Women as offenders
Women as victims

The role of corrections in supporting women with histories of sexual abuse

Mary Stathopoulos and Antonia Quadara

A Report for the Women's Advisory Council of Corrective Services NSW

Women as offenders, women as victims. The role of corrections in supporting women with histories of sexual abuse.

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Australian Government
Australian Institute of Family Studies
Australian Centre for the Study of Sexual Assault

NSW GOVERNMENT Justice
Corrective Services

The Corrective Services NSW Women's Advisory Council was established to draw attention to significant issues that relate to women in the criminal justice system and provide links between government and non-government agencies with a mandate to develop and administer policies, services and programs that affect women offenders serving a custodial sentence or under Corrective Services NSW (CSNSW) supervision in the community.

In 2010, the Council raised the issue of the high number of women in custody who have histories of childhood, adolescent and adulthood sexual assault with the then CSNSW Commissioner. The view that custody is not an appropriate environment for addressing trauma and its manifestations in behaviour was being challenged in the literature at this time, as part of a shift in approaches to treatment and management of women in custody and recognition of the need to address these histories and reduce associated behaviour patterns.

In response to the Council's request, the Commissioner agreed to fund research on the impact of sexual trauma on women's pathways to crime and the role of corrections in supporting women offenders with these histories. Parameters of the study were established and the Council commissioned the Institute of Family Studies' Australian Centre for the Study of Sexual Assault to undertake the project and produce a paper.

A draft of the paper was circulated to members of the Council and CSNSW staff, who provided feedback which questioned aspects of the methodologies used and a number of assertions made by the researchers. In response, the paper was modified and strengthened.

The Women's Advisory Council thanks CSNSW, particularly Assistant Commissioner Luke Grant, for financial support for the project and staff for their interest and input.

The Council also wishes to thank the researchers for their commitment to this important and complex subject.

Sally Trevena
A/Chair
Women's Advisory Council

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Overview

Women in the correctional system have high rates of sexual victimization across the lifecourse, typically beginning in childhood and often accompanied by other forms of interpersonal violence. There is growing recognition of women offenders' high levels of previous victimization, their particular pathways into offending, and their high levels of need relative to male offenders, across correctional settings and in the correctional literature.

The purpose of this review was to develop an evidence-informed framework to guide corrections' approach to supporting women offenders who are survivors of child sexual abuse (CSA). We reviewed a wide range of literature across three key domains, namely the profile of women offenders, current theory and practice in offender rehabilitation, and the impacts of child sexual abuse and repeat victimisation.

The clinical literature on child sexual abuse and cumulative harm has found that early onset lifecourse victimization results in complex mental health problems that profoundly affect self-regulation, healthy attachments, and cognitive and neurological development. Although it is not possible to suggest a causal link between a history of sexual victimisation, such a history and its effects appear to be central features of women's pathways into offending, their experiences of custody, and their capacity to engage in rehabilitation programs. For female offenders with CSA histories, "complex trauma" emerged as a key lens through which to view their needs – as both victims and offenders.

A second lens is gender difference. Current theory and practice about offending risk and rehabilitation suggests that dominant rehabilitation frameworks have not adequately addressed the specificity of women's offending. There is evidence to suggest that women's pathways into – and out of offending – are qualitatively different from men's, and that the individual, interpersonal and social meanings of gender difference shape women's offending pathways.

Efforts to support or provide counselling to female offenders with CSA histories in correctional settings need to include the following: the establishment of a sense of personal, interpersonal and environmental safety as it is the most crucial element of trauma-focused interventions; a whole-of-system approach to supporting the safety principle; and an awareness of the pervasiveness of trauma in the offending pathways of these women. Two existing frameworks are particularly useful for CSNSW to consider: a trauma-informed framework and a gender responsive programming framework.

This report integrates these two key constructs of trauma and gender into one framework to guide subsequent steps in the development and implementation of policies, practices and programs for women with sexual abuse histories in correctional settings.

Part A reviews the literature upon which the framework is based. An overall framework describing the principles and their implications for policies and practices are described in Part B.

