Hazardous Journeys to Better Places:

Positive outcomes and negative risks associated with the care pathway before, during and after an admittance to The Dochas Centre, Mountjoy Prison, Dublin, Ireland

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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A report for the
Health Service Executive

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HEALTH SERVICE EXECUTIVE

Available from www.hse.ie

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ISBN 0948562579

Barcode ISBN

Printers

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ACKNOWLEDGEMENTS

The authors are particularly grateful for the advice and assistance of Julian Pugh, Co-ordinator of Drug Treatment Services (Prisons), whose original idea provided Health Service Executive funding for the project. We wish to thank the staff of the Dochas Centre, including Governor McMahon and Governor Baxter, for all their assistance in helping us to complete this study. We would like to thank all the women who answered our questions. We sincerely hope that our efforts will help towards bettering their lives and the lives of the others who will follow them.

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Forward

This significant report examines the lives and outcomes of a group of women who exist on the periphery of society within the prison microcosm. Despite the best efforts of many agencies, these women are marginalised and their lives characterised by a chronic cycle of deprivation, danger and chaos. The label of borderline personality disorder is applied to many who are seen to be beyond the remit of treatment.
It is axiomatic that human beings are responsible for the choices which they make and the outcomes of such choices. However, a humane and just society must surely provide a right of access to appropriate services to assist those who offend to break free of destructive lifestyles. Without such supports, the journey will in many cases lead to relapse, recidivism and even death.

This research was undertaken by Dr. Comiskey who is also principal investigator with the ROSIE study. This is a national longitudinal study commissioned by the NACD to investigate the nature and extent of opiate use in Ireland. The data strands used in both in the Rosie study and this present study are similar to those used in other international studies and thus allow for comparative analysis.

It is heartening to note that the women in this study were found to receive good care in the Dochas Centre, which care appears to have sustained many of them following release from prison. However, despite the best efforts of the individuals and agencies who do provide support for such women, this report shows service provision is not co-ordinated in an effective manner for the benefit of clients. In many instances, services are fragmented, demarcated or subject to insular allegiances to various models of intervention. Ideally, psychosocial services and those within the social inclusion ambit should be integrated with clinical services and whilst the safeguarding of confidentiality is vital, these structures should nevertheless allow for client involvement and inter-agency information sharing.

The Health Service Executive has a significant part to play, together with other service providers and the Irish Prison Service, in the planning of services to meet the needs of this particular group of people. We are moving away from a silo mentality of service provision to one that embraces overall care co-ordination. Such a system would integrate services and provide for the continuity of separate care episodes. Such a system would encompass periods of imprisonment as a different episode within overall care co-ordination. To this further this end, the Health Service Executive is keen to engage with the Irish Prison Service and other agencies to meet the challenges highlighted in this report.

I wish to thank the authors and all the individuals who made this research possible. Most importantly I wish to thank all the women who recounted their life experiences.

I commend this report to all agencies and individuals who work with women who have encountered misfortune, homelessness, addiction and involvement in the court and prison system. I invite others to give a commitment to join me in establishing an agenda and appropriate mechanisms to address the needs identified in this report.

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National Care Group Manager Social Inclusion Services

Reflections on *Caged Bird* by David Clarke, 1965

By Fiana Griffin

In *Caged Bird* the yellow bird is poised for flight, wings outstretched, frantic to escape from her cage, yet many of the bars to her cage are missing. Why does she stay? The picture creates a feeling of unease as we puzzle over the paradox of a creature choosing captivity while apparently wanting to be free. A vague air of menace surrounds the cage, which appears to be suspended in a chaotic, stormy sky above inhospitable rocks. There is no suggestion of a haven to be found anywhere. Does fear, whether of predators, the elements or unknown dangers make the bird prefer the safe misery of life in a cage to a life of destructive freedom?

Forty years after it was painted, *Caged Bird* by David Clarke (1920-2006) symbolises something of the conflict experienced by the women prisoners who spend time in Dochas, as documented in *Hazardous Journeys to Better Places*. Homelessness emerges as a key issue from this illuminating report. Because of the gaps in the system, and despite the best efforts of various service providers, these vulnerable women prisoners are often released to freedom without even a guarantee of a safe place that night. Many of them are hopelessly, helplessly astray in society, a prey to dangers from without as well as from their own self-destructive patterns, with as little chance of long-term survival as a tropical bird that escapes into a cold Irish night. Some, recognising that at least in Dochas they will stay alive, re-offend in order to be incarcerated again.

David Clarke was an artist whose vehicle for thought was art. Where others wrote essays, he explored issues through painting a number of pictures on the same theme. No explanations offered, the pictures were his statements, for each to read in the light of their own experience and understanding. *Caged Bird* was the first in a series; the last, called *The Guitarist* depicts a bird in small, bright open cage on a table beside a gentle figure strumming a guitar, a full moon shining in a clear sky. If and when the bird emerges, it will no longer be such a hazardous journey, but a hopeful transition to a better place of creative peace, instead of the chaos and menace of *Caged Bird*. This report offers the possibility of a similarly changed outlook, when its recommendations have been implemented.

Executive Summary

This study was an eighteen-month process evaluation and treatment outcome study of female drug-using prisoners admitted to The Dochas Centre, Mountjoy, Dublin, Ireland. Questions addressed in the process evaluation included the nature and extent of treatment provided, discharge planning, aftercare arrangements, internal and external co-ordination and a study of the integrated care pathway. The outcome evaluation looked at whether clients of the service had changed over time. It addressed questions on treatment of drug use, whether clients were better off than before treatment, and whether clients reduced their drug use.

Key activities in process and outcome evaluations include; A review and audit of existing treatment methods and resources; Identification and critical analysis of programme logic models; Focus groups and discussions with programme participants and other key stakeholders and a survey of the population being evaluated. Within this study we implemented these four methodologies.

We recruited 40 drug-using women who had been admitted to The Dochas Centre. We re-interviewed these women 6 months later and had full follow-up information on 75% and contact information on 97.5% of our original cohort. Measuring key outcome variables before during and after their admittance and release from the Dochas Centre we found the strongest positive outcomes among the crime variables and varying positive improvements in drug use and treatment. Physical and mental health showed only minor improvements and some of these measures deteriorated.

Associated with the improvements were very significant negative risks. In particular, the risk of death, overdose, self-harm and homelessness. During the 6 month follow up period 3 (7.5%) of our original cohort of 40 women died. Risks were present and experienced by members of our cohort at the point of release. We found a statistically significant increase in attendance at Accident and Emergency Departments at the 6 month-follow up interviews. The reasons for attendance were in all cases for serious health problems including self-harm, gang rape and drug and alcohol overdose on release.

With regard to clients expectations and experiences of services they had accessed we found that when asked what they expected to get out of their time in the Dochas

Centre, 11 women (27.5%) said they expected nothing. This expectation was reflected also in the follow up interviews where 19 or 70%, when asked if the Dochas Centre had helped them in any way, said yes it had helped. With regard to clients experiences of other services, clients usually had either no comments or had some negative encounters with services. Where encounters had been negative, clients usually expressed the view that they had felt a loss of dignity or respect.

From our qualitative interviews with key stakeholders of the care pathway we found that stakeholders views reflected those of our clients. It was found that there was a lack of co-ordination of in-reach services to the women s prison. Stakeholders felt that the current range and number of agencies providing in-reach services to the women s prison is sufficient but that the fact that agencies are not aware of the other services providing support to the same individual as themselves results in poorer overall outcomes for the individual thus highlighting an overall lack of co-ordination and planning of the care pathway for the individual woman.

In spite of the negative risks, we can imply from our results that the 6 month period did have a positive impact on key outcome measures and that the women showed some improvement at that time. To what extent this improvement is sustainable and can be attributed to the Dochas Centre and/or to the stage at which the women are at in their drug-using career is uncertain and would require further longitudinal information on the women and the care process.

1. Aims and Objectives

This report aimed to conduct an eighteen-month treatment outcome and process evaluation study of female drug-using prisoners admitted to The Dochas Centre, Mountjoy, Dublin, Ireland. The study was longitudinal and was conducted in two stages. Prisoners were interviewed within one month of admittance and were subsequently followed up six months later. These follow-ups were within the wider community or within the prison setting. The objective was to model the care pathway of the women and in so doing provide an evaluation of the treatment and process outcomes.

2. Introduction

Needs assessments evaluate the capacity of a service in terms of the prevalence and incidence of drug use within a particular community. They evaluate the appropriate mix of services and the coordination of services within a system of care. Process evaluations look at how a treatment or programme operates. They focus on how services and systems of services operate. Questions addressed include the nature and extent of treatment provided, discharge planning and aftercare arrangements and internal and external co-ordination. Other ingredients include programme logic models and integrated care pathways. Outcome evaluation studies look at whether clients of a service have changed over time. An outcome evaluation addresses questions on treatment of drug use, including whether clients are better off than before treatment, and have clients reduced their drug use as a result of their treatment. (Marsden et al, WHO 2000)

The need for evaluation of drug treatment programmes at local, European and global level has been well documented (Comiskey, Crispino and Cassidy 2003, EMCDDA 1999 and Marsden et al, WHO 2000). With an ever increasing drug-using population in Ireland (Comiskey, 2001 and Kelly, Carvalho and Teljeur 2003) and subsequent increases in the demand for treatment services, there is an increasingly urgent and pressing need for integrated and co-ordinated treatment service models and the development of appropriate care pathways. Within this scenario treatment services in the prison setting play a crucial and pivotal role. This has also been recognised within the Irish prison system. One of the first evaluations within an Irish prison system identified the outcomes from group work with HIV positive prisoners and more recently research has illustrated both the benefits and failings of drug treatment programs in male prisons (Pugh, 1995 and Pugh and Comiskey, 2006). In addition in the United Kingdom an elevated risk of serious harm and death has been identified

among drug users following their release from prison. Studies confirm this elevated risk following release (Shewan et al, 2000). Shewan et al report that one quarter to one third of female drug fatalities in an area of Scotland were people who had been released from prison in the last year, with 30% of these deaths occurring approximately a month after leaving prison. These results clearly identify the need for a continuum of care. It is this continuum that we propose to model within this first Irish study.

3. Background

Demographics

The likelihood of women being imprisoned is substantially less than men. In England and Wales, for example, less than 6 % of the total prison population are female (Borrill et al., 2001). Generally women prisoners are criminally unsophisticated and are mainly incarcerated for property offences such as shoplifting (Morris et al., 1995).

Male and female prisoners are more likely to come from deprived social backgrounds but women may have lower incomes, levels of educational attainment and employment rates than men (Peters et al., 1997). In a study published by the Home Office, nearly 60% of the female prisoners in the sample were living solely on benefits prior to incarceration (Morris et al., 1995). More than a quarter of these women said they had never worked before.

In addition, accommodation has been identified as a key issue for women in the Criminal Justice System and many report changeable and unstable living situations prior to imprisonment (Morris et al., 1995).

Children

Many female drug-using prisoners are young single mothers (Peters et al., 1997) and while in prison often have difficulties keeping in touch with their children (Morris et al., 1995). Such women have expressed concern regarding their drug use but may be reluctant to enter into community treatment due to difficulties in obtaining suitable childcare or fears of losing custody (Henderson, 1998). For this reason it is important that incarceration be used as an opportunity to offer high quality treatment to these women.

Drug Use

The link between drug use and crime has been well established as drug-users often need to engage in criminal activity to fund their drug habits, (Inciardi et al., 1994).

The prison population has been identified as a group that are at risk of substance abuse and studies have shown that women prisoners have higher levels than their male counterparts (Maden et al., 1994). In English prisons, 40 % of women report regular use of illicit drugs compared to 33% of men (Marshall et al., 2000). Most of these women are dependent on heroin and continue to use when they are in prison (Borrill et al., 2001).

Physical & Mental Health

Generally female prisoners have poor physical and mental health relative to the general population. They have higher rates of HIV and Hepatitis C and are more likely to suffer from respiratory illnesses. Female drug-using prisoners have higher levels of depression, anxiety and borderline personality disorders than their male counterparts (Madden et al. and 1994, Henderson, 1998). They are also more likely to have a history of sexual abuse and display signs of suicidal and other self-harm behaviours (Peters et al., 1997). This would suggest that female drug-using prisoners have particularly poor mental health and are a very vulnerable group. In spite of this, many women who seek help in prison for depression and anxiety do not receive any intervention other than medication. This is not in line with the multi-disciplinary model of mental health, and the need for additional psychological interventions in prisons has been recognised (Borrill et al., 2001).

Unique needs of Women

Female prisoners have unique needs that must be considered when addressing the provision of services in prisons. As many female prisoners are mothers, they are often concerned about child-care arrangements and how their children are coping without them. Visits are the most common method of keeping in touch with children but they are, in many cases, too short and infrequent to establish or maintain good quality relationships (Morris et al., 1995). Female prisoners have higher rates of drug abuse, mental illness and self-harm behaviours than their male counterparts (Peters et al., 1997). In addition, it as been reported many of these women have suffered sexual abuse prior to incarceration. Treatment services in prisons must allow for and address these particular issues if they are to meet with any success.

Risk of Death

Previous research has indicated that newly released drug-using prisoners are at an increased risk of overdose (Seaman et al., 1998). This is true of male and female prisoners. However, it has been reported that women are at an increased risk of death post release. It has been suggested that after decreased opiate use in prison, women are more susceptible to overdose upon release due to reduced tolerance (Shewan et al., 2000).

A study investigating post-release mortality among 63 female prisoners in Australia found that the majority died of drug related causes. Most of these women died as a result of drug overdoses involving heroin mixed with other substances including benzodiazepines, amphetamines and methadone. Death, in many cases, occurred soon after release with all but 8 of the women dying within 18 months of being released from prison (Davies & Cook, 2000).

Similarly a study conducted in the Strathclyde region of Scotland investigated the deaths of 14 former female prisoners. Drug overdose involving heroin and benzodiazepines was the most common cause of death and all occurred within a year of release. The risk of death among drug-using prisoners was higher than for that of non-using prisoners and than that of the drug-using population in Glasgow (Shewan et al 2000).

Within Ireland it is reported that 13% of drug related deaths are associated with imprisonment or recent release from prison. Opiate related deaths account for the largest proportion of deaths among drug users in Ireland. A review of coroners cases found the poly substance use was common among drug users that had died, (Byrne, 2002).

Treatment

The National Treatment Outcome Research Study (NTORS) in the UK has supported a correlation between drug use and crime in such a way that a reduction in drug use is associated with a reduction in crime (Gossop et al., 1998 and 2001). This research highlights the importance of drug treatment programmes in prisons so as to reduce recidivism rates as well as drug use in prisoners.

It has been pointed out that the Criminal Justice System is an ideal medium through which drug treatment can be provided, as large numbers of problem drug users pass through it (Inciardi, 1996). Considering the exceptionally high rates of heroin users in women s prisons, effective gender appropriate drug treatment programmes must be made available. A multi-disciplinary model with extensive primary care, health

education, social support, psychiatric, psychological and self-help programmes has been suggested (Borrill et al., 2001).

Through care

A study carried out on female prisoners in the UK found that although women with drug problems were aware of their need for treatment, there was a lack of through care after the initial assessment and detoxification (Borrill et al., 2001). It is important that unmet demand for treatment services be addressed if drug treatment in prison is to be met with a greater degree of success.

