked about a subsequent relationship which also became violent, and the disruptive effect it had had on her life, leading her to become homeless:

I: Have any of them ever put you in hospital?
R: No … I’ve had … from the second one I had lots of bumps and bruises, and cuts and all sorts of stuff … and he strangled me, suffocated me, yeah … [laughs] … and when I left him, that’s when I got back on the drugs. In and out of B&Bs again.

(N02, Great Yarmouth)
This story was common to several of the women we talked to:

R: I just walked out on him one night. Smashed a cup over my head, and I thought I’m not taking any more. And I just left, and never went back.

I: So, what did you do when you left?

R: Went, walked into the city ... Just walked into the city, to one of my mum’s friends, stayed there the night and then started hanging around on the streets.

(N08, Great Yarmouth)

One woman who had escaped a violent relationship with an ex-partner, who had also been supplying her with drugs, had been housed near to the family of her attacker and expressed feelings of extreme anxiety about the possibility that he would be able to find her on release, after serving what was only a short sentence.

Several women had accessed services jointly with their partners, and stressed the importance of being able to begin treatment together. One woman spoke about how her partner had gone with her to a drug agency, but she had been unable to be titrated at the same time as her partner, who had subsequently ended up using again with her. However, subsequently they had been able to access services jointly, with positive results. Another woman had become aware of her local service because her husband had used their needle exchange.

Other women had started using - and injecting - drugs with groups of older friends, relationships which they now recognised as potentially exploitative:

“I think about it, it wasn’t really thrown in my face, it wasn’t forced upon me. I didn’t feel bullied into taking it. It was ... I used to sit there and smoke it, they used to sit there and inject it. I actually got to the point where I asked if I could, you know ... have a hit. I know they should have said no, thinking about how young I was, but it was my choice, to have my first hit ... but they never forced it upon me.” (N06, Norwich)

“I suppose I was used quite a lot.” (N04, Cromer)

Drug-using friends could also try and draw women back into using:

“You’d think, wouldn’t you, that your friends ... they’d be happy for you. And they’d be
all ... oh, well done. But it’s not like that. They ... they get quite angry with you, and ... envious, I should imagine. They really do try and tempt you into using. To the point where they’ll offer to share their drugs with you. [laughs]” (N13, Norwich)

4.2.5. Family relationships and support networks

Many of the women had lost contact with their families during periods when they were going through a particularly heavy period of substance abuse. This was often a deliberate choice on their part, because they were ashamed of their circumstances and the effect their behaviour was having on their families - or simply because in several cases their lifestyles had become so chaotic that it was impossible to maintain contact:

R: I had about a four year gap when I haven’t seen any of my family at all. Not even my children. Didn’t see them because ...I just ... I don’t know .... I don’t know why ...
I: Did you just not feel able to?
R: No ... because, I don’t know ... two weeks had passed, then three, and a month, then two months. And I really wanted to go, but the longer I left it the worse ... it was to get in contact, do you know what I mean?
I: You thought they’d be angry with you?
R: Yes, definitely.

(N01, Great Yarmouth)

Several women had chosen not to contact their children for long periods of time out of concern for their well-being, because they did not want the children to see them when they were using heavily:

“They longest I haven’t seen them is about four, five months. That was because I had drink in my hand all the time, and I just didn’t want to impose that onto my children. So I just went. For five months. And my mum called me a heartless bitch, but it’s not because I’m a heartless bitch, I just didn’t want my kids seeing me like that, you know. (N03, Great Yarmouth)
Several of the women talked about how their children were living temporarily with other family members, and it was clear that this was an valuable source of support - particularly in avoiding having children taken into care;

R: He’s living with his nan. With his dad’s mum.
I: And you get on with her?
R: Oh yes, yes … she’s lovely.
I: So you’re happy with where he’s living?
R: Yes, I know he’s safe and happy there. I know he’s fine there.
(N02, Great Yarmouth)

In some cases, financial support from family and friends could prevent women from having to commit offences to finance their drug habit:

“See … over the last few years I didn’t have to go out shoplifting, because my mum would send me money, and … you know, one of my friends sends me money, to help me out and that … you know, if I got stuck or anything. And I’ve got my benefits, so … I didn’t really need that sort of … I didn’t have to … I wasn’t well either, so people didn’t mind helping me out, you know I didn’t have to tell them I was in drugs. They probably thought I just needed it for something else.” (N03, Great Yarmouth)