Introduction to the Report

Purpose of the review

In December 2010, Corrective Services New South Wales (CSNSW) commissioned the Australian Institute of Family Studies to review the available evidence about how the effects of sexual victimisation interface with offending and reoffending pathways, and what directions could appropriately be taken to address sexual victimisation in the correctional context.

The key objective was to develop an evidence-informed framework to guide interventions and support (including health and other allied services) for women in correctional settings with sexual victimisation histories. Specific consideration was to be given to: the relevance of victimisation in women's offending pathways and behaviours; support currently available to women in other correctional systems that addresses sexual victimisation; best stages/s in an offender pathway to participate in support program for their victimisation; the risks/issues involved in addressing sexual trauma therapeutically in a corrections context; issues in relation to Aboriginal women in corrections; and issues in relation to women with complex needs and particular combination of needs (see Appendix A).

We reviewed a wide range of literature across three key domains in order to develop a framework to guide interventions for supporting women with victimisation histories. These domains were: the profile of women offenders, current theory and practice in offender rehabilitation, and the impacts of lifecourse victimisation.

The report contains two parts. Part A reviews the relevant literature that would enable a consideration of how the effects of sexual victimisation interface with offending and reoffending pathways. Part B synthesises the key issues into evidence-informed framework to inform the broad directions CSNSW might consider for addressing sexual victimisation in the correctional context.

This introduction describes the key findings from the literature review. It also describes the key approaches taken in developing the evidence informed framework to assist CSNSW in their consideration of policy and practice in addressing women offenders' trauma histories.

Reviewing the literature on women, offending and trauma

In the last two decades, there has been a significant increase in the number of women entering correctional facilities in Australia and around the world. Many of these women have histories of physical and sexual abuse in childhood, adolescence and adulthood, socially disadvantaged backgrounds, and mental health needs. This has lead to a proliferation of debates around women's needs in a correctional environment, the extent to which they are qualitatively different from men's, and what this suggests about supporting women's rehabilitation and desistance from crime.

The overall purpose of the following literature review was to advise CSNSW about how the effects of sexual victimisation interface with women's offending and reoffending pathways. This then became the basis of the suggested directions to address these effects within a correctional setting.

Approach taken in reviewing the literature

The key aim was to develop an evidence-based framework to guide programs and support strategies for women in correctional settings, based on an assessment of the research in relation to:

- The relevance of victimisation in women's offending pathways;

- The most appropriate stages in an offender's pathway to participate in programs specifically related to their victimisation;
- Issues in relation to women with complex needs and Aboriginal women; and
- Issues involved in addressing sexual abuse trauma therapeutically within a correctional context.

We reviewed the available research about how the effects of sexual victimisation interface with offending and reoffending pathways, and what directions could appropriately be taken to address sexual victimisation histories in the correctional context. This was done in two stages:[1] a scoping exercise that involved an initial review of the literature, consultation with the Assistant Commissioner Offender Services and Programs and the Principal Advisor Women Offenders, and feedback from the Women's Advisory Council.[2] As described below, this process helped inform the next stages of the review.

Outcome of scoping exercise

A scoping analysis was undertaken early on to determine the most relevant and/or promising research literature that were to be the focus of this report. Key areas of enquiry were:

- The impacts of child sexual abuse on women's participation in, and the outcomes of, offender programs;
- The impacts of a sexual abuse history on women's wellbeing in correctional contexts; and
- The best ways of addressing both dimensions within a correctional context.

Literature searches were undertaken using both Australian and international databases.[3] Subject terms we used were: female prisoners; female offenders; Aboriginal women prisoners; trauma; women in crime; sexual abuse. More targeted searching was undertaken through the use of key word searches in relation to: recidivism, complex trauma, complex needs, treatment needs, women's imprisonment; and rehabilitation.