Women in prison have stressed the importance of having someone to talk to about their problems but in spite of this only a small minority of women receive any form of therapy while they are in custody (Borrill et al., 2001). Psychological therapies and guided self-help courses may benefit the women by helping them manage their distress without resorting to illicit substances.

Irish Female Prisoners

As in other countries, women are underrepresented in the prison population in Ireland. In 1996, for example, less than 10% of those convicted of indictable offences were women (Bacik, 2002). There is a high turnover of women prisoners in Mountjoy Prison in Ireland and the majority of the women entering the prison have committed non-violent crimes such as theft and drug related offences (Carmody & McEvoy, 1996).

More recently in the Irish Prison Service Annual Report 2004 authors state that women accounted for 906 or 11% of all committals in 2004. In addition the increase of one-third in the number of females committed under sentence in 2003 was maintained in 2004. This continued to result in pressure on female prisoner accommodation. This is also reflected in the daily average numbers in the prison and on temporary release. The Dochas center has a bed capacity for 81 women but on average in 2004 there were 84 women committed with an additional 35 on temporary release (IPS, Annual Report 2004, Table 6)

Most female prisoners in Ireland come from and are raised in inner city Dublin. They are usually young, most are in their mid-twenties and are often unemployed. Female prisoners in Ireland, like those in the UK, have high rates of drug abuse. The most common drug used by Irish female prisoners is heroin, with injecting being the most common route of admission. They also have high rates of viral infection with an estimated 13% HIV and 22% Hepatitis C positive (Carmody & McEvoy, 1996).

In Ireland during 2004, a total of 356 HIV infections were newly diagnosed. Among IDUs, there were 71 HIV infections newly diagnosed compared to 49 in 2003 and 50 in 2002. 2004 was the first year that hepatitis C was notifiable in Ireland and 1,154 cases were reported. (HPSC, 2004). In developed countries, it is estimated that 90% of people with chronic hepatitis C are current or former injecting drug users or have received unscreened blood or blood products. There is currently no enhanced surveillance system for hepatitis C in Ireland. However, previous studies in Irish settings indicate that the hepatitis C epidemic in Ireland is mainly occurring in injecting drug users and is strongly associated with sharing syringes or other drug paraphernalia. (Smith et al., 2003).

Although female prisoners have been shown to be a very vulnerable sub-section of the population, there is a lack of research on the treatment needs of women in Irish prisons (Carmody & McEvoy, 1996). It is important that this area be investigated to ensure service provision is properly equipped to address the specific needs of these women.

4. Methods

Overview of the study design

In order to identify and assess the continuum of care or care pathway we conducted a process and outcome evaluation type study. Key activities in process evaluations include:

1. A review and audit of existing treatment methods and resources
2. Identification and critical analysis of programme logic models.
3. Focus groups and discussions with programme participants and other key stake-holders.
4. Survey of the population being evaluated.

Within this study we mainly focused on activities 3 and 4 above and report here on the methods employed and results obtained. Activities 1 and 2 formed part of our background and ongoing reading and research to enable us to place our results in context.

There are several different designs in an outcome study. We adopted a naturalistic observational study. Within such a study clients are assessed usually before during and after they complete a treatment programme. Our clients were interviewed within one moth of admittance and were followed up and interviewed again 6 months later.

Within this study the outcome evaluation was conducted as part of activity 4 above and the qualitative results were part of activity 3.

The research instrument design and influences

International guidelines for instrument design were adhered to. As part of the pre design process instruments from international outcome research were studied. Finally an adaptation of the MAP (Marsden et al., 1998), DORIS and ROSIE (Comiskey et al., 2003a) instruments was chosen. Input on the pre pilot design of both the study and the instrument was sought at a planning meeting held with the operational team of Mountjoy Prison and Governor Lonergan, Governor McMahon, Governor Baxter and their staff. Prior to the main study a pilot study to assess the instrument design and study feasibility, prison access and interview length was conducted with 6 women. Following the compilation of the pilot report final changes were made to the instrument design.

Data quality, storage and ethics.

Several databases were set up to record the interviews. This data was analysed using the statistical package SPSS. Confidential and identifying data on the women was not entered into these databases. All data was stored in a secure and locked cabinet. Throughout the different stages of the study, from pilot to recruitment to follow-up quality assurance and validity checks were performed on the data and progress monitored. Ethical approval for the study was sought and gained from the Irish Prison Service Ethics Committee. In addition, all clients recruited to the study were provided with written summaries of the research objectives and signed copies of their informed consent.

Data analysis and reporting

For the quantitative data, descriptive statistics at recruitment, changes in outcomes at 6 months and descriptions of changes to the care path ways were provided. In order to assess changes, descriptive statistics comparisons were made between the full and followed up cohort. In order to test statistical significance, matched pairs t-tests for means and McNemar tests for changes in frequencies for categorical data of matched pairs were conducted on the baseline and follow-up data for the followed-up cohort only.

For the qualitative data we performed thematic content analysis, data reduction, data display, conclusion drawing and verification. Throughout the 18-month period of the

study we provided ongoing verbal and formal written 6 monthly reports. This allowed a two-way process for feedback and formative/action research.

Stakeholder Interviews

Semi-structured interviews were carried out with eight participants that are based in either the voluntary or statutory sectors, or the prison services. All of the participants work with women who have been in prison in various capacities. Each interview was loosely organised around; the key identifiable needs of the women, gender specific issues, gaps in service provision, and suggestions for moving forward. After each interview, issues that arose informed consecutive interviews and so contributed to a broad and in-dept collection of data. The data were transcribed verbatim, coded and analysed according to patterns that emerged.

The methodological approach used in this analysis is a grounded theory approach. Essentially the entire section is inter-related and the development of the analysis is built up with each of the findings as they are presented. That is, each example that is discussed is part of the build-up to an overall conclusion of inter-related factors. Each finding informs the overall analysis from different angles.

Limitations

Due to time and resources only eight service providers were interviewed which is only a small sample from those working in the field. Additionally, the examples used in this section are by no means exhaustive but do highlight apparent gaps in service provision and explore possible routes towards challenging those gaps.

5. Results — Entering the Dochas Centre

Recruitment

Baseline recruitment took place between May 2003 and January 2004. In total 40 first-round interviews were conducted. All baseline interviews took place in the Dochas Centre. Participants were either beginning a sentence or recently detained on remand. Staff at the Dochas Centre were central to the co-ordination of the interviews, identifying women who fit the research profile, asking them if they were willing to take part, and organising a room in which to carry out the interview.

Baseline interviews mainly took place in a training room located in the school at Dochas. Alternatively, the professional visiting boxes were used. Before beginning the interview the research project was explained to each woman. Participants were

given the opportunity to ask questions before during and after the interview. The consent form was signed at the end of each interview when participants had a clearer idea of what the study entailed. Contact information was gathered from each participant in order to facilitate tracking for follow-up interviews. This was not always comprehensive as many participants were homeless and had tenuous links to fixed addresses. Of the 40 interviews that took place one is incomplete and without consent.

The recruitment phase began at the same time that the prison GP s were on strike. That strike lasted 3 months (May 3, 2004 until August 10, 2004), and had a very definite impact on women who were active heroin users entering the Dochas Centre during that period.

Demographics

A total of 40 women were recruited from the Dochas Centre. These women s ages ranged from 16 to 43 years with a mean age of 26.67 years and modal ages (most frequent) of 23 and 29 years. Thirty-nine of the 40 women were born in Ireland. Twenty-three of the women (57.5%) had children under the age of 18 years. Of the 23 women that had children, one woman had 5 children, 4 women had 3 children, 12 had 2 children and 6 women had 1 child. In the majority of all cases the children did not live with their mother.

The majority of women completed their education at age 15 and had received only a lower secondary education. Fourteen (35%) of the women left school before the legal age of 15 years. However, 23 women (57.5%) did say that they had achieved some educational qualification and 10 of these said they had received a Junior Certificate. In spite of this education, 7 (21%) had difficulties with reading, 8 (24%) had difficulties with writing and 5 (15%) had difficulties with numbers.

When asked their usual occupation over the last 3 months, 26 women (65%) responded that they were not working and 7 of these women said they were unable to work. No women were working full-time but 3 (7.5%) were working part-time prior to their incarceration. Two women said they worked in the home and 2 said they were in prison for the last 3 months. The women had an average of 677.1 Euro a week to live on. The table below outlines the ways in which the women financially supported themselves in the last 3 months.

Table 5.1: How have you financially supported yourself?

	n	%
Social welfare	30	75.0
Family/Partner	25	62.5
Burglary/Theft	19	47.5
Handling stolen goods	13	32.5
Prostitution	10	25.0
Fraud/Forgery	10	25.0
Selling drugs	7	17.5
Loans	7	17.5
Wage	3	7.5
Casual work	3	7.5
Begging	3	7.5

The women were asked where they lived prior to entering the Dochas Centre. Ten women (25%) were living in their own or rented accommodation and seven (17.5%) were living in their family home. Twenty-one of the women (52.5%) were living in unstable accommodation, including hostels, B&B s, the home of friends or on the streets. When specifically asked if they had any housing problems, 26 women (62.5%) said they had problems with homelessness. This figure is higher than other figures in the current literature and perhaps gives a more accurate picture of the scale of the problem of homelessness among women. Seymour and Costello (2005) found that of a sample of 50 women prisoners 33% were homeless on committal to prison. Furthermore, an analysis of Probation and Welfare records by these authors suggested that almost half of those homeless (43%) were women despite women making up only just over one-fifth of the community based sample. It is recognised that official statistics generally grossly under-represent the number of homeless individuals in the criminal justice system and our results on not just homelessness at the time of committal but general problems with homelessness also indicate this.

Entering Dochas

Upon entering the Dochas Centre the women seldom received verbal or written information and relied either upon their past experiences or other women to provide them with this. Only 3 women said they were provided with written information and 9 with verbal information. However, the majority of the women had been committed to the Dochas Centre before. In spite of this they did have unanswered queries about

how the system worked and had various worries about self, family members, bullying in prison and their health.

When the women were asked if they were worried about themselves upon entering the Dochas Centre, 21 of the women answered yes. The reasons they specified are shown in the table below.

Table 5.2: Why were you worried about yourself?

	n
Afraid of other female prisoners	7
Mental health related concerns	5
Physical health related concerns	3
Drug & Crime related concerns	2
Concerns regarding the prison system	2
Other concerns	2

Twenty-two of the women in the sample were worried about their family, 19 were worried about their children and 13 were worried about their partner when they entered the Dochas Centre. Twenty-four women were worried about housing, most of whom (19) implied that they were homeless and were concerned about where they would go when released. Eighteen of the women were worried about their health when they entered the Dochas Centre and the reasons are outlined below.

Table 5.3: Why were you worried about your health?

	n
General physical and mental health problems	7
Viral illness (Hepatitis or HIV)	3
Had a blood clot/ stroke	3
Respiratory problems	2
Coming off drugs	2

In addition, 6 women were worried about employment, 5 were worried about education and 6 were worried about bills.

Drug use and initiation

With regard to their drug use, women were asked a range of questions on the nature and frequency of their use. All 40 women had used opiates with age of first use ranging from 11 to 26 years of age. Twenty-two women (55%) had had at least one overdose in their lifetime and 19 of the women (47.5%) had used opiates within the last 30 days. When asked about initiation into drug use, women were first given a chance to provide their own reasons for initiation and their responses are detailed below.

Table 5.4: Why started using?

	n
Friends were using	12
Had been abused	7
Family members were using	4
Boyfriend was using	4
Family problems	4
Was depressed	3
Curiosity	2
To come down off ecstasy	2
Don t know	1

Women were then prompted and asked to respond to specific reasons on their drug use initiation. With these questions women were able to say yes or no to several reasons for their initiation. The five most common reasons women responded yes to were, friends were using, 32 women said yes this was a reason for their initiation, problems at home, 23 said yes, victim of a sexual assault 15 women said yes, problems at school 13 said yes, victim of an assault 13 said yes and victim of a crime 12 said yes. What is surprising here is the number of women (37.5%, n=15) who say they have been a victim of a sexual assault and have said that this was one of their reasons for their initiation into drug use. It is commonly reported in the literature that peer pressure is one of the main reasons for initiation of drug use (Mayock, 2005) It is also widely accepted that the age of initiation is a key factor in the severity of subsequent drug use (Pudney, 2002). Results within this study provide information on additional confounding reasons for the initiation of drug use.

With regard to current drug use, 21 women (52.5%) said they had used heroin in the last 30 days and 11 (27.5%) reported using daily. Of the women that reported using heroin in the last 30 days, 6 injected and 15 smoked the last time they used. Of the seventeen women that used alcohol in the last 30 days, 10 drank at least once a day. Twenty-seven women used benzodiazepines and most of these women (66.6%) used them at least once a day. Twenty-four women had used cannabis in the last 30 days and most of these women (58%) smoked it at least once a day. The table below shows the number and percentage of women in the sample that reported using the following drugs in the last 30 days.

Table 5.5: Drugs used in the last 30 days

Drug	n	%
Methadone (in treatment)	33	82.5
Benzodiazepines	27	67.5
Cannabis	24	60.0
Heroin	21	52.5
Alcohol	17	42.5
Methadone (outside of treatment)	11	27.5
Cocaine	8	20.0
Ecstasy	7	17.5

Treatment for Drug Use

In looking at the women s histories of drug treatment, 36 of the women in the sample (90%) had received methadone treatment in the past and 34 (85%) said they had been prescribed methadone in the last 3 months. Twenty-four (60%) had a structured or supervised detoxification in the past and 7 (17.5%) had one in the last 3 months. Eighteen (45%) had been in a residential drug treatment programme and 2 (5%) had been in one in the last 3 months. Twenty-eight of the women (70%) had one to one counselling in the past and 11 (27.5%) had it in the last 3 months. Thirty of the women (75%) had been to Narcotics Anonymous and 16 (40%) had gone in the last 3 months. However, many of the women who had received drug treatment in the past said they had problems with the service. The most common problems mentioned were that they were detoxified too quickly, there was no follow up or that it was too difficult for them to stay off drugs.

What is interesting within these results is the fact that while 34 women said they had received methadone treatment within the last month only 11 said they had received some form of counselling. It is well recognised from the first methadone trials by Dole and Nyswander (Dole and Nyswander, 1965) that psychotherapy is a key element in successful outcomes from treatment with methadone. Clearly the women in this study either were not receiving any counselling as part of their methadone treatment or did not recognise that counselling formed part of their treatment. This point is further emphasised by the women s comments on how difficult it was to stay off drugs

With regard to current treatment for their drug use, 28 women (70%) said they were receiving treatment for their opiate use prior to entry to the Dochas Centre. Twenty-six women (65%) were on methadone maintenance, one was on a methadone detoxification and one was in a rehab centre.

Of the 28 women receiving drug treatment prior to incarceration, exactly half said their treatment continued when they entered and half said it had changed in some way. The ways in which treatment was changed or altered slightly in some cases is detailed below.