Interviewees were realistic about the damage that their years of drug use had caused to family relationships, and recognised that rebuilding those relationships would take a considerable amount of time and effort:

“I did have support from my mum, when I was in prison she writ to me and that … then got released and haven’t kept the contact up. I think she just gets pissed off with me keep going round there and her saying ‘Are you clean?’ and me saying ‘No I’m not’. So that’s the way it … so I’ve just distanced you know. Stopped the stress from both parts.” (N06, Norwich)

While family relationships could be highly problematic, a powerful sense of obligation to family members and their need for support could provide a powerful motivation to change: “
I just thought, well, I need to be clean for my family, and my children, and my mum. Because they all need me, my family.” (N01, Great Yarmouth).

4.2.6. Patterns of offending and drug/alcohol use

The majority of women interviewed had a history of committing acquisitive crimes, usually theft/shoplifting, and handling of stolen goods. Several also had convictions or cautions for drug offences and public order offences (such as being drunk and disorderly), or criminal damage. A small proportion of interviewees also had convictions for fraud. Violent offences were much less common, with only two interviewee reporting a conviction or caution for ABH. One of the women also reported having received a conviction for prostitution/breach of an ASBO. Several of the women interviewed in the community had experience of custodial settings, and some had been to prison on several occasions. One of the women was serving the second half of her sentence in the community, having recently been released from HMP Peterborough. The majority of the women interviewed (11) had previous convictions (only two reported that this was their first offence), and of those all had committed five or more offences. It should be noted that if researchers had been able to conduct interviews with females currently in custody at HMP Peterborough, then it was anticipated that a higher incidence of sex work would have been uncovered (although several interviewees talked about their past experiences of sex work, and suggested that this was directly linked to their substance misuse). For example, in 2008/9 the Enhanced Arrest Referral scheme worked with 41 women at HMP Peterborough, the majority (approx 80%) of whom were engaged in sex work.

For many, entering the criminal justice system was seen as an opportunity to access help:

“Sometimes you need to be caught to get the help” (N04, Cromer)

Prison was also seen by many as the only way of accessing the treatment they needed, which was often either unavailable in the community or involved a lengthy wait. More than one woman talked about using prison as a detox facility:

“It’s taken quite a few deliberate attempts going to jail to get clean. Because I’ve used jail as rehab. I’ve asked the courts to send me away, for like a year … not the short sentence
that I've done.” (N07, Norwich)

However, interviewees also expressed frustration at the overall lack of a preventative approach to problematic drug use, and the fact that services were often not available until matters had reached crisis point.

All except one of the interviewees reported using drugs daily prior to their most recent offence, and the majority had been involved in drug use for a considerable length of time, ranging between three and ten years. Most women we talked to were heroin users, although several used both heroin and crack. Cocaine was used less frequently. Several women reported having started using marijuana as a teenager, after which they progressed to amphetamines and/or ecstasy and then heroin. Progression onto using crack was seen as particularly problematic, with several women reporting that this coincided with an escalation in their offending behaviour and a subsequent deterioration in their personal and social circumstances. For example, one woman reported that the beginning of her crack use was also the point at which she had also become involved in prostitution, and consequently started to take significantly more risks with her personal safety:

“I would do worse things to get it” (N04, Cromer)

A clear distinction was drawn between marijuana use, which was commonly seen as a ‘normal’ adolescent activity, and the use of harder drugs. In contrast, few women reported experiencing problems with alcohol use and saw themselves as either non-drinkers or social drinkers. Two women reported problems with alcohol, but felt that they had generally been able to deal with their problem drinking independently. Only one of the women we talked to had sought outside help with her alcohol use.

Most of the women saw a direct link between their drug use and offending behaviour, particularly where they had stolen/shoplifted in order to buy drugs. As one woman who had shoplifted to fund her heroin habit remarked quite simply, “If I wasn’t on drugs, I wouldn’t have been shoplifting.” On the other hand, this was not the case with those reporting alcohol misuse, who typically had felt they had no need to commit acquisitive crime to fund their drinking as ‘booze is

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53 Other interviewees talked about the lack of availability of residential rehabilitation across the county, with most facilities charging unaffordable fees.
cheap enough to get’. However, when this was explored further, they did report committing public order offences while under the influence of alcohol\textsuperscript{54}.