Summary of findings

Overall, the literature we reviewed demonstrated that:

- Women in corrections have extensive victimisation histories.
- Women enter the correctional system with greater disadvantage than men in terms of material or socio-economic disadvantage, and with higher levels of psychological distress. Drug misuse appears as a maladaptive coping mechanism.
- The high level of need the women bring with them upon entry into corrections are likely to have impacts on treatment and rehabilitation interventions with women offenders

However there was less certainty about the frameworks and models for effective rehabilitation and support interventions (demonstrated by the debates regarding gender-responsive programming), and the appropriateness, costs and benefits of addressing sexual abuse trauma therapeutically in custodial settings.

Finally, there were significant gaps in the research on women offenders, specifically:

- The concept of trauma (as it is explored in the extant sexual assault literature); and

[1] As per the Consultancy Agreement.
[2] The Women's Advisory Council provided feedback both on the scoping review, and at a verbal briefing by ACSSA co-ordinator, Dr Antonia Quadara and the principal author Mary Stathopoulos on 25 February 2011.
[3] Australian databases searched included Australian Criminology Database, (CINCH), Attorney General's Information Service (AGIS) and Family & Society Plus. International databases searched were: National Criminal Justice Reference Service Abstracts Database (NCJRS); PsycINFO; Psychology and Behavioural Sciences Collection; ProQuest Social Science Journals; SocIndex; and PubMed.

- The evidence in relation to complex trauma, complex needs and sexual victimisation.

In addition to a short review, we provided a summary table of key themes and issues in the areas of enquiry, gaps, and suggestions about what the final review should focus on.

We were subsequently asked to concentrate on promising directions in supporting women offenders with trauma histories in relation to:

- Complex needs (impact of complex trauma, dual diagnosis, co-occurring disorders);
- Treatment and rehabilitation programs (needs, participation, effectiveness for women);
- Frameworks, approaches and models for intervention regarding reoffending;
- Frameworks, approaches and models for intervention regarding sexual abuse trauma.[4]

This scoping review and the table are reproduced at Appendix B.

Reviewing the literature on frameworks, approaches and models

Approach

As described in the project objectives, the overall purpose of the research was to provide advice on:

- the relevance of child sexual abuse in the lives of women offenders;
- key issues involved in addressing such victimisation histories within a correctional context; and
- the broad directions that CSNSW could consider in altering current policy and practice in addressing women offenders' trauma histories.

In addition to the research literature on the profile of women in correctional settings, we reviewed national and international literature in relation to the following four areas: the impacts of child sexual abuse, and chronic and poly-victimisation; trauma interventions; current debates regarding women, offending and rehabilitation; and current approaches to addressing women's victimisation histories in correctional settings. The approach to the literature review was informed by the purpose and objectives of the project. In order to achieve these we needed to canvas research across the diverse substantive areas listed above, with the consequence that the research evidence came from different disciplines, focused on different populations and employed different methods.

As such, we undertook:

- a narrative analysis of the substantive areas of interest;
- a critical analysis of key areas of debate (e.g. where there is a lack of consensus about key issues); and
- a realist analysis[5] of current approaches to supporting women with trauma histories and other co-occurring needs.

The key themes and findings from the diverse literature were then synthesised into a framework, the aim of which is to guide the direction/s CSNSW may wish to take in addressing women offenders' trauma histories.

[4] There was also an interest in women in prisons not only as adult survivors but also as mothers and how this might interface with child protection.

[5] A realist analysis or synthesis differs from systematic reviews in that its aim is not ask "what works?", but what are the underlying mechanisms, contexts, and conditions that are necessary to support interventions. A realist synthesis draws on a range of evidence, (e.g. qualitative or quantitative data, ethnography, narrative studies) as its purpose is to understand the real world application of frameworks and interventions (Pawson, 2002; Pawson, Greenhalgh, Harvey, & Walshe, 2004).