Table 5.6 How has your drug treatment changed?

	n
Taken off benzodiazepines	6
Treatment has stopped	4
Counselling has stopped	2
Methadone dose has increased/decreased	2

Physical and Psychosocial Health - Current Health

When asked to rate their current health, none of the women rated it as excellent, 19 rated it as good, 12 as fair and 8 rated their health as poor. Twenty-three of the women (57.5%) said they had a health problem in the last 3 months that caused them pain or limited their activities. These health problems are outlined below.

Table 5.7: Women s descriptions of their health problems in the last 3 months

	n
HIV/Hepatitis C	4
Stomach related problems	4
Drug related problems (overdose/paralysis)	3
Psychological problems	2
Respiratory problems	2
Blood clot/stroke	2
Dental problems	2

The women were also specifically asked about their mental health. They were asked how many days in the last 90 they experienced a variety of symptoms. Their responses are shown in the table below. Fifteen women in the sample (37.5%) had previously attempted suicide and 2 had attempted suicide in the last 3 months.

Table 5.8: How many days in the last 90 have you experienced the following symptoms?

	Mean	+/-SD
Tense	49.2	43.0
Suddenly scared for no reason	22.1	38.4
Fearful	34.2	42.2
Nervousness/shakiness inside	41.8	43.2
Terror/panic	25.4	38.7
Hopelessness about the future	32.1	40.1
Feeling worthlessness	26.1	38.8
No interest in things	44.8	43.6
Lonely	53.8	41.6
Thoughts of ending your life	8.8	25.0

Use of Health Services

Twenty-two of the women (55%) in the sample had stayed overnight in hospital in the past year. They stayed an average of 73.5 days (SD=92.9). Twenty-four of the women (60%) had visited an Accident & Emergency department an average of 4.6 times (SD=5.7). Twenty-two of the women (55%) had been to see a G.P. in the last year an average of 32.4 times (SD=38.2)

Crimes and Sentences

With regard to crime, women were asked a range of questions on the types and frequency of the crimes they had committed. These included drug possession and supply, theft, forgery and fraud and assault. The table below shows the number of women who ever committed each crime, the number who committed those crimes in the last 3 months, the number of women who were arrested for those crimes and the number who were arrested for them in the last 3 months.

Table 5.9: Crimes committed

Crime	Ever committed	Committed in last 3 months	Ever arrested for	Arrested for in last 3 months
Drug possession	36	24	13	1
Theft from a shop	33	15	31	13
Handling stolen goods	30	13	24	7
Selling/Supplying	20	7	8	0
Theft from a person	19	7	15	4
Criminal damage	17	3	15	4
Breach of the peace	15	9	13	6
Soliciting	14	8	11	6
Fraud/Forgery	14	3	7	2
Assault	14	6	11	3
Theft from a vehicle	13	2	7	0
Driving under influence	13	3	3	0
Theft from a house	12	4	5	1
Theft of a vehicle	11	0	9	0

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The most common crimes committed by the women in the sample were drug possession, theft from a shop and handling stolen goods. In the last 3 months 60% of the women committed drug possession, 37.5% stole from a shop and 32.5% handled stolen goods. The crime the women were most commonly arrested for was theft from a shop with 32.5% of the women being arrested for this crime in the last 3 months.

Apart from this occasion, 30 of the women had been remanded in custody before and 5 had been remanded in the last 3 months. Apart from their current sentence, 25 of

the women had received a custodial sentence before and the average total time spent in prison was 29.5 months (SD=39.7). The average length of their current sentence was 14.4 months (SD=12.1).

Six of the women (15%) had been victims of crime in the last 3 months, 3 had been assaulted (1 sexually) and 2 had been robbed.

Expectations from Dochas

Finally, women were asked about their expectations of services in the Dochas Centre. The number (and percentage) of women that expected each service are indicated below. The implications of these expectations need to be considered by the health and prison services in terms of existing services available.

Table 5.10: Women s expectations of services in the Dochas Centre

Expectations	n	%
Access to G.P. if needed	33	82.5
Access to Dentist if needed	33	82.5
Access to Education and Training	31	77.5
Access to a Counsellor	31	77.5
Drug Treatment if needed	30	75.0
Access to other medical services	27	67.5
Help with reading and writing	7	17.5

We can see from the results above that women expect both medical and educational support of the Dochas Centre. When we asked specifically what sort of training the women would like replies varied and are provided in table 5.10a below.

Table 5.10a Training and educational expectations of the women upon entering the Dochas Centre.

Art, photography, cookery, jewellery making.	1
Arts and crafts	1
Computers	2
Cooking and photography.	1
General	1
Good courses	1
Hairdressing	3
Hairdressing, computers, art.	1
Help with reading and writing.	1
Junior cert	1
Life skills course	1
Options in Dochas and to learn telephone skills and job applications.	1
School	3
Would like to do Leaving Cert.	1
Missing	21
Total	**40**

When asked what they expected to get out of their time in the Dochas Centre, 11 women (27.5%) said they expected nothing, 8 women (20%) said they expected to get a place to live upon release, 7 women (17.5%) said they expected to get off drugs, 7 (17.5%) said they expected to have time to think and get their lives back together, 7 women (17.5%) said they expected to get educated and two women (5%) said they expected to get a job when they got out.

When asked how the Dochas Centre could help them, 7 women (17.5%) said it could help them get a place, 6 (15%) said it could help get them off drugs, 5 (12.5%) said it could help them through providing counselling and 5 (12.5%) said it could help them get a qualification.

6. Results - at follow up, six months later

The follow-up interview process.

The longitudinal design of the study necessitated a follow-up interview to review the women s care pathway 6 months after their initial interview within the Dochas Centre. At this six-month stage the women fell into one of three follow-up categories, A) released from the Dochas Centre since the first interview, B) released from the Dochas Centre and subsequently detained again within the prison and C) still detained within the Dochas Centre since the time of the first interview.

Considerable time and effort was invested in contacting the women for their follow-up interview. Where addresses were available, letters were sent to participants prior to arranging a second interview in order to remind them of the study and inform them that we will be contacting them. Some participants provided addresses of service providers (statutory/community) as points of contact. Letters were forwarded to these addresses for the woman s attention. Letters were then followed up by phone calls and arrangements to meet were organised. These second interviews were conducted within the clients homes or some other suitable space that was suggested by and was convenient for the client.

The Dochas Centre and associated personnel were extremely helpful in the follow-up process. Regular contact was maintained with the prison. The Governor notified the project if any of the women were detained during the follow-up stage and these women were then contacted and interviewed in a private setting within the prison.

As an incentive and in order to achieve higher follow-up rates a payment of 30 euro was offered to the women for taking part in the follow-up stage. Where women were interviewed in the Dochas Centre the money was credited immediately after the interview to their shop account.

Follow-up rates

High follow-up rates within the study were obtained and are comparable with rates found within international treatment outcome studies, (Cox and Comiskey, 2006), (Gossop et al 2001). Outcome data were obtained for 39 (97.5%) of the original cohort of 40 women. This included full follow-up information on 30 (75%) of the women with 27 of the women completing the full interview and 3 deaths. The table below provides details on the outcome information obtained.

Table 6.1: Contact rates at 6 months.

Outcome	Number	% of Cohort	Cumulative %
Death	3	7.5	7.5
Interviewed	27	67.5	75.0
Not interviewed but client known to be on national central methadone treatment list	6	15.0	90.0
Not interviewed but client known not to be on national central methadone treatment list	3	7.5	97.5
Unable to contact client directly (no consent)	1	2.5	100.0
Total	40	100.0	100.0

The in-treatment status of clients was confirmed by the national central methadone treatment list. In addition this was also confirmed in some cases by the clients close relatives. With regards to the deaths of three clients these deaths were also confirmed by one or more of the national central treatment list, the Governor or a close relative of the client.

Comparing the full and followed up cohort data at recruitment.

Prior to the full analysis of the follow-up data at 6 months a comparative analysis of the full cohort and the follow-up cohort was performed. This enabled us to ascertain if there were any fundamental differences at baseline between those who were successfully interviewed at six months and those who were not. No differences between the two were identified. Results for basic demographic, education, drug use and other variables are provided in the tables below.

Table 6.2 How old are you? (in years)

Not re-interviewed	Mean		29.00
	95% Confidence Interval for Mean	Lower Bound	23.99
		Upper Bound	34.0132
	Median		29.00
	Minimum		21.00
	Maximum		43.00
Re-interviewed	Mean		25.42
	95% Confidence Interval for Mean	Lower Bound	23.94
		Upper Bound	26.89
	Median		25.00
	Minimum		18.00
	Maximum		32.00

Table 6.3: At what age did you finish your education? (in years)

Not re-interviewed	Mean		14.50
	95% Confidence Interval for Mean	Lower Bound	13.47
		Upper Bound	15.53
	Median		14.50
	Minimum		12
	Maximum		17
Re-interviewed	Mean		15.35
	95% Confidence Interval for Mean	Lower Bound	14.44
		Upper Bound	16.27
	Median		15.00
	Minimum		11
	Maximum		20
	Range		9

Table 6.4: Past 3 months average money to live on per week (euro)

Not re-interviewed	Mean		1000.64
	95% Confidence Interval for Mean	Lower Bound	220.04
		Upper Bound	1781.24
	Median		537.50
	Minimum		134.00
	Maximum		3500.00
Re-interviewed	Mean		552.48
	95% Confidence Interval for Mean	Lower Bound	209.65
		Upper Bound	895.32
	Median		315.00
	Minimum		.00
	Maximum		4000.00

Table 6.5: How long is this sentence for? (in months)

Not re-interviewed	Mean		10.56
	95% Confidence Interval for Mean	Lower Bound	6.26
		Upper Bound	14.85
	Median		12.00
	Minimum		3.00
	Maximum		18.00
Re-interviewed	Mean		16.89
	95% Confidence Interval for Mean	Lower Bound	8.46
		Upper Bound	25.33
	Median		12.00
	Minimum		2.50
	Maximum		60.00

Table 6.6: Age used first drug

Not re-interviewed	Mean		13.04
	95% C I for Mean	Lower Bound	10.99
		Upper Bound	15.08
	Median		13.00
	Minimum		9.00
	Maximum		22.00
Re-interviewed	Mean		14.43
	95% C I for Mean	Lower Bound	13.44
		Upper Bound	15.41
	Median		14.00
	Minimum		10.00
	Maximum		21.00
	Range		11.00

Table 6.7:Times ever overdosed.

Not re-interviewed	Mean		2.63
	95% C I for Mean	Lower Bound	1.15
		Upper Bound	4.10
	Median		2.50
	Minimum		1.00
	Maximum		6.00
Re-interviewed	Mean		5.35
	95% C I for Mean	Lower Bound	2.08
		Upper Bound	8.61
	Median		3.00
	Minimum		1.00
	Maximum		20.00
	Range		19.00

Table 6.8: Minimum frequency of heroin use in last 30 days

Not re-interviewed	Mean		26.50
	95% C I for Mean	Lower Bound	8.37
		Upper Bound	44.63
	Median		30.00
	Minimum		1.00
	Maximum		60.00
Re-interviewed	Mean		31.40
	95% C I for Mean	Lower Bound	10.26
		Upper Bound	52.56
	Median		30.00
	Minimum		1.00
	Maximum		90.00

Table 6.9: In total how long have you spent in prison (in months)

Not re-interviewed	Mean		31.54
	95% Confidence Interval for Mean	Lower Bound	3.52
		Upper Bound	59.56
	Median		14.00
	Minimum		3.00
	Maximum		156.00
Re-interviewed	Mean		28.34
	95% C I for Mean	Lower Bound	11.42
		Upper Bound	45.26
	Median		12.00
	Minimum		.50
	Maximum		162.00

Having established that there are no major differences between the recruited and followed-up population, we are now in a position to compare outcomes for the followed up clients six months after their entry to the Dochas Centre. This we do below. First we discuss the experiences of the women while they were in the Dochas Centre, then we look at what happened to the women upon release and finally we measure the key outcome variables of drug use, accommodation, heath, psycho/ social functioning and crime. We do this in order to assess if the time at the Dochas Centre and the 6-month journey have had a negative or positive impact on the women s lives.

Within the Dochas Centre — Experiences and Services

For the majority of women followed up and interviewed at 6 months the time spent at the Dochas Centre had been of some help. Nineteen or 70%, when asked if the Dochas Centre had helped them in any way, said yes it had helped. Ways in which the prison helped varied from help with risk to the woman s life due to her drug use to help with education and training. The detailed responses of the women are very interesting and are provided for the reader below. However, it is disappointing to note that 8 or 30% of the women felt that Dochas had not been of help to them.

Table 6.10: How does/did Dochas help you during your sentence/remand?

Did help. Being away from home was good. Relieved to be away at the time.
Felt they were there for her. Helped with school.
Gave her time to think about what she wanted in life but it was the time she had for herself - NOT Dochas Centre really.
Helped her a lot, gave her a quick detox (was on methadone, then reduced every 5 days). Got to see counselors, they were good.
Helped her to come down off methadone.
Helped to get her head together a bit.
If she didn't get locked up she would be dead by now. Got her on a drug treatment program. Clean now.
No - all it did was stop her drinking but once she got back out she started again.
No - they did nothing for me. (5 women)
No they didn't help. You have to do it yourself. You have to decide to stay off the drugs yourself.
Not helpful - probably as children weren't with her, found that difficult.

Table 6.10 Continued: **How does/did Dochas help you during your sentence/remand?**
Rehab helped her to do her NCVA. Helped her stay clean.
Thinks it's much better than the boys prison. Got her clean so many times, she thinks she would have been dead without the help at being clean now and again.
Very good to her. Trusted her to go to Aislinn (drug treatment) every week and to return again.
Yeah. Helped get her off drugs and she got clean while she was in there.
Yes - Education and the courses, you can continue them outside as well.
Yes - got her back into a routine but she had nothing to go back to when she was released.
Yes - helped build up confidence, time to think, do things in here not on the outside; exams, eating properly. This changes a lot and helps get health back.
Yes - on a professional level. On a personal level more, recovery wise. Can go to any officer, they'd help you. They are brilliant. Not the same person.
Yes - they helped her get clean.
Yes, has made her look at life in a different way. She doesn't get stressed and problems don't seem so big. Aiming to get off medication. Has certificates for health and fitness training.
Yes, there are good resources in Dochas - Drug treatment, education, housing. If you're committed to sorting things out, it can help.
Yes. It gave her a routine and a break from drugs. She got straight, got her head together.

Women were also asked about the outcomes to their expectations upon entry for access to a regular routine, meals, sleeping and medical and educational services. In each case the majority of women said that they did receive regular services (regular routine, 85%, regular meals 93%, regular sleep 73%, drug treatment 86%, GP if needed 82%, dentist if needed 72%, other medical services 75%, education and training 93 %). There was however one notable exception to this: only 48% of women said yes they had access to a counsellor.

Finally, at the 6-month follow up stage, the women were also asked a series of questions to look at the details of some of the services they had accessed while they were in the Dochas Centre. With regards to accessing training courses, over 70% of

women interviewed said they had participated in education and training during their sentence. The courses that women participated in included computers, hairdressing, health and fitness, drugs, photography, arts and crafts, cooking and English. None of the women continued with any education or training after they left the Dochas Centre although some did express an interest in doing further courses.

Women were asked if they had received any help from social welfare services during their time at the Dochas centre and only 4 of the 27 women or approximately 15% said yes, they had had some contact from these services. The reasons for the contact varied and are provided below.