4.2.7. Engagement with services

Most of the interviewees had been involved with services on more than one occasion; the majority had been involved with services twice (sometimes with the same service, sometimes with different services), although one woman had made five attempts to gain control over her drug habit. Services with which women were involved included The Matthew Project, TADS, NORCAS, Probation and the Bure Centre (now DIP). Referrals came from a variety of sources, including the police, prison officers, probation, social services, and family/friends. Surprisingly, none of the interviewees reported being referred by their GP. Several had also referred themselves, sometimes alone and sometimes along with their partner. Most felt that their involvement with services had helped them manage/reduce their drug/alcohol use and associated offending, although previous ‘failures’ in engaging with services were not necessarily seen as the result of shortcoming in the services themselves. On the contrary, several women were at pains to emphasise their personal responsibility for non-completion of programmes. Changes and improvements in personal motivation were seen as the key catalyst for successful engagement with services, although the provision of a supportive environment in which to achieve change was also important:

R: My motivation … I think this time I’ve got more motivation. If I think about it, each time I’ve come here, I’ve got on with every person I’ve had … but I’m more in a place in my head, this time.
I: What do you think has made that difference?
R: I just think I’ve had enough of being a drug addict. I’ve now got to the point where I’m tired of it, don’t want to do it every day. Whereas before I still … still liked it.
(N06, Norwich)

“Because I’m bored with it now. To be honest, I think that’s half the battle. I know there’s the physical addiction, but there’s a mental addiction to it as well. I’m just getting bored of it now. I’ve lost so many good friends … through overdosing and that. And I nearly went over the other week. Which scared me a little.” (N13, Norwich)

\textsuperscript{54} One woman also reported committing a serious assault while drunk.
Various ‘turning points’, such as reaching a certain age, were also key factors in becoming ready to engage with services:

“This you know, I really want to make something of myself. It’s scary, because I’m nearly ... what? I’m nearly thirty. I’ll be thirty soon, and I want to do something by the time I’m thirty.” (N01, Great Yarmouth)

“I don’t want to be one of the old lags who’s going to jail in their forties and fifties. That frightens me, so ... I have to be responsible for myself, because in the next twenty years, when I’m in my fifties, when my body’s getting a little bit older, if I don’t sort my shit out now, then I am going to be ... I’m going to be ... in a really bad position.” (N07, Norwich)

4.2.8. Views on services

For many of the women, accessing support had been a long and difficult process for them to negotiate:

“It’s been a constant struggle for me to get help with my drug use.” (N04, Cromer)

Several of the women reported experiencing considerable problems with asking for or accepting help due to a lack of trust or issues with authority (as a result of their past experiences). They identified more readily with particular workers rather than with the service they represented, which was seen as something quite impersonal and remote; many of the interviewees were in fact unsure for which organisation the worker they talked about relating to actually worked. Qualities which were particularly valued included a friendly, open, non-judgemental and non-intrusive attitude.

“They’re actually approachable and you can talk to them” (N03, Great Yarmouth)

“It’s like you’ve got a team of mates. That’s the big thing. They talk to you like an equal, and they talk sense” (N04, Cromer)

“I like _____ because she’s got compassion, and she believes in me ... and she knows I’m
“dedicated to getting my family back” (N05, Cromer)

“I know she understands and she doesn’t patronise me.” (N07, Norwich)

“I just feel that they’ve covered all the bases, really. Not been too intrusive, but have been there, if I’ve needed more.” (N13, Norwich)

Many women simply wanted the opportunity to let off steam to someone who would listen to them. Workers were also valued for the positive emphasis they placed on women’s capabilities, rather than focusing on past failures:

“They make you believe in yourself, like you can do it …” (N03, Great Yarmouth)

Workers also frequently acted as an important source of emotional support, and it could be easier to talk to them rather than a family member, to whom women might be unwilling or unable to disclose information about their drug/alcohol use or offending. Relationships with workers could counteract the social isolation experienced by several of the interviewees:

“I don’t have to be alone” (N03, Great Yarmouth)

Several interviewees talked about the need for involvement in practical activities, to provide them with some sort of structure to their day and to stave off boredom, and along with it the temptation to use drugs:

R: Things they can propose to you to do to keep your mind occupied. Because obviously when you get off it, you need something to keep your mind ticking over. So you don’t think oh, I’m bored - and go back on it.
I: So do you think boredom’s a really big problem then?
R: For some people. Obviously I’ve done it, been bored and though oh bugger, I’ll just get one. I’ve done it. So boredom is a big thing, isn’t it?
(N02, Great Yarmouth)

Group work was particularly valued for the sense of purpose and routine it provided, as well as the opportunities it gave women to access peer support - and develop coping strategies:
“We just did a lot of work together, on our reasons why we think we use and triggers, what could trigger us into using. Coping strategies, things like that, which was really good. Because now I've got them there. At first I though this is ridiculous, it's not working but I did realise … I remember a lot of it now. Like if I'm walking into town, and something triggers, I recognise it ... so I can use what we've done. Try and stop myself from scoring.” (N13, Norwich)

A flexible approach on the part of project staff was seen as essential to engaging effectively with services - particularly an appreciation of the difficulties often experienced in making - and keeping - appointments. Women particularly valued being given the opportunity to make choices, and also being given a second chance when things didn’t work out:

“I just feel that I know ______, that I can just go in and say ... I wasn’t to try again. It’s just made it easier, knowing her, instead of it being a bit formal with someone who you just think of them as a keyworker.” (N06, Norwich)

“I think what’s good about them is that ... like me, I haven’t got clean every time I’ve come here but they’ve taken me back every time ... To have a script stopped and then give me a month, and then give me another one, to me that’s asking a lot. And they’ll think I’m taking the piss, but you know I’ve actually shown them that ... I am trying. Because I think it is really hard for them sometimes to see if people are really trying. Because there are so many people who ... just abuse it. If I think about it, in the past I have.” (N06, Norwich)

“Most people don’t make it the first time.” (N09, Great Yarmouth)

The importance of providing continued support was mentioned in all of the interviews. Several women expressed particular anxiety about the possibility of their involvement with services coming to an end:

“I do believe they genuinely worry about me. They don’t just leave me, and that’s the...”

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55 Suggestions from interviewees for tackling this issue included a gradual phasing out of contact, and giving clients a contact number they could use if there were issues they wanted to discuss, such as a possible relapse.
good thing about them. I’ll be so gutted, I really will, when they’re not working with me.” (N03, Great Yarmouth)

“If I got told I had to leave tomorrow, I wouldn’t know what to do.” (N04, Cromer)

Women also highlighted the need for immediate, responsive support:\footnote{Women also highlighted the need for immediate, responsive support:\footnote{Women also highlighted the need for immediate, responsive support:\footnote{Women also highlighted the need for immediate, responsive support:\footnote{Women also highlighted the need for immediate, responsive support:}}}

“When your heart and your head say you want to get off, you need help now - not eight months down the line” (N05, Cromer)

Conversely, other services\footnote{Conversely, other services\footnote{Conversely, other services\footnote{Conversely, other services\footnote{Conversely, other services were criticised for their application of narrow eligibility criteria, and inflexible ways of working. For example, one woman who had accessed alcohol services in another area, was particularly critical of the fact that eligibility criteria were too unreasonable, making it difficult for anyone to access help:}}}

were criticised for their application of narrow eligibility criteria, and inflexible ways of working. For example, one woman who had accessed alcohol services in another area, was particularly critical of the fact that eligibility criteria were too unreasonable, making it difficult for anyone to access help:

R: He just basically said [no] because … I need to be drinking every single day to get help from that service.
I: So you weren’t drinking enough?
R: Yes, yes … that’s exactly what they said.
(N03, Great Yarmouth)

The coverage of services in some areas of the county was raised as one area in which improvements could be made, particularly in North Norfolk where it was felt that there was less available. This applied not just to drug and alcohol services but to services dealing associated issues, such as bereavement counselling.