While systematic reviews of the research and empirical evidence – particularly randomised controlled trials (RCTs) – are increasingly viewed as the "gold standard" for literature reviews (Booth, Papaioannou, & Sutton, 2012; Cooper, 2010), for this project, there is very little research on the interface between child sexual abuse, trauma, custodial populations, trauma support, and rehabilitation that would meet standards required for a systematic review due to the ethical and practical limitations of designing RCTs for such an issue. Indeed, it has been noted that standards for research evidence on effectiveness such as those set out by the Cochrane Collaboration have come from the medical sciences, and questions remain as to their applicability where social interventions with complex populations are concerned (Grossman & Mackenzie, 2005; Smyth & Schorr, 2009).

Key themes in the literature

Compared to the international and particularly US research, the Australian evidence base is fairly thin. The literature was consistent in identifying a trifecta of factors that characterise women in corrections: mental illness/poor mental health; alcohol and substance dependency; and histories of early interpersonal victimisation, particularly child sexual abuse. Based on what is known about the long-term consequences of trauma, these three characteristics would seem to be interrelated. What is striking in the literature is not only the centrality of these three elements, but also how they are further connected to a range of other experiences. Whether they are Canadian, Scottish, British, American or Australian studies, the same profile and needs of female prisoners are identified. In no particular order these are:

- Histories of childhood victimisation, particularly sexual abuse;
- A background of state care;
- Mental disorders such as borderline personality disorder (BPD), major depression, post-traumatic stress disorder (PTSD);
- Intellectual and cognitive impairments;
- Substance abuse and dependency
- Housing instability;
- Primary care for dependent children;
- Low educational attainment;
- Minimal employment histories compared to male prisoners; and
- Subsequent victimisation as adolescents and adults such as sexual assault and family and domestic violence (e.g. Corston, 2007; Gelsthorpe, 2010; Ogloff, Davis, Rivers, & Ross, 2006; Salisbury & Van Voorhis, 2009)

Based on the broader literature on the bio-psycho-social consequences of chronic trauma, a history of sexual victimisation appears to be a common element in women offenders' profiles, their experiences of custody, and their capacity to engage in rehabilitation programs. The clinical literature on child sexual abuse and cumulative harm has found that early onset lifecourse victimization – particularly child sexual abuse – results in complex mental health symptoms that profoundly affect an individual's capacity for self-regulation, healthy attachments, and cognitive and neurological development. As such we have identified "complex trauma" as a key lens through which women's treatment needs – as both victims and offenders – can be viewed.

A second lens concerns the role of gender and gendered differences in pathways to offending. Current scholarship on women offenders, re-offending and rehabilitation suggests that dominant rehabilitation

frameworks have not adequately addressed the specificity of women's offending. Specific findings from the review, which informed the framework described in Part B, are that:

- Women's pathways into – and out – of prison are qualitatively different from men's. Types of offending, the circumstances of offending, sentences, length of stay, number of episodes in custody and rate of return differ;
- Women enter prison more socially disadvantaged and have higher levels of need compared to men (e.g. in relation to substance abuse, mental illness, unemployment, being primary carers of dependent children);
- Women offenders have significant histories of sexual abuse and other forms of victimisation;
- There is significant debate and empirical research regarding the validity of the risk-needs-responsivity model underpinning offender rehabilitation for women offenders; and that
- Interventions for women – both in terms of criminal rehabilitation and general wellbeing – need to acknowledge:
    - The nature of trauma resulting from child sexual abuse and other sexual victimisation;
    - The interconnected nature of trauma, mental illness, substance abuse, and how this might shape women's pathways to offending; and
    - That the correctional environment has been based on the male offenders and *their* gendered pathways into offending and risk/security management, which can result in retraumatising practices and environments for women offenders.

This last point is important. Despite the consistency of these findings, there is little work – national or international – that synthesises their implications for an overall understanding of how correctional approaches can best support women offenders, both as victims and as offenders. In particular, although there is wide recognition by correctional systems of women's particular pathways into offending (gendered pathways), and that the trauma of child sexual abuse is part of this, there is seldom an integration of trauma *and* gender-responsive frameworks into a holistic approach to women's rehabilitation (e.g. K. Blanchette & Taylor, 2009). A rapid evidence assessment of the "what works" literature for the UK's Ministry of Justice concluded that although there are some suggestions about what is effective in reducing women's reoffending "there are gaps in the evidence regarding some of the most frequently cited issues like victimisation and self-esteem" (Lart, Pantazis, Pemberton, Turner, & Almeida, 2008).