Table 6.11 Type of contact with Social Services

Baby was taken away.	1
Did not receive help but really did need help with her daughter.	1
Not relevant	22
Probation officer for impending court case.	1
Probation officer helped with housing.	1
Social services were in contact with her partner while she was inside.	1
Total	27

Women were asked about drug treatment and other medical services they had received during their stay at the Dochas Centre. Twenty-five (93%) of the 27 women interviewed at 6 months said that they had received treatment for their drug use and 22 of these 25 (88%) said that they had received some form of methadone substitution treatment. Six women of the 27 women (22%) also said that they were receiving treatment for alcohol use while at the Dochas Centre. Eight women (30%) were also receiving other medical treatments. These were for a range of medical conditions including, 1 HIV, 2 asthma, 1 pregnancy, 1 sleeping problems, 2 psychiatric problems and 1 patient was attending the GP for depression and bullying problems.

Leaving the Dochas Centre — Risks and Release

Three (7.5%) of the original cohort of 40 women recruited to the study died within the 6-month follow-up period of the study. We were informed of these deaths by close

associates or family members and two of the deaths were confirmed by the national central methadone treatment list. All 3 of the women had been released from prison. The women died in varying circumstances the details of which are not known to us at this time. These tragic and sad results highlight the very real and urgent risks associated with the release of female drug using prisoners. The follow up data discussed below provide detailed information and evidence on the problems and risks faced by the women upon release.

The majority, 22 (81.5%) of the 27 women interviewed at the 6-month follow-up stage, had left the Dochas Centre since the first interview. Seven of these women had left and been readmitted and 5 (18.5%) had not been released at all in the 6-month period. The reasons for their release are presented below. It is interesting to note that 10 (45%) women received temporary or early release while only 7 (32%) had served all of their sentence.

Table 6.12 Why were you released?

		Frequency	Percent	Valid Percent
	Was on remand and was not sentenced	5	18.5	22.7
	I received temporary release	7	25.9	31.8
	I received early release	3	11.1	13.6
	I had served all of my sentence	7	25.9	31.8
	Total	22	81.5	100.0
	Missing (not relevant)	5	18.5	
Total		27	100.0	

The experiences of those women who had been released were sought. We found that upon release, women experienced many worries similar to those they experienced upon their committal six months previously. A summary of the women s concerns are provided in the tables below.

Over half of the women (12 out of the 22 releases or 54.5%) were worried about themselves at the time of release. These worries were in connection with health and medical reasons or accommodation concerns. Transcripts of replies are provided verbatim below.

Table 6.13: Why were you worried about yourself?

Back to square one.
It was near Christmas - money.
No fixed abode - no accommodation. Brought to Wellington Quay and them some place on South Circular Rd.
No GP. Has serious illness and had been in a coma before (pancreas).
Not on methadone, worried about going back on drugs.
Nowhere to stay and had no money.
Worried about going back on drink.
Worried about going back on drugs.
Worried about going back on gear.
Worried that she'd slip out of line and end up back inside.
Worried what was going to happen, if she was going to go back to drugs.
Worries, bullied before entering prison.

In addition 50% of the women were worried about money, 50% of those with children were worried about their children, 35% were worried about their partners and 14% were worried about other family members.

Women were also worried about their health. When they left the Dochas Centre 48% said they were worried about their health. The range of medical problems experienced by the women can be seen below.

Table 6.14 Why were you worried about medical/health?

Asthma, bronchitis and hep C.
Because she was on drugs before coming into Dochas the first time she was worried she would go back on drugs.
Has problems with pancreas from alcohol abuse.
HIV positive, hasn't been for appointments in Mater hospital.
HIV+, Hep C+ and septicaemia.
Was very overweight, comfort eating in prison.
Worried about going back on drink.
Worried about going back on drugs.
Worried about going back on gear.

Finally 52% of the women were worried about their accommodation. The reasons expressed by women are provided below. We can see from the table of replies that the main concern of the women is that they have no stable home.

Table 6.15: Why were you worried about housing?

Didn't have a place to live when released.
Didn't know if she could come home to live with her mum.
Her main concern. On homeless list over 6 years.
No fixed abode.
Not worried - could go back to xxx. Partner and son were in a BnB there.
Nowhere to go. Homeless. Didn't have a place set up cause she was released early
Nowhere to live, nothing was set up for her.
Nowhere to stay out on the streets.
Rent too dear. Looking for something else.
Was served an eviction notice while in prison.
Worried about a place to live. Is homeless as had been thrown out.

Women were asked if they received any assistance or help with their concerns as they left the Dochas Centre. Of the 20 women who replied 17 or 85% said they had received no assistance. The women s opinion was sought on what information or assistance could help with their concerns and their replies are provided below. We can again see from these replies that the main help the women would have liked was with accommodation.

Table 6.16: What additional information/assistance could have helped?

Could have helped with housing problems. She was given an eviction notice while in prison. Could have helped sort it out.
Don't know, didn't get any information from anyone.
Maybe a month before you leave, they should put you in touch with someone to help you with housing, education and getting a job.
Needed help with finding a place. She went to 136 Tus Nua but found it very hard being there.
Needed to know which welfare officer was linked to and where to go.
None - they did enough.
None
She feels it is up to herself.
She needed help getting a proper place to stay.
They could have got her set up with a methadone clinic. She may not have gone back on the gear.
They could have made sure there was someone to collect her. She was just thrown out the door.
They could have set her up with a place to stay. She had to go out on the street or to a hostel where there were people taking drugs.
They should get her a place to live. That's the main thing. Then she could sort herself out with a job and get her life back together.
They should have set her up with a place to live.
To get her a place when she got out. She had to go to Wellington Quay, then got a place with the Simon community.
Would have liked a proper counsellor but Dochas only had a nurse.
Would have liked some proper housing to help with getting a job.

The accommodation problem is discussed in greater detail within the qualitative interviews with service providers in the qualitative section. However, within these quantitative interviews we can see that the problems of accommodation and continuity of treatment is continually being referred to by the women and is compounded by several factors. These factors include the common practice of early and temporary release often with little or no notice for either the women or those working on treatment and accommodation services on their behalf. Evidence for this

can be found in replies to the question on notice the women received of their release. Sixteen (73%) of the 22 women released were either told on the day or received no notice of their release. A further 4 (18%) of the 22 women received either 2,3,5 or 7 days prior notice to their release.

The risks women are exposed to upon release are considerable and are one of the main findings of this study. We asked women what happened immediately upon their release and their replies are detailed below. We can see from these replies that immediately upon release women s experiences ranged from gang rape, overdose, prostitution, poly drug use, homelessness and/or some other exposure to considerable risk. Only 7 of the 22 women released (32%) went home (5 to their mother s home) and did not report any trauma or risk events.

Table 6.17: What happened with you immediately after you were released?

Brought to Wellington Quay, and then stayed in various BnB's before Regina Hostel.
Came home. Was to be evicted but sorted it out herself. The prison was no help. She would have lost the flat if she hadn't got out. Was using cocaine after release but has stuck to methadone since.
Had a place to stay (her mams) and the course but she fucked up, went back on the streets, selling drugs and using coke.
Moved in with her mum and/or family.(7 women)
She was homeless and went to Wellington Quay. The Simon Community gave her a bed but she went back on drugs as she wasn't on a methadone programme. Has since come off drugs by herself.
Stayed in Tus Nua hostel but thrown out for drinking. She was robbed in there and then 'snapped'. Shouldn't have been thrown out. Went to Wellington Quay, got room in BnB, been there 6 months. Still hasn't got her own place. On a waiting list for council place.
Supposed to go to Naas for 8 weeks to live with aunt but didn't get on well so left 1 and 1/2 weeks early. Living in xxx town with brothers wifes sisters daughter. Allowed home to xxx for 6 days after Christmas.
Thrown out of Dochas, walked to mother's. Husband brought her home, they fought, she went out to get tablets. Was drugged and gang raped by 3 men. Left in a coal bunker. Found by taxi driver and brought to hospital. Went back on tablets but clean now. Court case pending.
Walked the streets. Rang the homeless free no. after 5.30. No hostel that night. Slept on street.
Was collected by worker from Tus Nua.
Went out and got a drink and has been drinking ever since. Stayed in a BnB the first night. Then got a flat
Went to 136 Tus Nua but came home 20 minutes late so got a lecture. She walked out and went to xxx hostel. It's a disgusting kip, full of homeless old women. Terrible place, should be closed down.
Went to homeless place, used drugs but didn't get strung out. Ended up in hospital for 4 weeks with an overdose and got an abscess after first using. Overdose accidental; used same amount as before she was prison but tolerance had decreased.
Went to live in Haven House (hostel).They kept her room for her. Couldn't get on methadone clinic straight away, went back on gear. Outreach worker got her onto methadone program on mobile bus. Eventually got into Mews.
Went to North Circular Road for 2 weeks went back to prostitution.
Went to Wellington Quay to get her cheque and the address of place where she had to stay - xxx. place.

We can see from the results above that there is considerable risk associated with leaving the Dochas Centre. This risk is reflected in the physical and mental health variables we examine below and can also be seen in the attendance at Accident and Emergency Departments in the 3 months before the recruitment interview and the 3 months before the follow-up interview. Details are provided in the tables below.

Table 6.18: Attendance at Accident and Emergency Departments in the last 3 months (statistics for the full cohort)

	N	Minimum	Maximum	Mode	Mean	Std. Deviation
How many days in the past 3 months have you attended A and E	16	0	7	0	.81	1.76
How many days in the past 3 months/since leaving Dochas?	11	1.00	6.50	1	2.00	1.69

We also found a significant difference in the mean number of times clients attended A and E with this mean increasing at follow-up. The table below illustrates this.

Table 6.19: Paired t- test on mean attendance at Hospital Accident and Emergency Departments (followed up cohort only)

	Mean number of times at baseline	Mean number of times at 6 months	N, number of respondents	t	p
Attendance at A and E in the last 3 months	0.33	2.67	6	-0.68	0.04

The reasons women went to A and E departments were asked at follow-up and these again highlight the real need to attend, and the considerable risks women experienced. These details are also provided below.

Table 6.20: Why did you attend an A and E Department?

Abscess and broken leg.	1
Abscess in mouth and throat.	1
Chest infection and HIV positive	1
Chest infection and overdose.	1
Collapsed in court.	1
Collapsed on the road and for self harm.	1
Drinking and going unconscious.	1
Drugged and gang raped. One night. Also had a broken toe.	1
Sore eyes and stomach	
Overdosed a few days after leaving prison.	1
Pancreas problems	1
Septicaemia from appendectomy scar.	1
Not relevant	15
Total	27

Having looked at the risks experienced we now look at the overall outcomes experienced by the women.

Changes in Outcomes at 6 Months — Drug Use

One of the primary variables of interest when modelling the care pathway of the women is their level of drug use 6 months after their initial interview within the Dochas Centre. Upon follow up we asked the women the same questions about recent drug use that we originally asked at recruitment. When questioned if they had used heroin within the last 30 days we found that the proportion using had dropped slightly from 53% to 46%. The details of the proportions using within the 3 followed up categories are provided below.

Table 6.21: Heroin - used in the last 30 days

			4.1a Heroin - used in the last 30 days?		Total
			No	Yes	
Group Classification	Not Released	Count	3	2	5
		%	60.0%	40.0%	100.0%
	Released	Count	8	6	14
		%	57.1%	42.9%	100.0%
	Released and Recommitted	Count	3	4	7
		%	42.9%	57.1%	100.0%
Total		Count	14	12	26
		%	53.8%	46.2%	100.0%

While the percentage who used heroin within the last 30 days only showed a slight improvement the frequency of use within the last 30 days showed greater improvements. The tables of these results are provided below.

Table 6.22: Frequency of Heroin use in last 30 days at Recruitment

		Frequency	Percent	Valid Percent	Cumulative Percent
	Once a day	6	15.0	33.3	33.3
	Twice a day	4	10.0	22.2	55.6
	Three times a day	1	2.5	5.6	61.1
	More than once a week less than once a day	2	5.0	11.1	72.2
	Once a week	2	5.0	11.1	83.3
	More than once a month	2	5.0	11.1	94.4
	Once in the past month	1	2.5	5.6	100.0
	Total	18	45.0	100.0	
	Missing	22	55.0		
Total		40	100.0		

Table 6.23 Heroin - frequency used in the last 30 days at follow up

		Frequency	Percent	Valid Percent	Cumulative Percent
	More than once a week but less than once a day	1	3.7	9.1	9.1
	Once a week	1	3.7	9.1	18.2
	More than once a month	1	3.7	9.1	27.3
	Once in the past month	3	11.1	27.3	54.5
	Other	5	18.5	45.5	100.0
	Total	11	40.7	100.0	
	Missing	16	59.3		
Total		27	100.0		

We see from the tables above that at recruitment 11 or 61% of the 18 women who replied were using heroin at least once a day, while at follow up the number using daily had reduced to 2 or 18% of the 11 women who replied. These two were identified within the data on the 5 women who said they had other frequency. Of the 5 who said other frequency of use, 2 were using daily, one had used once, one had used twice and one had used five times within the last 30 days. However, when asked how they had used heroin the last time, 6 of 21 or 29% of those who replied at recruitment had injected and 71% had smoked. At follow up these percentages were very similar and did not show improvement , with 30% saying they injected the last time the used.

From the data on the frequency of drug use within the last 30 days and information on the category other we were able to compute a new variable which looked at the minimum number of times the women used heroin within the last 30 days. From this we found that there was a considerable reduction in the level of use from recruitment, with an average minimum use of 30 times per month, to follow-up at 6 months where the average minimum number of times used fell to 7 times per month. That is to say that at recruitment on average the women were using heroin at least daily while six months later this reduced to less that twice a week. Details on this variable are provided below.

Table 6.24: Heroin - Minimum number of times used in last 30 days at recruitment

N	Minimum	Maximum	Mean	Std. Deviation
18	1.00	90.00	29.50	26.92

Table 6.25: Heroin -Minimum number of times used in last 30 days at follow up

N	Minimum	Maximum	Mean	Std. Deviation
11	1.00	30.00	7.36	11.31

With regard to the use of cocaine, at follow up 4 of 26 women who responded (15%) said they had used cocaine within the last 30 days. Two of these 4 (50%) said they had used it daily and one (25%) said she had injected the last time she used. While these numbers are of concern and illustrate the risks to the women, it was encouraging to see that all of these percentages had dropped from those observed at recruitment. At recruitment 9 of 38 women who replied (24%) said they had used cocaine within the last 30 days. Of these 9, 6 (67%) said they had used daily and all 9 (100%) said they had injected last time.

With regard to the use of other drugs, improvements were also seen in the use of non prescription methadone. At follow-up, 2 of 26 women (8%) said they used methadone outside of treatment within the last 30 days compared with 11 of 38 women (29%) who said the same at recruitment. A reduction was also noted with the use of ecstasy in the last 30 days. At follow-up, 1 of 25 women (4%) said that they had used ecstasy within the last 30 days compared with 7 of 38 (18%) of women at recruitment. A slight reduction was also found in the use of alcohol, which was down from 44% used in the last 30 days at recruitment to 40% at follow-up. However, a slight increase was noted in the use of cannabis (up from 62% to 65%) and tranquillisers and barbiturates (up from 69% to 73%). However, the proportion of people using tranquillisers and barbiturates daily decreased from 65% (15 of 23 who replies) at recruitment to 22% (4 of 18 who replied) at follow-up.