The slowness of the titration process was also seen as particularly problematic, with long waits meaning that by the time titration was available women had already started using again:

“I should be able to come in here, them take a urine sample off of me … speak to my doctor, speak to whoever it is who does the scripts and all the rest of it, and be able to get titrated within the same day or the next day. Because it’s not three week’s time that I

\footnote{By contrast, prison based services such as CARATs were often seen as unresponsive and overstretched due to a chronic lack of resources.}
\footnote{Although this did not include any Norfolk-based services.}
need the help. I need help now. Because if I don’t get any help now ... I'm going to go into the city and I'm going to go and rob. It’s not because I want to, it’s because I have to.” (N07, Norwich)

Another woman spoke about how her partner had gone with her to a drug agency, but she had been unable to be titrated at the same time as her partner, and he had subsequently ended up using again with her. Outreach support was highly valued by several of the women, who felt uncomfortable accessing services in certain locations because of the likelihood of encountering other drug users and the temptations/threats this was likely to pose to their own recovery. Women with small children also saw outreach support as particularly valuable, and a means of accessing services which would otherwise be difficult for them to maintain contact with. Several interviewees also highlighted the need for out of hours and weekend support:

“The weekends are always the worst.” (N04, Cromer)

Peer to peer support was also seen as a valuable resource for helping women remain drug-free, and empowering women by seeing them in terms of their capabilities, knowledge and experience - rather than deficits and problems. Several of the women spoke very positively about having the opportunity to give something back, and to support other women in the same position that they had once been themselves:

“I've taken a lot from society in my life, I'd like to give a little bit back.” (N03, Great Yarmouth)

“I'm on the other side now, trying to help people” (N04, Cromer)

While the input of agency staff was seen integral to success, it was recognised that those who had been in similar situations could empathise in a way that others couldn’t.

5. Conclusion

The research project has sought to tease out gaps in provision of services for adult female offenders with substance misuse problems. For practitioners, it has used two separate

58 Although the women were aware of the resource implications.
electronic questionnaires plus personal and telephone interviews. For service users, it has used in–depth interviews. We have chosen these methods as the best ones to explore the meanings with which practitioners and service invest hold of the services they provide and receive.

One noticeable point which emerged from the research was that some practitioners, and this comment probably applies more to the probation services, tended to see their role as providing a particular, pre-defined ‘service’ to female offenders with alcohol and drug problems and who saw limited usefulness in drawing upon the experiences of the offenders in helping to shape these services. This may be reasonable, given the fact that probation officers have clearly set goals which they have to achieve. However, the research suggested that female offenders with problem drug or alcohol use were able to reflect upon their experience of services and to provide insights which were worth noting. As Hankins (2008) argues:

Gender-responsive policies and programming for women do not fall from the sky. They are anchored in ‘Nothing about us without us’ principles with systematic inclusion of women drug users in the design, planning, implementing, monitoring and evaluation of policies, strategies and programmes.

The recommendations which we give below largely derive from consulting the female service users, whose comments sometimes echo and enlarge upon the results of the questionnaires and interviews with professionals, but often bring fresh perspectives. For example, although all professionals are aware of the importance of partners in maintaining or helping to stop a drug/alcohol habit, the service users felt that really this was not made apparent in practice. So the interviews with service users almost always included a discussion on the importance of partners, whereas questionnaire replies and interviews with professionals tended not to dwell on this issue.

Overall, the provision of services is good, but there are areas where coordination might need improving (particularly with reference to the areas of housing and mental health). In terms of practitioner attitudes, we think that the views of service users ought to be considered more and linked to this, the views of the partners of service users need to be explored.

The research also indicated that there were problems relating to those groups where the female service user was the lone female in group sessions. In terms of attitudes towards the services,
we found that there were concerns over the stigma which many females felt about themselves as a result of their problem drug/alcohol use. This seemed to influence their attitudes to services. A number of women who had successfully overcome their offending and their problem drug/alcohol use were willing to use their experience to provide some form of peer group mentoring. Greater use of these women might be helpful in showing service users with low prestige that it is possible to overcome the problem alcohol/drug use.

Both practitioners and service users also raised the problem of travel to the centres where services were located as a particularly pertinent issue.

Finally, the research threw up the tremendous importance of people as opposed to services. Female offenders with problem alcohol/drug use tended to identify with the individual or individuals working with them far more than the agency who employed the practitioner. We are not too sure what practical implications this might have, but it would suggest that an ideal model would be where the practitioner is in a position to provide/liaise all the resources which the service users need. This takes us back to the importance of effective and smooth inter-agency collaboration.