Moreover, although there is a strong body of evidence to suggest that women's pathways into – and out of – offending are qualitatively different from men's, and that the individual, interpersonal and social meanings of gender difference shape women's offending pathways, overall, there is a lack of consensus in the extant criminological literature (including penology) about the relevance of gender in offending, about what the implications of accepting that notion of "gendered pathways" are for correctional policy and practice, or even how to conceptualise gender and gender difference. In this report we have understood gender as**: a social and structural location that is personally, experientially felt and made sense of.** For our purposes, gender is <u>not</u> a demographic feature, a personal attribute, a socialised role or biological sex.

Synthesising the literature

When the key findings are synthesised, it becomes clear that women offenders' histories of victimisation over the lifecourse, which typically includes child sexual abuse, cannot be separated from their pathways into – and out of – the criminal justice system.

As demonstrated in Part A, child sexual abuse has been experienced by at least 1 in 2 women offenders. Typically this victimisation begins early in life, with many survivors experiencing multiple instances of sexual victimisation as children, young people and adults. In addition such victimisation is located within, and also precipitated by, broader contexts of social disadvantage and vulnerability (e.g. poverty, family conflict, intergenerational trauma, low educational attainment, and housing instability). Like other survivors of sexual victimisation, trauma for women offenders is a lived, *proximal* experience affecting all facets of their social, mental and physical wellbeing**.** This is <u>not</u> to imply a causal or linear relationship between victimisation and offending but to note that the trauma arising from early onset, chronic sexual victimisation – typically perpetrated by care givers, guardians, family members – is pervasive, and cannot be contained to particular areas of an individual's life.

This significantly reframes the purpose and objectives as they were originally envisaged. That is to say, it is not possible to identify (for example) the "most appropriate stage" in offenders' pathways where trauma can be dealt with, because, based on the trauma literature, sexual abuse trauma is not experienced by survivors as distinct from other aspects of their functioning, world view, or sense of self. This presents a significant challenge for many treatment and rehabilitation frameworks, which have tended to keep separate trauma interventions from other treatment interventions (e.g. substance abuse, anger management, parenting). While this review was not about rehabilitation *per se*, it has been impossible to not talk about such frameworks or the debates they have occasioned. This is because at the heart of the debates and research are differing perspectives not only about the specificity of women's offending pathways, but also about the extent to which sexual and physical victimisation should be recognised as central to those pathways. As such, we have provided a brief synthesis of the debates, discussions and empirical research in relation to rehabilitation frameworks in Chapter 3 of Part A.

The pervasiveness of trauma also has implications about how correctional systems address trauma itself. Based on the growing evidence about the role of trauma in mental health, social functioning, substance abuse and so on, responding to trauma and acknowledging its impacts needs to be integrated across operating practices, programs and policies. At the same time, we acknowledge the risks of conflating women's trauma histories with their offending pathways, of suggesting causal links between these issues, and of attempting therapeutic interventions for that trauma in a penal setting designed for offender rehabilitation. In other words, an awareness of, and orientation towards, trauma needs to be integrated into correctional responses to female offenders, while also being balanced against the *raison d'etre* of a correctional system and its operating environment.

In terms of how correctional institutions address this, two broad directions emerge. The first relates to addressing, on the one hand, the status of women within such settings as victim/survivors. In this view, addressing sexual abuse histories requires two broad types of intervention: those that directly address the impacts of trauma; and those that integrate an understanding of trauma into their design and delivery. The second direction relates to addressing the role, relevance, and extent of gendered differences in offending and rehabilitation. Major reports and inquiries have increasingly called for a "distinct, radically different, strategic, proportionate, holistic, woman-centred, integrated approach" in treatment and service provision for women who offend (Corston, 2007). A growing literature and empirical evidence base indicates that the dominant framework for classifying offenders and assessing their criminogenic needs (i.e. needs that are correlated with recidivism) may not, of its own, sufficiently reflect the particular profiles of women offenders (Van Voorhis, Wright, Salisbury & Bauman, 2010).