Overall, we can deduce from the results above that the 6 month follow-up period did have a positive impact on drug use outcome measures. To what extent this can be attributed to the stay at the Dochas Centre or to the stage at which the women are at in their drug using career is uncertain and would require more detailed analysis.

However, we do know that the average sentence among the women was 14.41 months at time of recruitment but the majority did not serve all of this sentence as we saw earlier.

Finally, in order to look at possible changes or movements in patterns of drug use, we compared the drug use of the followed-up cohort of 27 women with their own drug use at recruitment. We looked at their use of each drug within the last 30 days at recruitment and at follow up. Within these results we did find reductions in the numbers using each drug with the exception of cannabis but we also found that some who had not used within the last 30 days at baseline did use within the last 30 days at follow up. This is to some extent to be expected as at recruitment the women were interviewed within the Dochas prison. Looking at heroin use more closely, we found a large reduction in the frequency of use from recruitment to follow up. Details of these results are provided in the tables below.

Table 6.26: Minimum frequency of heroin use in last 30 days

Mean at baseline	N	Mean at 6 months	N	t	df	p
32.0	5	7.7	5	1.69	4	0.175

Table 6.27:Used Heroin in the last 30 days, Crosstabulation

			Used Heroin in the last 30 days		Total
			No	Yes	
Heroin - used in the last 30 days/since leaving prison?	No	Count	7	7	14
	Yes	Count	5	7	12
Total		Count	12	14	26

Table 6.28: Used Methadone outside of treatment in the last 30 days, Crosstabulation

			Used Methadone outside of treatment in the last 30 days		Total
			No	Yes	
Methadone (outside treatment program) - used in the last 30 days/since leaving prison?	No	Count	15	8	23
	Yes	Count	1	1	2
Total		Count	16	9	25

Table 6.29: Used Cocaine (powder) in the last 30 days Crosstabulation

			Used Cocaine (powder) in the last 30 days		Total
			No	Yes	
Cocaine - used in the last 30 days/since leaving prison?	No	Count	18	4	22
	Yes	Count	1	2	3
Total		Count	19	6	25

Table 6.30: Used Tranquilisers/Barbiturates in the last 30 days, Crosstabulation

			Used Tranquilisers/Barbiturates in the last 30 days		Total
			No	Yes	
Tranquilisers - used in the last 30 days/since leaving prison?	No	Count	4	3	7
	Yes	Count	1	18	19
Total		Count	5	21	26

Table 6.31: Used Crack Cocaine in the last 30 days, Crosstabulation

			Used Crack Cocaine in the last 30 days		Total
			No	Yes	
Crack cocaine - used in the last 30 days/since leaving prison?	No	Count	23	2	25
	Yes	Count	1	0	1
Total		Count	24	2	26

Table 6.32: Used Ecstasy in the last 30 days, Crosstabulation

			Used Ecstasy in the last 30 days		Total
			No	Yes	
Ecstasy - used in the last 30 days/since leaving prison?	No	Count	20	3	23
	Yes	Count	0	1	1
Total		Count	20	4	24

Table 6.34: Used Cannabis in the last 30 days, Crosstabulation

			Used Cannabis in the last 30 days?		Total
			No	Yes	
Cannabis - used in the last 30 days/since leaving prison?	No	Count	7	2	9
	Yes	Count	4	13	17
Total		Count	11	15	26

Table 6.35: Used Alcohol in the last 30 days, Crosstabulation

			Used Alcohol in the last 30 days		Total
			No	Yes	
Alcohol - used in the last 30 days?	No	Count	11	4	15
	Yes	Count	3	7	10
Total		Count	14	11	25

Changes in Outcomes at 6 Months — Physical and Mental Health

Of 10 physical and mental health variables measured we found minor decreases in 6 variables measuring the average number of days the women experienced these symptoms in the preceding 3 months. The comparisons of the results at recruitment and at follow-up are provided in the tables and figures below.

However, we did find that the proportion of women who described their health as poor or fair increased from 51.3% at recruitment to 63.0% at follow-up. In addition, the percentage of women who had tried to commit suicide within the last 3 months increased from 7% at recruitment to 11% at follow-up. Given the analysis of the medical data, it would be prudent to conclude that although the women s drug use had declined their health problems remained or it could perhaps be suggested that with the decline in drug use women became more aware of their physical and mental health, which could be viewed as a positive step. However, it is of grave concern to

note in the table below that one woman who had attempted suicide at recruitment still continued to do so and that 3 women had attempted suicide since leaving prison. Again, while the health variables showed some minor improvements, they also highlighted the considerable risks the women are exposed to in terms of their mental health and self harm.

Table 6.36: Crosstabulation: Attempted suicide in the last 3 months/since leaving prison x Attempted suicide in the last 3 months

		Have you attempted suicide in the last 3 months?		Total
		No	Yes	
Have you attempted suicide in the last 3 months/since leaving prison?	No	16	1	17
	Yes	2	1	3
Total		18	2	20

Table 6.37: How many days in the last 90 have you experienced the following symptoms, (results are based on the full cohort or 40 women at baseline and 27 at follow up)

	Mean at follow up	+/-SD	Change
Tense	39.9	38.9	-9.3
Suddenly scared for no reason (increased)	29.3	37.8	+7.2
Fearful	32.8	41.5	-1.4
Nervousness/shakiness inside	38.6	43.4	-3.2
Terror/panic	19.8	33.9	-5.6
Hopelessness about the future (increased)	47.0	43.5	+14.9
Feeling worthlessness (increased)	40.3	41.9	+14.2
No interest in things	40.3	42.1	-4.5
Lonely	40.9	42.7	-12.9
Thoughts of ending your life	1.8	6.3	-7.0

Figure 1: Confidence intervals for mean number of days feeling tense in the last 3 months.

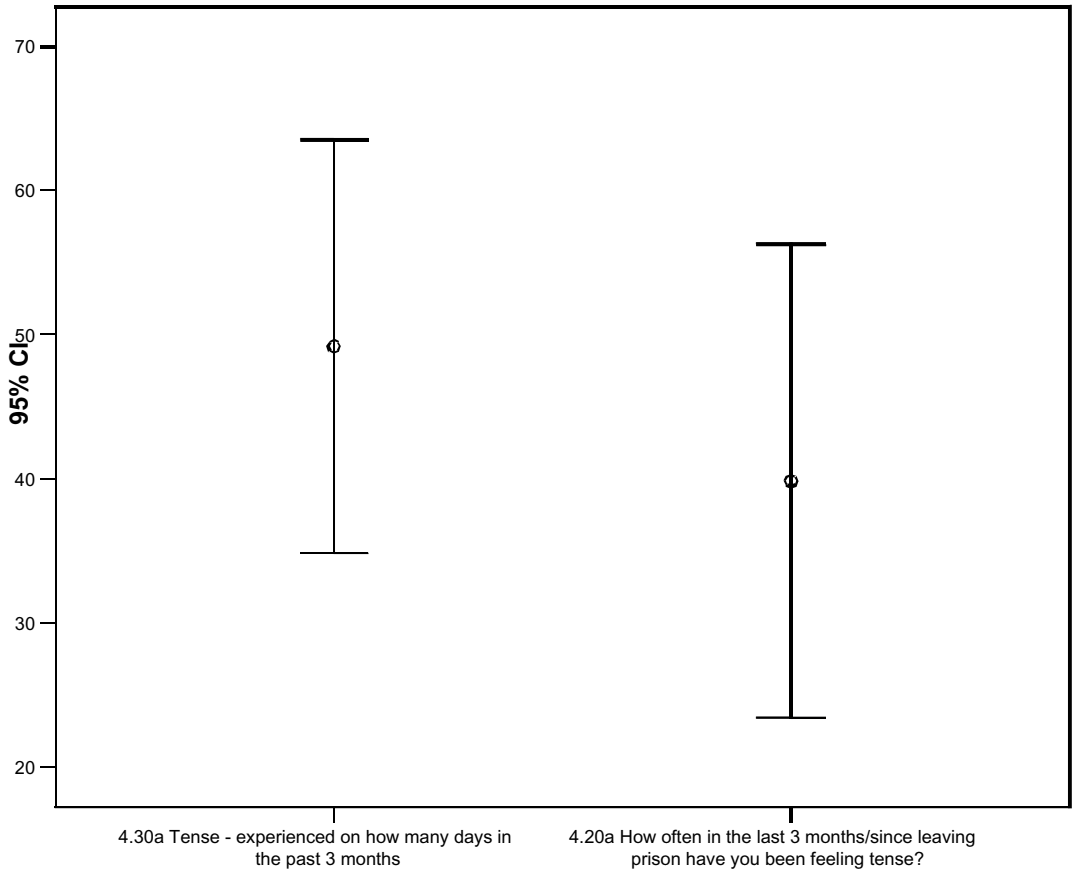


Figure 2: Confidence intervals for mean number of days feeling suddenly scared for no reason in the last 3 months.

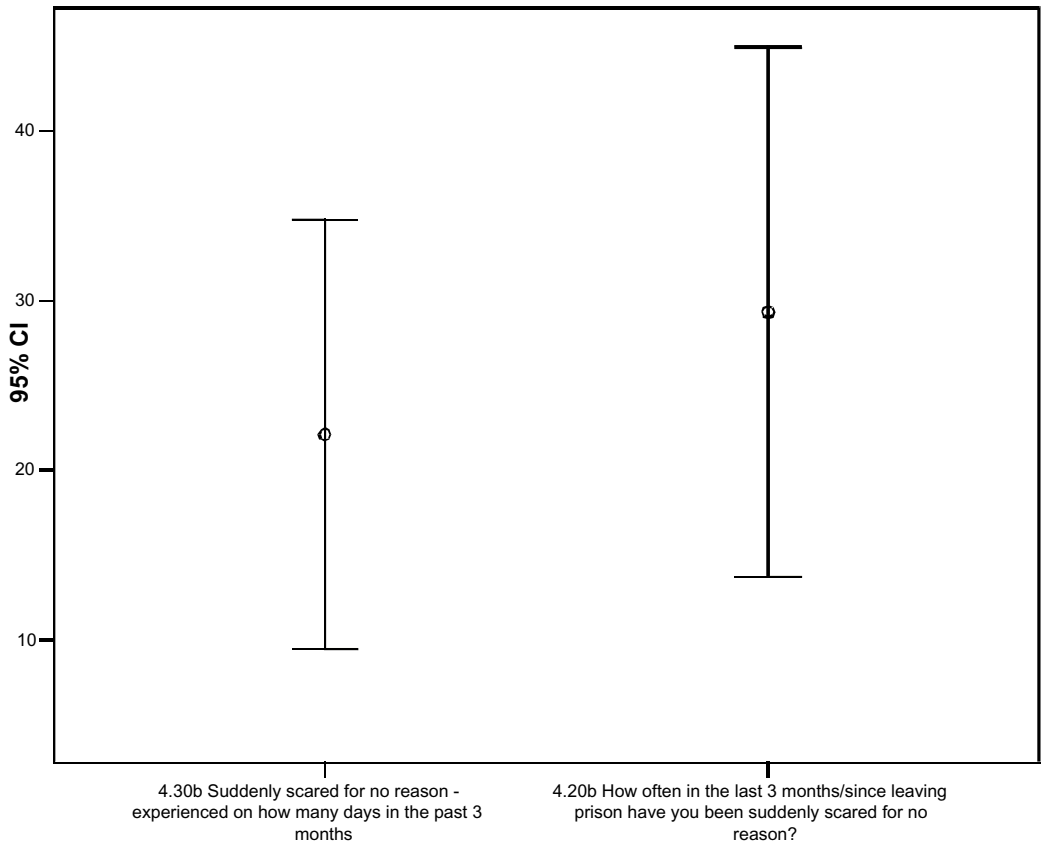


Figure 3: Confidence intervals for mean number of days experienced nervousness in the last 3 months.

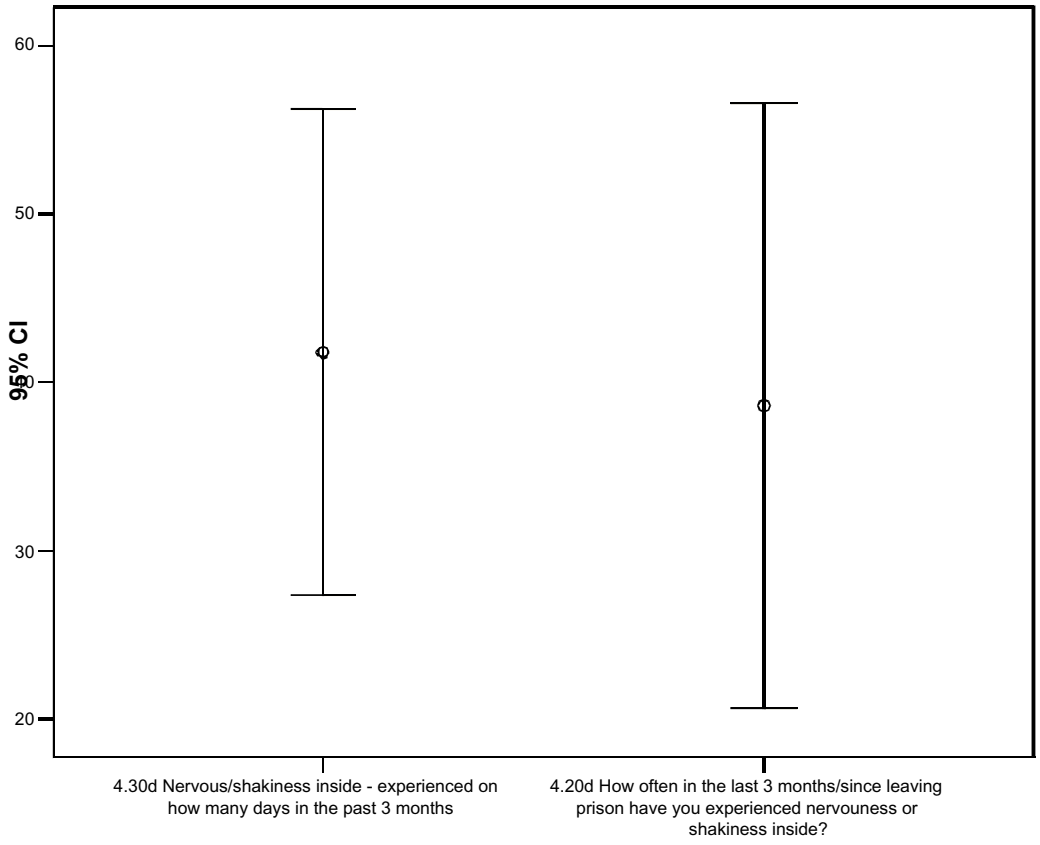


Figure 4: Confidence intervals for mean number of days experienced spells of terror or panic in the last 3 months.