6. **Recommendations**

- Maintain and strengthen the flexible and personalised nature of the support provided to female clients. This was particularly valued by the women we talked to, who tended to identify with individual workers rather than particular services, and was an important factor in maintaining their engagement with services. Having one worker as their main point of contact was important to clients, many of whom needed time to build up trust in services.

- Acknowledge the importance of providing flexibility in services in order to maximise women's engagement. Both female offenders and professionals consistently highlighted the centrality of providing ongoing support beyond statutory obligations, and in many ways the transition period from intensive support to a greater level of independence needs to be seen as a key risk period where women could potentially relapse. The period immediately after release from custody was also seen as a key risk period, and women need rapid access to services in order to manage their transition to the community effectively and maximise their engagement with services.
• Recognise the importance of other family members, particularly partners. For example, many people (both male and female) access services via their partners. Where possible, partners should be able to access services such as titration, as part of substance misuse treatment, at the same time thereby avoiding the risk of subsequent relapse in the non-using partner.

• There is a need for increased support to those women who are mothers, given the centrality of the family to resettlement processes which has been recognised both in previous research and recent policy developments. Motherhood had acted as a powerful motivator of change for several of the interviewees, and encouraged them to change their behaviour and positively engage with services. However, women with substance misuse issues can equally find motherhood particularly challenging, and the extra pressures on them can also increase substance misuse. Several women also talked about the stresses caused by child protection cases - as did a number of the professionals surveyed - and the need for extra support during such periods. Where children are taken into local authority care, women’s loss of their role as mother can also escalate patterns of substance misuse. It would be particularly useful to explore further how services in Norfolk can recognise these issues and support women in overcoming them, and negotiating care proceedings. There is also scope for considering how substance misuse services and child protection agencies can build on and improve existing partnership working.

• Supporting members of extended family, such as parents of substance misusers (many of whom take responsibility for dependent children) where appropriate is also important. Several interviewees talked at some length about how their substance misuse had affected family relationships, and the importance of family in moving on. Interviewees greatly valued the support given to them in rebuilding these relationships, as well as the support given to parents by services.

• Given the initial indications from the interviews with both female offenders and professionals, it is clear that further work is needed on the mental health issues faced by female service users, and the nature of the relationship between mental health problems and substance misuse (dual diagnosis). It would also be useful to explore the issues raised around the problems involved in partnership working between drug/alcohol agencies and mental health agencies, with a view to improving the continuity of support offered to women across Norfolk.
• Evidence from other research has demonstrated the effectiveness of women-only sources, and this type of provision should given priority where possible. While not all of the women we interviewed felt that this would prevent them from accessing services, several talked about feeling less comfortable in accessing mixed services - particularly in group work situations, and for some it could be a source of acute anxiety and distress. Some women expressed a preference for working with a female member of staff - although this was by no means universal, and several reported excellent working relationships with male workers.

• Concerns about variations in the geographical spread of provision and the availability of services also need to be addressed. Women often have to travel considerable distances to access services, and could benefit from more accessible services based in their area, or from more outreach work. Alternatively, consideration could be given to providing transport for women with difficult journeys.

• Research has consistently shown housing as being central to the effective resettlement of female offenders, and having stable accommodation can provide a catalyst for changing patterns of substance misuse. There needs to be a closer liaison with housing providers and the possibility of providing adequate housing more quickly. Housing provision also needs to take into account some women’s experiences of violent victimisation, and their continued vulnerability. Further provision of supported housing, which was valued by both providers/practitioners and service users would be a positive development.

• Investigate the possibility of supporting clients to set up peer support groups, such as the one already successfully operating in Cromer at ‘The Junction’. Many of the women interviewed for the research were keen to move on and to use their experiences in a positive way, to support people who were in the same situations and experiencing similar difficulties. This could be an important way of equipping women with skills for future employment, and building self-esteem, by enabling them to be seen in terms of their positive qualities, rather than deficits and problems.

• Acknowledge the importance of providing a clear and consistent structure to each day in order to build the foundations of a drug free life and a positive future. Several interviewees stressed the part played by boredom and loneliness, often as a result of cutting themselves
off from previous friendship networks and associations with other substance misusers. When this support comes to an end or is unavailable (for instance at the weekends) there is an increased risk of falling back into substance misuse.
Bibliography