Part B provides a framework that synthesises these issues and tensions into broad directions regarding organisational policy and practice for CSNSW internal consideration.

Interventions for women with sexual abuse histories

Based on the literature, interventions to support women with sexual abuse histories who are in corrections need to:

- Focus on stabilisation (developing a sense of safety and bodily integrity);
- Integrate an awareness of the impacts of trauma into non-trauma-specific programs (e.g. in relation to alcohol, drugs and addiction; aggression and violence; education, training and employment; readiness; and parenting); and
- Embed and support these interventions through policies, practices and workforce development that:
    - Understand the long-term impacts of victimisation and trauma on survivors;
    - Understand the roles of victimisation, socio-economic disadvantage, relationships, and gender in women's offending pathways and rehabilitation needs.

Where there is provision of sexual abuse counselling, which focuses on moving towards processing trauma memories, this should ideally be independent from the correctional system and undertaken by sexual abuse and sexual assault specialists. At the same time, the extent to which such practitioners should interface with other treatment providers and corrections management staff in providing integrated support for women and their rehabilitation is a live issue for the consideration of CSNSW.

Key frameworks to inform the development of interventions

In light of the research evidence, two frameworks together provide a general scaffolding in which the above points could sit. A **gender-responsive framework** is based on research into women's pathways into prison. As a philosophical and organisational approach, it make a number of recommendations about how prison practices, operating environment and rehabilitative frameworks can take "the circumstances of gender" into account (Bloom, Owen, & Covington, 2003). However, there are some limitations with gender-responsivity. One is the danger of essentialising women to perceived characteristics (e.g. being relational). A second aspect is that the bio-psycho-social impacts of trauma are not always an explicit element of programs. Thus an approach such as a **trauma-informed framework** (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Jennings, 2004), which is informed by the research on victimisation trauma and its effects, provides a therapeutically– and psychologically–informed perspective.

It is important to note that these frameworks are not themselves empirically tested interventions. Rather, they provide a structure for locating policies, practices and programs that aim to address the trauma needs of women offenders, as well as the rehabilitation and wellbeing needs. In Part B, we have brought together the key principles of each framework and their key elements for the CSNSW's consideration.

PART A: Addressing sexual abuse trauma in correctional settings: A review of the literature

Introduction

The following review comprises five areas of analysis:

1. **The profile of women offenders:** summarises the evidence base regarding women's pathways into offending, their experiences of victimisation and their mental, physical and social health needs.
2. **The consequences of sexual abuse and multiple victimisation: "Complex trauma":** reviews current research from the fields of mental health, psychology and traumatology about the impacts of child sexual abuse and revictimisation on survivors' mental, emotional, cognitive and social wellbeing. This chapter suggests the "complex trauma" construct as the most promising for understanding the impact of the sexual abuse experienced by many women in the correctional system.
3. **Therapeutic approaches for sexual abuse counselling and recovery:** summarises the key issues in addressing sexual victimisation therapeutically.
4. **Gender and rehabilitation:** provides a critical review of the existing literature about how, in light of women's particular circumstances of offending, to best rehabilitate women offenders; and
5. **Current approaches to addressing women's victimisation histories in correctional settings:** considers what models or frameworks are available to assist a correctional system and its services to support female offenders and their needs as victim/survivors of child sexual abuse. These include frameworks such as: trauma and recovery; trauma-informed care, and gender responsivity.