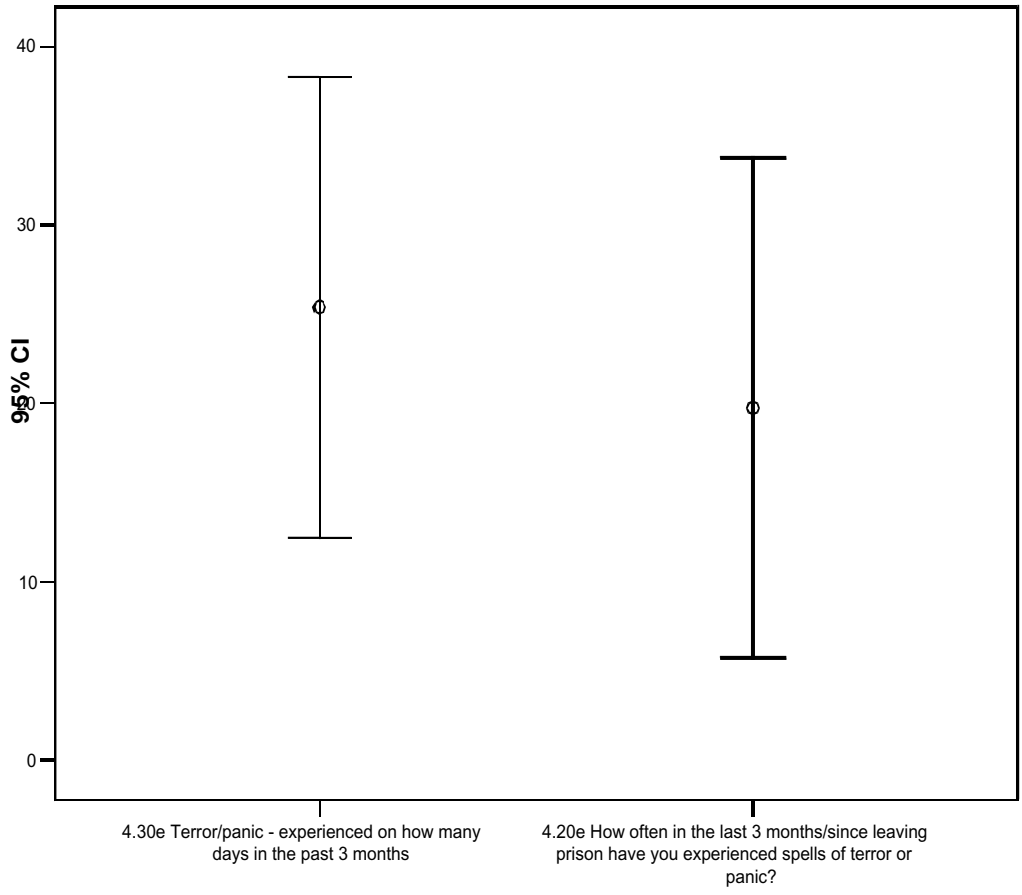


Figure 5: Confidence intervals for mean number of days feeling worthlessness in the last 3 months.

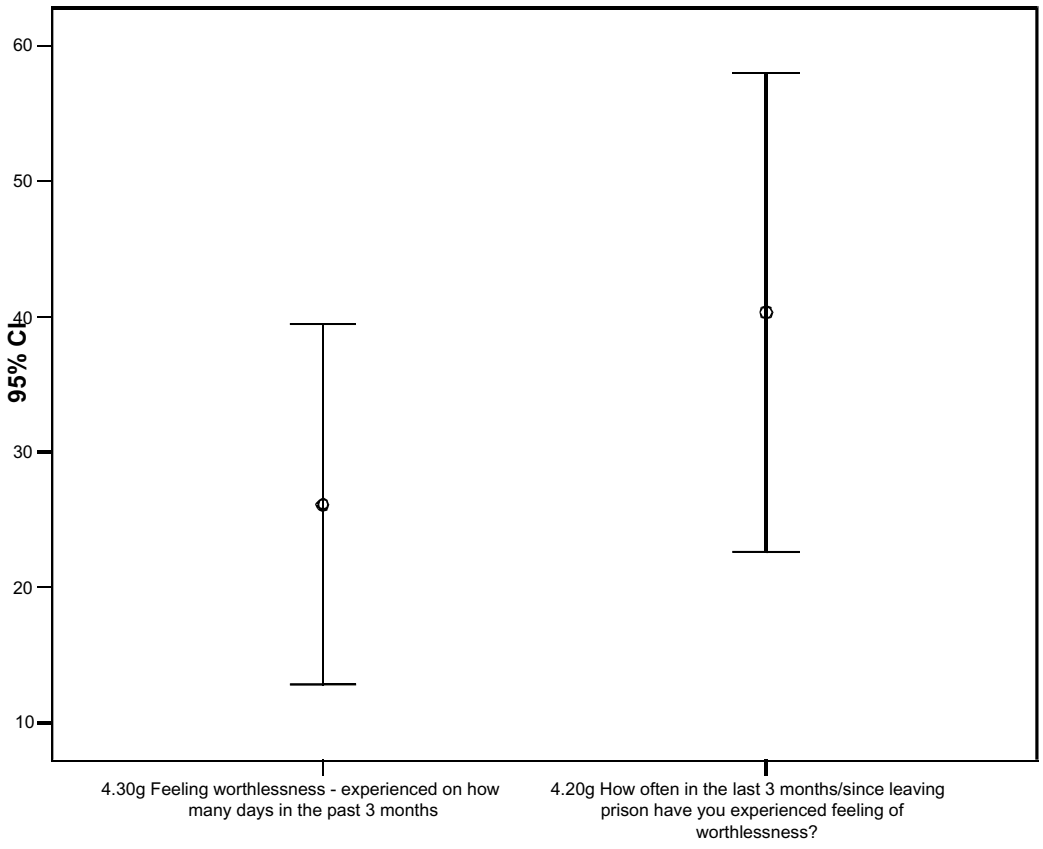
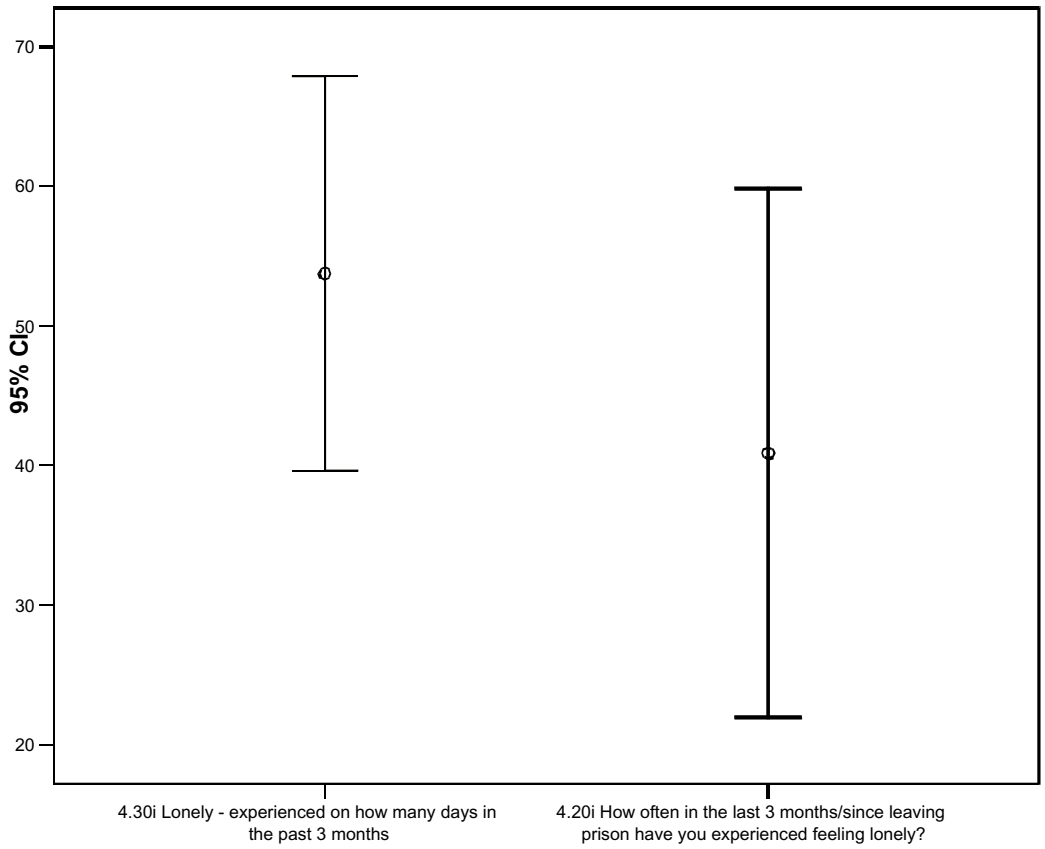


Figure 6: Confidence intervals for mean number of days lonely in the last 3 months.



Finally, to look at changes or movement in health outcomes for individuals, we compared the followed up cohort of 27 women with their own 27 responses at baseline. Again, we found only some minor improvements in physical health and some deterioration in mental health. We can see from the table below that of the 11 clients who said their health was good at recruitment, 5 of these said their health was only fair at follow up, 5 said it was good and 1 said it was now excellent.

Table 6.38:How is your health, Crosstabulation

			How is your health at recruitment?			Total
			Good	Fair	Poor	
In general how would you say your health is/since leaving prison?	Excellent	Count	1	0	0	1
	Good	Count	5	2	2	9
	Fair	Count	5	6	3	14
	Poor	Count	0	1	2	3
Total		Count	11	9	7	27

Similarly, when the women were asked if there was any health problem that caused them pain, 18 women said yes there was and 6 months later 13 of these still had a health problem that caused them pain. Also we see from the crosstabulation below that 3 women who previously did not have a health problem that caused them pain did have a problem 6 months later.

Table 6.39: Any health problem in past 3 months caused pain/limited you, Crosstabulation

			Any health problem in past 3 months caused pain/limited you		Total
			No	Yes	
In the past 3 months since leaving prison any health problem caused pain/limited you	No	Count	5	5	10
	Yes	Count	3	13	16
Total		Count	8	18	26

Only minor improvements were noted in the replies on suicidal thoughts. At recruitment 6 women experienced suicidal thoughts within the last 3 months and at the 6 month follow up 3 women continued to do so and 2 women who did not have these thoughts at recruitment did so 6 months later.

Table 6.40: Have you thought seriously about committing suicide in the last 3 months, Crosstabulation

			Have you thought seriously about committing suicide in the last 3 months		Total
			No	Yes	
Have you thought seriously about committing suicide in the last 3 months/since leaving prison?	No	Count	14	2	16
	Yes	Count	2	3	5
Total		Count	16	5	21

Finally, the mental health of the followed up cohort was analysed in greater detail and t tests comparing the mean number of times the women had experienced the range of mental health symptoms were computed. No significant differences were observed between recruitment and follow up but in the majority of cases (6 out of 10 symptoms) the mean number of times an emotion was experienced decreased. There were, however, some feelings that had increased These details are provided in the table below.

Table 6.41: Number of times mental heath symptoms experienced in that last 3 months, 90 days, (results based on the followed up cohort of 27 women)

Symptom	Mean number of times at baseline	Mean number of times at 6 months	N, number of respondents	t*	p
Feeling tense	56	42	22	1.57	0.13
Suddenly scared for no reason	23	29	24	-0.76	0.46
Feeling fearful	38	32	23	0.68	0.51
Nervousness or shakiness inside	44	36	24	0.92	0.37
Spells of terror or panic	29	17	23	1.35	0.19
Hopeless about the future	36	45	22	-.0.92	0.37
Feeling worthless	27	38	22	-1.36	0.19
No interest in things	39	40	22	-0.13	0.90
Feeling lonely	53	39	21	1.33	0.20
Thoughts of ending life	5	2	18	0.68	0.51

* Negative t values indicate a deterioration.

Changes in Outcomes at 6 Months — Crime

At follow-up the women were asked the same series of questions relating to crimes committed within the last 3 months. We can see from the table below that there was a substantial reduction both in the proportion of women committing these crimes and in the average number of times these crimes were committed. There was only one exception to this and that was the average number of times soliciting within the last 3 months although this showed some increase the proportion of women soliciting within

the last 3 months did show a decrease. A similar pattern was found when we analysed the data from the followed-up cohort of 27 women only. Only the crime of soliciting exhibited an increase in the mean number of committals in the last 3 months. In addition, we found that the reductions were statistically significant for the variables of theft from a person and theft from a shop. The reduction in the crime of handling stolen goods approached significance with p = 0.06.

Table 6.42: Changes from recruitment to follow-up in the proportion committing crime and in the average number of times crime committed within the last 3 months.

Crime	% Committed in last 3 months	Average number of committals in last 3 months	% Committed in last 3 months since/ leaving prison	Average number of committals in last 3 months/since leaving prison
Theft from a shop	47%	46	33%	21
Handling stolen goods	42%	50	22%	17
Selling/Supplying	35%	76	11%	31
Theft from a person	37%	20	15%	5
Criminal damage	18%	1	4%	1
Breach of the peace	64%	3	4%	1
Soliciting	62%	33	30%	45*
Fraud/Forgery	21%	32	7%	6
Assault	46%	2	4%	1
Theft from a vehicle	15%	2	4%	1
Driving under influence	23%	52	0%	0
Theft from a house	36%	3	0%	0

7. Results — Stakeholder Qualitative Interviews

7.1 Introduction

It is very clear that the group of women who are the focus of this report have multiple and often complex needs. The aim of this section of the report is to gain a more in-

depth understanding of the landscape of service provision for the women and the difficulties experienced not only by the women but also by service providers within that landscape. Many current policy and strategy documents highlight the fact that there is a need for more integrated service provision in order to meet the needs of marginalized groups. (Homelessness — An Integrated Strategy, 2000; The Youth Homeless Strategy, 2001; The National Drugs Strategy, 2001; The Report of the Expert Group on the Structures and Organisation of Prison Health Care Services, 2001, among others). This section of the report draws attention to some of the gaps in service provision for the group of women in this report, highlighting areas in need of focus if we are to facilitate a more integrated sphere of service provision. The findings follow the pathway of service provision of homeless women particularly, while in custody, while leaving prison, and when in the community. Homelessness, it should be noted, is only one major issue for the women, but an issue which is at the foreground due to a recognised need for appropriate accommodation to be secured before other issues can be addressed.

Although not all of the service providers interviewed for this component of the research were working within the homeless sector, the problem of homelessness was identified as a central need by all of the stakeholders. For this reason, the framework for this section is essentially built around the issue of homelessness and the provision of services to homeless women. What will become evident from this discussion is not only the very important need for greater collaboration between the various services, but the need for collaboration that is based on the needs and reality of this group of women s lives. The literature consistently highlights the need for services to be client centred or needs driven, and many services are striving in difficult circumstances to meet this approach. But the women that are the focus of this study are mobile, their needs are complex and multi-dimensional and that, it will emerge, presents many challenges for the arena of service provision. Often the huge amount of energy and effort put into service provision by those working in the area becomes diffused due to a lack of communication, coordination and collaboration between service providers who, ultimately, have similar overall aims.

In highlighting the above issues, the objectives of this section of the report are:

- To gain a greater understanding of the arena of service provision that currently exists for women who come in contact with the prison system.

- To explore some of the gaps evident in the provision of services to the women which are evident in the pathways taken from prison back into the community.

- To assess the nature of the gaps identified.

- To get a sense of the difficulties experienced by service providers in the delivery of services to this group of women.

- To explore routes through which challenges to current service gaps might be met.

7.2 Methods

Semi-structured interviews were carried out with eight participants who are based in either the voluntary or statutory sectors that work in the prison or in the community. All of the participants work in various capacities and to varying degrees with women who have been in prison. The questions during each interview were organised around the following areas: key identifiable needs of the women that service providers would identify, gender specific issues, gaps in service provision, and suggestions for moving forward. After each interview, issues that arose informed consecutive interviews and so contributed to a broad and in-depth collection of data. The data were transcribed verbatim, coded and analysed according to patterns that emerged.

The methodological approach used in this analysis is a grounded theory approach. Essentially the entire section is presented in order to highlight the complexity of inter-related issues that not only are experienced by the women themselves but also by service providers working within the constraints of available resources, time, and place, as well as within a diverse sphere of service provision. A grounded theory approach does not test a pre-determined hypothesis but rather is explicitly emergent. The aim ultimately is to understand the research situation and in doing so sets out to find what theory accounts for the research situation as it is.

7.3 Limitations

Due to time and resources only eight service providers were interviewed, which is only a small sample from those working in the field. Additionally, the examples used in this section are by no means exhaustive but do highlight apparent gaps in service provision and areas where greater integration between services is required. It is also necessary to explore possible routes towards challenging those gaps.

7.4 Qualitative Results

Section I
A Key Primary Need

1. Housing

This report along with others (O Sullivan, 2002) has highlighted that housing is a primary need for many women that are problematic drug users and leaving prison. Housing was identified by all of the stakeholders as a priority need. While women leaving prison may well have a range of other key needs, it was stressed that in order to address any or all of those needs secure accommodation must firstly be obtained.

What would you see as a primary need that the women have? (Interviewer)

Well, if you haven t got anywhere to lay your hat — you know, nowhere secure . Like when you find somewhere secure, you find that there is awful lot that you want to make happen, but you need to feel secure (Service Provider, Homeless Sector)

Many of the women in this study are found to be homeless and a large number of the key findings from the interviews with stakeholders are directly or indirectly related to the issue of homelessness. Factors identified by service providers, which contribute to women becoming homeless, are similar to those found in the literature. Among those are issues associated with family conflict, overcrowding in the family home and/or alcohol or drug misuse. Other evidence highlights the fact that having a history of institutional care is commonly found among homeless people. Fitzpatrick and Clapham (1999) refer to what they call push factors those being, factors like those mentioned above which result in young people being told to leave the family

home, resulting in their homeless status. Added to this situation is the fact that often young people that experience push factors have few life skills and knowledge with which to make successful transitions to new homes.

The women coming through (this service) all seem to be coming from a situation of family conflict where it s either domestic violence, being asked to leave because of anti-social behaviour, or younger women being kicked out of the family home. (Service Provider, Homeless Sector)

A recent report funded by the National Advisory Committee on Drugs which looks at the issue of drug use among the homeless population highlights how being homeless and being a drug user can have a wide range of negative consequences on many levels such as exacerbating physical and mental health issues, an increase in risky drug-taking behaviours, especially among injection drug users, and greater difficulty accessing not only homeless services, but also drug and health services (Lawless & Corr, 2005).

1.1 Gender

Many of the key informants described the cycle of drug addiction, homelessness and frequent spells in prison as a cycle that makes this client group difficult to reach. It was highlighted that gender greatly impacts upon how life lived on the margins is experienced. Gaining a more in-depth understanding of the women s gender specific experiences provides greater insight into the complex and multi-dimensional issues that many of the women grapple with. In the following excerpt some gender issues are teased out as one participant explores possible differences between working with men and women. Interestingly, rather than arriving at any definite conclusions, this participant highlights the ongoing complexities that service providers are faced with which are difficult to resolve.

I worked with [homeless men] for nine years before I came [to work here] . And it is very different. Just the complexity of needs with the women, compared with the needs of the men. Maybe it s because it s nearly easier to become homeless if you are a man or something, or walk into that cycle through marriage break-down and the rest . Maybe it s harder, I don t know, maybe it s harder or, it should be harder anyway to become homeless if you are a woman . Especially a woman with a family, so that what led up to that [the point of becoming homeless] maybe is just so

many things that s why they (women) present with an awful lot of needs . very complex very different. (Service Provider — Homeless Sector)

Another participant, based in the prison, highlights some of the reasons that he has observed that explain why men and women have very different prison experiences.

.. virtually all the women have kids. It s a common theme among them here. Phone calls to kids, [worries about] who s looking after the kids on the outside. They are constantly looking for extra phone calls. They need to speak to this person because there s one or two kids there. They need to speak to that person cause there s more kids there. They need to speak to their social worker whose looking after the kids for them. Fellas . no..they don t have those worries, but the women do. The women are much more emotionally attached to the family, mothers, fathers.. if someone gets sick etc.. The women are constantly on edge in here. They have constant pressures coming from their families and what they ve left on the outside. Fellas will come in and do their time. They actually leave that behind them. (Prison Services — Staff)

Key issues that emerge here for women in particular are their ties to family members, their own roles as mothers, their responsibility for keeping things on the outside going while they are in prison. It will become evident later in this section of the report that these familial networks are highlighted by key informants as crucial in many ways not only for the women as carers and parents but also as a factor which is identified as central part of the complex process of re-integration and (re)habilitation for women who are drug users and homeless drug users.

2. Service Provision Gaps

2.1 Exiting the prison - Slipping through the net

While it was acknowledged by many of the key informants that more recently there have been improvements in relation to release processes, it was also stressed that gaps remain in this very important transition period between being in prison and moving back into the community. Many of the problems associated with this time of transition are linked to issues of homelessness and family conflict. Women were

being released from prison without having secured accommodation upon release. While the literature highlights problems around current emergency accommodation services (O Sullivan 2002 and Bergin et. al, 2005), it was found that accessing any sort of accommodation for homeless women leaving prison was sometimes problematic. What has emerged from discussions with some service providers based in the prison and in the community is that there are various factors that can impact negatively on this time of transition. One such factor is difficulties experienced while trying to access accommodation for the women.

Timing your exit

The time of day that a homeless woman is released from prison can impact upon whether or not emergency accommodation can be found for her. For example in cases where court sessions are held in the afternoon a woman may be released late in the day and at the last instance it may become evident that she has no accommodation for that night. An example of how this can happen was given by a staff member of the prison service who explained that some of the women, when asked prior to court appearances if they have somewhere to go to should they be released, identify an address so that being homeless will not affect the court s decision . Prisoners are aware that not having an address can prevent them from getting temporary or early release.

So I will get temporary release for them (the women). That comes back down approved possibly, and then you ring the mother, just to confer with her (as to whether X is residing at that address) [Mother] No she s not staying here! and then you have to go back and start the whole process again. But these things are linked, the fact that they don t have an address is linked to their drug addiction. (Prison Services — staff)

Engaging services

Another interviewee described a situation where last minute accommodation needs to be sourced for women who get released without an address to go to. A lack of coordinated service provision again emerges which creates immense difficulties, not only for the women, but the service providers themselves. The first port of call for accessing emergency accommodation is the Homeless Persons Unit (HPU). The HPU operates a daily helpline for homeless women. As part of advocacy work

carried out by service providers they too often try to make contact with the HPU on the client s behalf.

O my god, I m very disappointed with that Don t get me wrong the (HPU) staff are lovely and brilliant on the phone, but sure it s only open It s no good from the point of the woman on the street. They (the HPU) are only open from 10am to 12pm in the morning. She (the client) comes out of court at 3 o clock and has to try and access accommodation. Did you ever try and get that phone, that helpline, that freephone? O, You d be on it half an hour ..

In-Reach Services

Service providers themselves have difficulty in carrying out their own duties due to un-coordinated service provision. Another issue that emerged during the interviews was the effect that both the overcrowding of prisons, and the short length of time that many women actually spend in prison has on the provision of in-reach services. In instances where service providers are carrying out in-reach services in an effort to set up accommodation and other supports around a woman it can happen that mid-way through the planning process the person may be released from prison.

It s an awful waste of time. You ve been working with someone, trying to put something in place and the next thing they re gone! (from the prison) (Service Provider — Homeless Sector/Statutory)

This lack of co-ordination also highlights a huge waste of what are already very limited resources dedicated to this group of people. This issue has been highlighted regularly in national and international literature and has been linked to the wider issue of sentencing, where women with complex needs (including drug addiction, homelessness, mental and physical health issues, among others) are repeatedly being held in prisons on remand for petty crimes, where they are not receiving the supports they need to begin to challenge their own criminal behaviour. (Roberts, 2005; Austin, 1992). The findings from the next section highlight the fact that the needs of this group of chaotic women also greatly challenge the parameters of service provision in the community.

2.2 Exiting The Prison — Caught in the net?

Analysis of the interviews also highlighted that not only are there evident problems around the lack of integration of services at the point of exiting the prison, but also highlighted the fact that often the issues that the women presented with challenged the service parameters of agencies that they did manage to access. In her report into the accommodation disadvantages experienced by homeless women, O Sullivan (2002) highlighted the lack of emergency accommodation that was available to women, along with key concerns that women leaving prison had around staying in emergency accommodation. The major issue highlighted was that emergency accommodation was seen by the women as a possible route back into a life of drugs and crime. The following section highlights some of the issues that were discussed during the interviews with key informants around the experience of providing services to women who have been released. It will be evident that similar issues to those found in O Sullivan s report still exist.

Challenging Behaviour or simply no beds?

All of the key informants were asked about the availability of accommodation services for women exiting prison. While analysing the conversations after interviews, it became obvious that the women very easily fell out of the flow of conversation that was taking place. When talking to all service providers from the statutory or voluntary sectors, the difficulty of keeping the women in the narrative or conversation can be analysed as testimony to the problems experienced by both sectors in providing services to this group. Very often, during analysis, it became obvious that in order to talk about the services that were being provided by participant organisations, limits to what could be provided for this group of women were more easily discussed than options available to them. The following two examples demonstrate this issue.

One interviewee based in the statutory sector talked about the problems of finding accommodation for women that are known within the services to lead chaotic lives. The conversation leading up to this point was concerned with the challenges of securing accommodation for women leaving prison. We were discussing the type of accommodation that would be sought in an emergency situation.

Interviewer: That s B&B accommodation is it, or a hostel?

Service Provider: Well it depends, it can be both. Generally it may be hostel accommodation but bearing in mind there are not a huge amount of hostel beds for women at the moment, and they will have to move on to a B&B. And again that can create a problem in itself because a lot of people who are constantly in and out of prison may be barred from a lot of accommodation..

As regards other options for the women, at present there are not any. As regards what happens to women who have nowhere to stay, it is difficult to get to the bottom of this problem. One suggestion was that in certain cases women re-offend in order to get back into the prison.

Another service provider spoke about difficulties experienced when trying to find emergency accommodation for women leaving prison at short notice. She begins here by referring to the free phone number provided by the Homeless Persons Unit.

Service provider: It s a free phone and it is difficult to get through. I ve been there (on the phone line) where I ve been told that there is no place for her So you might hear this thing where there s hostel accommodation (for the women).. there isn t enough hostel accommodation, and that s my experience.

Interviewer: And what happens then to the woman there is no place for?

Service provider: Indeed

Drinking, getting high and sleeping in alleyways or buses was the response received from this service provider who had asked this same question of some of the women she often encountered on the streets while on route to work.

3. Issues in the Community

Service Provision to women in emergency accommodation

The De Paul Trust have set up a programme specifically targeted at women leaving the prison system. The aim of the project is to provide supported independent living

accommodation for women leaving prison and in so doing support the women at an individual level to work through personal issues. One of the criteria for entry to the programme is that the women need to be drug free. Many of the women in this study are not drug free. It is widely acknowledged that drugs are available in the prisons and that some prisoners engage in illicit drug use. While the service run by the De Paul Trust obviously fills a much needed gap in service provision, it is not suitable for many of the women in this study.

As a result, homeless women leaving the prison system that do secure emergency accommodation are housed in Bed and Breakfast and hostel accommodation within and around the city centre. In the event of being supplied with accommodation, the next step is to try and also provide a level of support to clients which will facilitate their movement from emergency accommodation to something more stable. Support services are available in different ways. In some cases part of an organisation s remit might be to link up with individuals or families in emergency accommodation on an in-reach basis to wherever the person/family is living, while in other cases services are available on site. Having spoken with service providers that deliver services in both of these ways it was found that engaging the women can be very challenging on various levels. Below are two examples of the difficulties of providing services to homeless women, (and families) that are accommodated in Bed and Breakfasts, and in hostels.

Bed and Breakfast Accommodation

One of the interviewees described the difficulties experienced in the provision of services to people in Bed and Breakfast accommodation. As the women very often lead chaotic lives and, as mentioned earlier, may be asked to leave their B & B for reasons of anti-social behaviour, movement from one site to another is not an unusual occurrence.

So, if they have been asked to move on from a B & B because of behaviour problems or because of difficulties with other families there, they may go to another B & B, but we might not be able to track them wherever they go. (Service Provider — voluntary sector)

This raises a number of issues for service providers. Two key issues that arise for service providers in this case are firstly that the service may not be able to locate the

client, and secondly, because many services are catchment-area based, clients may move out of the service provider s geographical area. This results in the need for a different service provider to work with the women and presents obvious issues for all concerned. As regards, service providers, there may be delays around linking in with clients due to workloads. Clients find themselves signing up with yet another service, and due to the obvious need for more joint working between agencies the current conditions are such that clients can easily fall out of the net of services altogether.

Hostel Accommodation

A number of service providers spoke about the fact that the women become entrenched in a life of hostel accommodation, prison remands, and problem drug use. One service provider who works on site within a hostel situation spoke about the difficulties on various levels of reaching the clients.

The key workers are new and they are struggling and getting demotivated, chasing, chasing, chasing The women are like leave me alone, I m grand, don t bother me which is very frustrating .. a lot of them have children (that they are currently not living with), a lot of them have loads of issues and there is such denial, and such peer pressure it s quite a large group of them and they are feeding into each other.. demotivation and all that ah, don t go to (service providers), you don t need to link with them, sure it s grand .. (Service Provider- Homeless Sector/Voluntary)

The environment of the hostel was identified as a key contributing factor to the us and them dichotomy evident in the above quote; the environment both as physical space and as the social environment of day-to-day life as a homeless woman.

You see the women come in here and maybe they are from Dochas (women s prison) and they are frightened or tense or they often feel like they are caged. What happens then is that the other women come to their rescue eventually, hopefully, and take them under their wing.. and then they re the only ones they have to rely on really because the environment is so bad. Then they start listening to them. Oh don t bother going to this or that service so it doesn t even help that you can t give people space or single rooms so that you can begin to work with them. And you can understand it. Why would they listen to me when there is a ring-leader among the women. She s streetwise, she knows it all. She s been through all the

treatment in the world and look at her now (Service Provider — Homeless Sector/Voluntary)

Living in hostel accommodation means that a number of people share rooms. In the case of the above-mentioned hostel there are six women to one room. The type of clique formation described is not surprising. It could be understood in various ways, for example as part of a survival mechanism, both in terms of access to material resources and in terms of a sense of belonging. The lack of quality accommodation within which support services can be provided was highlighted by the interviewee as contributing to the stagnation of this group of homeless women. Stagnation essentially means that the women continue to use drugs, they continue to avoid any underlying issues that they might need to deal with, and continue to be involved in petty crime. It is not difficult to see how the women end up back behind bars.

Being back in prison seems to become just part of the cycle of life for the women. There is this constant movement from streets to hostels to prison and boundaries between all three seem to get blurred. In all three places the women slip through the net of service provision, in all three drug use is part of daily life, and it seems, the same group of women move through all three arenas. Probably the two factors that impact the most upon changes to this population are young homeless women that slowly become entrenched, and high death rates evident in the findings of this report and documented by service providers working with this group of women.

Bridging the Gaps.

As part of the interviews with the service providers they were asked about any ideas that they had which would contribute to breaking the cycle outlined above. A number of interesting ideas emerged from the conversations which will be outlined below. The key ideas that emerged are the very obvious need for greater communication and greater collaboration, and the less obvious vital need for space where the women s agency can be understood and harnessed so that they too can contribute to the process of their own (re)habilitation.

Highlighted by all of the participants in this section was the urgent need for services to begin to work together. It is obvious from the section above that there are glaring gaps in communications between service providers that impact negatively on the lives of the women involved. Additionally, it is not difficult to imagine how the lack of

co-ordination also impacts negatively on the general morale of those working in the field. Many of the service providers sounded frustrated during the interviews; keenly interested in working with this group, but frustrated at the lack of progress and the lack of process, regularly witnessing their efforts diffuse, again. The need for collaboration and cooperation between agencies was highlighted as crucial to any movement forward in a situation which seems to have arrived at stalemate. At the centre of many of the suggestions was the need to co-ordinate all the services that have contact with the women, but how that might be done was suggested in different ways.

Co-ordination between services

According to one service provider,

I suppose the ideal really is [that] we have to have some continuity of service, where you have somebody coming in homeless at the very beginning. That the first time they approach the Homeless Persons Unit, that at that stage somebody does a very good assessment of them. A care plan is done at that stage and that it is followed, that there s continuity throughout and everybody knows. So, that at the beginning when they come in you say, right, here you are, this is the plan to get you out , because that doesn t happen. Once you get into homelessness you re stuck there. You re stuck! (Service Planner)

Yet this same person acknowledges that arriving at this point is not easy. When asked about the problem of confidentiality between services and the coming together of agencies working with different remits and ethos, it was highlighted that the theory and practice of the issue were very different.

Yes, I gave you the answer, you care case manage people from the minute they get in to the minute the get out. But, I didn t say it was easy.

It was acknowledged that due to the chaotic nature of the women s lives the care plan would be thrown off course along the way, that it should not be imagined that clients would move through their care plan in a linear fashion, but ultimately, it was suggested, that if the overall plan of case management could be adhered to it might get people out the other side .

For other service providers the question of who would manage the care plans was an issue. All service providers working in the prison and in the community addressed the fact that the resources they currently have are stretched and taking on the job of managing care plans would not only require a designated person but would also change the way that current systems run albeit in what appears to be a form of crisis management.

Co-ordination of services (in-reach to the prison)

One service provider spoke about the benefits that could come out of greater co-ordination between all of the community based services that pass through the prison. It was highlighted that although many different service providers enter the prison to work with the women, even those working with the same woman are not co-ordinated. More often than not service providers are not aware of the other services that their clients are linked in with. This gap was identified as a particularly useful site, which could be harnessed for the arrangement of service level agreements which would ultimately involve and benefit the women. The interviewee below suggests that there is no need for extra services but rather more of an emphasis on co-ordination of what already exists.

I don t think there is a need for a whole new set of case workers going in [to the prison] from the outside, they have enough [among the service providers that already exist]. But it is important to co-ordinate all the services that go into the prison and make that a meaningful programme . There needs to be some kind of collective aim, like [for example] we met up with X agency recently about one woman and agreed that if she joined a specific programme run by (the service), she could then come [here to our service]. That s three way, but you know that s not common practice (Service provider — Homeless Services /voluntary sector)

Stressed here is the fact that there are service providers already working with the women who present with complex needs. The need identified is for collaboration between services so that those who specialise in the various areas that are relevant to clients needs can work together with them towards positive outcomes.

Whether working with women specifically in prison or more broadly in the community, the obvious gap which emerged is the mechanism through which the co-ordination of services can happen so that the needs of individuals can be met.

An additional issue which also came to light during the interviews was the importance of including the women themselves in the process of their own route out of the chaotic lives that many currently lead. This final section below discusses

Active Agents or Passive Recipients?

Another pattern that emerged from the interview data is that many of the service providers that work closely with the women provided some fascinating insight into the women s everyday lives. Evidence-based knowledge has been identified as a crucial element of evaluating and generating better services. Service providers that work day-to-day with the women in this study have access to a unique form of knowledge which is an understanding of the everyday world that the women experience. The ongoing challenge for service providers is their ability to incorporate what is learned from clients into their provision of services. Doing so means giving those who are marginalized what has dangerously become a clich — voice . If services are to be shaped so that they meet the needs of clients, it is essential that the identification of those needs are not based on the values and norms of the providers of services, whatever sphere they are based within.

The information generated from the interviews with service providers provides an indication of the in-depth knowledge that they have acquired about the lives of the women. The aim of this section is to draw some of these insights to the surface so that they can be recognized for their importance in the decision-making process, in the process of shaping service provision for this group of women. By not acknowledging what is already learned, the efforts of service provision may well be fruitless, both in terms of wasted resources and poor results for the client group themselves.

The following passage provides exactly this kind of insight into the lives of many of the women that are the focus of this study. The interviewee is talking through the ongoing issues that the women are faced with once they are released from prison — the cycle of their lives including living in hostels and bed & breakfasts, time spent in

prison, drug addiction, family breakdown and mental illness, and the overall lack of daily structure in their lives.

Most of the people that come in here [prison], the chaotic ones especially, they ve never worked. They don t know what it is like to hold down a job. So, most employers aren t going to employ them. So what you are looking for out there is some kind of an employer .. that isn t going to go ballistic if they re an hour or two late coming in the morning . They need something that they are going to do, that will give them a lot of leeway that will appreciate where they re coming from, where they have been . that s not based on profits . (Prison Services — Staff)

Such insights are invaluable. While the dialogue may appear defeatist or fatalistic it is argued here that it is in fact is the opposite. It is about the reality of the women s lives. The challenge to service provision is in harnessing that information and using it to benefit all involved. Two key issues that emerge are that firstly, the women do not and probably won t fit into a framework of rehabilitation that is based on economics. Measuring their progress according to someone else s profits or expenditure will only result in their having been set up to fail. The second issue, which is related to the first, is that perhaps then as a route out of the cycle that the women s lives have become, is not to seek an employer or occupation that requires them to meet strict rules and regulations as a first step.

Another interviewee raised this same issue while thinking through the complexities of providing services to the client group. She began by talking about how in society we measure success or failure in economic terms according to indicators such as employment uptake etc

It s just a very odd way to work with women. I suppose to my mind a gauge of why this is a difficult client group, why women don t have that easily identifiable need, is because they see themselves as providers, not as receivers. So the idea of Ya, I definitely want to do X kind of employment It wouldn t be as strong for women to have a vocation in that sort of way. Yes, they want something meaningful to do with their day, and they d want to be productive to society but that doesn t necessarily come through a wage packet at the end of the week. And I suppose it s about . what is being offered to them so far, hasn t been the thing that would make them say, O, I m going to make a change for that. (Service Provider — Homeless Sector/Voluntary)

These kinds of insights found throughout the interviews provide an evidence base from which to approach service provision. It means that services are meeting clients where they themselves are at, and while people who find themselves entrenched in a cycle of homelessness and drug addiction may have difficulties naming their personal needs, the issues that are important to them are usually evident in the less obvious ways that people interact within, and enter into dialogue about, their own life-worlds.

Understanding what is important — A concept of home

Much of the discussion on the provision of services in this section has revolved around the issue of homelessness. In line with this theme, one of the service providers who has worked for a number of years with marginalised and homeless women began to discuss the concept of home, from the point of view of the women that she would have worked with.

very few of the women that I ve met would actually see themselves under a roof on their own with fridge, cooker etc . That s not what they view as home, stability. It s with children, with partner, back with Mother, in a supported housing scheme moving [from this service] into another supported housing scheme . Because once they have received that level of support, where somebody is there for them at the end of the day and stuff like that. So it s not about a flat [of their own], which is a very male orientated rehabilitation. [Women s] visions of home are a lot less tangible than just the sort of housing progress, move on sort of option . (Service Provider — Homeless Sector/Voluntary)

Family and social networks as highlighted at the outset of this study are an integral part of the everyday lives of the women. In the same way that these networks contribute to the intense distress that women experience in prison, so too are they an integral part of any process of their (re)habilitation. This example suggests that providing housing for women needs to be done in a way that facilitates a process of family/social mediation, (notwithstanding the provision of other services based on need) so that they can begin to rebuild their own worlds according to their own norms and values. This example shows how it is crucial that we begin not only to understand the lived experience of people living on the margins of society but also that their world-view, their values and norms need to be a central factor in any two-or three-way agreement with services which is about their lives and their (re)habilitation.

Community participation has been identified as a vital component of any move towards a more socially inclusive society and the involvement of citizens in the development of policy is a key principle of the NAPS/NAPincl. The findings from this study highlight that allowing individuals to participate in the planning and decision-making processes which will impact on their own lives may require a shift in thinking by service providers and policy makers, so that an inclusive level playing field can be created.

8. Conclusions

From the quantitative interviews and outcome data we can conclude that care pathways through the Dochas Centre are complex and fragmented. We found that upon entering the centre, women had high positive expectations but also expressed negative criticisms of the services they received. At entry, the needs of the women varied from drug treatment needs, physical and mental health needs to psychosocial needs. Interviewing the women six months after their entry to the Dochas Centre we found that the majority of the women exhibited some improvements across these strands. However, their journey along the care pathway was fraught with very serious and unacceptable risks to their health and well being.

From the qualitative interviews it was found that there is a severe lack of co-ordination of in-reach services to the women s prison. Stakeholders felt that the current range and number of agencies providing in-reach services to the women s prison is sufficient but that the fact that agencies are not aware of the other services providing support to the same individual as themselves results in poorer overall outcomes for the individual.

Homelessness was a key issue for women entering and exiting the prison. Homelessness is only one of a number of needs that the women in this study have, but in order for them to begin to address their individual needs they firstly need secure accommodation. This finding concurs with the first recommendation in a report published by the Simon Communities of Ireland: a Settlement First approach should be taken in the delivery of services to homeless people (Bergin *et al*, 2005). There are not enough emergency accommodation beds available for homeless women who present with challenging behaviours.

There is a great need for *appropriate* accommodation for the women in this study, such as hostels that accept women with substance misuse issues, single space units where women can have the space to address personal issues in a more *normal* living situation, and low to medium threshold supports available to them within a hostel setting.

The current landscape of service provision is not integrated enough, resulting in a number of loopholes that women, are falling through upon leaving custody. There is a need for greater co-operation, collaboration, and communication between current agencies. The current landscape of services appears to be set up in such a way as to fail to recognize the inter-connected nature of [the women s] needs (Rankin & Regan, 2004:i).

Marginalised women are not merely passive recipients of services but are active agents of their own lives. It is imperative that any moves towards greater integration between services are inclusive of the choices, views, and ideas that women themselves make in relation to their own life courses.

Service providers working in both the state and voluntary sectors expressed feelings of exhaustion, frustration, and exasperation experienced while trying to provide assistance to marginalized women in often under-resourced services, unsuitable working environments, and in a sphere of un-coordinated service provision.

A case management approach was suggested in our qualitative interviews as a way of meeting the needs of women with multiple needs coming out of the prison system. Such a coordinated approach could assist both service providers and clients, ensuring that the key needs of the women are being met in a comprehensive and coordinated manner. Given the considerable risks these women face there is clearly a need to explore and evaluate such an approach in further studies.

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Appendix I: The Baseline Survey Overview

1. Client Demographic details
2. Client contact details
3. Sentence information
   - 3.1 Information on current sentences
   - 3.2 Information on past sentences
4. Support upon entering the Dochas Centre
   - 4.1 Information provided
   - 4.2 Client concerns
   - 4.3 Information wanted
5. Previous services accessed
   - 5.1 In the past year
   - 5.2 Problems encountered
   - 5.3 Perceived needs
6. Historical and current profile of client
   - 6.1 Education and training
   - 6.2 Employment
   - 6.3 Finances
   - 6.4 Accommodation
   - 6.5 Health mental and physical
   - 6.6 Relationships
   - 6.7 Children and childcare
   - 6.8 Drug and Alcohol Use
   - 6.9 Violence and Abuse
   - 6.10 Treatment
7. Client expectations/aspirations
   - 7.1 During the sentence
   - 7.2 For the future
8. Services
   - 8.1 Knowledge of existing services
   - 8.2 Impediments/obstacles to accessing services
   - 8.3 Services needed/wanted or perceived to be needed
   - 8.4 Now
   - 8.5 In six months time (post release)
   - 8.6 Proposed solutions

Reflections on *Caged Bird* by David Clarke, 1965

By Fiana Griffin

In *Caged Bird* the yellow bird is poised for flight, wings outstretched, frantic to escape from her cage, yet many of the bars to her cage are missing. Why does she stay? The picture creates a feeling of unease as we puzzle over the paradox of a creature choosing captivity while apparently wanting to be free. A vague air of menace surrounds the cage, which appears to be suspended in a chaotic, stormy sky above inhospitable rocks. There is no suggestion of a haven to be found anywhere. Does fear, whether of predators, the elements or unknown dangers make the bird prefer the safe misery of life in a cage to a life of destructive freedom?

Forty years after it was painted, *Caged Bird* by David Clarke (1920-2006) symbolises something of the conflict experienced by the women prisoners who spend time in Dochas, as documented in *Hazardous Journeys to Better Places*. Homelessness emerges as a key issue from this illuminating report. Because of the gaps in the system, and despite the best efforts of various service providers, these vulnerable women prisoners are often released to freedom without even a guarantee of a safe place that night. Many of them are hopelessly, helplessly astray in society, a prey to dangers from without as well as from their own self-destructive patterns, with as little chance of long-term survival as a tropical bird that escapes into a cold Irish night. Some, recognising that at least in Dochas they will stay alive, re-offend in order to be incarcerated again.

David Clarke was an artist whose vehicle for thought was art. Where others wrote essays, he explored issues through painting a number of pictures on the same theme. No explanations offered, the pictures were his statements, for each to read in the light of their own experience and understanding. *Caged Bird* was the first in a series; the last, called *The Guitarist* depicts a bird in small, bright open cage on a table beside a gentle figure strumming a guitar, a full moon shining in a clear sky. If and when the bird emerges, it will no longer be such a hazardous journey, but a hopeful transition to a better place of creative peace, instead of the chaos and menace of *Caged Bird*. This report offers the possibility of a similarly changed outlook, when its recommendations have been implemented.

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