1. The profile of women in corrections and their offending pathways

A significant evidence base demonstrates that both the profile of female offenders and their pathways into offending are fundamentally different compared to male offenders (for example, Carlen, 1983; Chesney-Lind, 1989, 1997; Daly, 1998; Kruttschnitt & Gartner, 2003; Salisbury & Van Voorhis, 2009; Worrall, 1990). Although the total number of women in Australian prisons is very much smaller than the number of men, they are nevertheless recognised as a "high needs" population. Specifically, women offenders demonstrate higher levels of previous victimisation, poor mental health and serious mental illness, substance misuse, unemployment, and low educational attainment compared to male offenders. A significant proportion – between half and two thirds – have dependent children. Their time in custody is different, with shorter, but more frequent periods of imprisonment. In short, despite the small size of the female correctional population, they present significant challenges, both from a rehabilitative perspective (i.e. reducing re-offending) and, relatedly, in terms of their general wellbeing.

The literature we reviewed was consistent in identifying a trifecta of factors that characterise women in corrections: mental illness/poor mental health; alcohol and substance dependency; and histories of early interpersonal victimisation, particularly child sexual abuse. Based on what is known about the long-term consequences of trauma, these three characteristics would seem to be interrelated. What is striking in the literature is not only the centrality of these three elements, but also how they are further connected to a range of other experiences. Whether they are Canadian,

Scottish, British, American or Australian studies, the same profile and needs of female prisoners are identified. In no particular order these are:

- histories of childhood victimisation, particularly sexual abuse;
- state care;
- mental disorders such as borderline personality disorder (BPD), major depression, post-traumatic stress disorder (PTSD);
- intellectual and cognitive impairments;
- substance abuse and dependency;
- housing instability;
- primary care for dependent children;
- low educational attainment;
- minimal employment histories compared to male prisoners; and
- subsequent victimisation as adolescents and adults such as sexual assault and family and domestic violence (e.g. Corston, 2007; Gelsthorpe, 2010; Ogloff et al., 2006; Salisbury & Van Voorhis, 2009)

On the one hand these are issues that are beyond the scope of this review, and in many ways are beyond what corrective services have been established or empowered to change – many of these experiences and needs are what women come into the system with. Further, the criminal justice decision-making that funnels women into (or away from) prison does not rest with corrections but with police and magistrates' courts (King, Bamford, & Sarre, 2005). On the other hand, they are central to the questions of the review about how sexual victimisation interfaces with offending and reoffending pathways, and what corrections can do to support women as victims within the correctional setting both in terms of their rehabilitative prospects and their wellbeing.

The following sub-sections review the evidence on: women's pathways into offending; the current profile of women offenders; and what this tells about the role of victimisation and trauma in female offending.

Characteristics of women's offending

Statistical analysis and empirical research on female offending since the 1980s demonstrate two things: that the trajectories by which women end up within the criminal justice system are not the same as men's offending trajectories; and that the types of offences they are engaging in also differ. More recent analysis also shows that the number of women entering corrections is increasing, both in Australia and internationally. These trends are summarised below. Box 1 (overleaf) provides a profile summary of women within the NSW correctional system.

Box 1 Profile of women in NSW correctional services

Number of women in the correctional system

In the 2011 census of NSW inmates, there were 703 women, comprising 7.0% of the total inmate population (Corben, 2011). Almost one third (30%) were Aboriginal or Torres Strait Islander. Just on 30% of female inmates were on remand. Nationally, at 30 June 2010 8.0% (2,228) of the prisoner population were women (Australian Bureau of Statistics, 2010).

Of the 16,632 individuals in NSW community corrections, 15.3% were women (Van Doorn & Geyer, 2011). Nationally, in the March quarter of 2011 there were 54, 757 individuals in community corrections; 18% were women (Australian Bureau of Statistics, 2011).

Types of offences

For sentenced female prisoners in Australia, the most serious offence with the highest proportion was illicit drugs (17%), followed by acts intended to cause injury (15%). The most serious offence for men was acts intended to cause injury (17%), followed by sexual assault (14%). In NSW, the most serious offence among female inmates was in the illicit drug offence category (21.3%), followed by acts intended to cause injury. For men, this was reversed – for 17.8% the most serious offence was acts intended to cause injury, followed by illicit drug offences (14.0%)

Security classification

Over three-quarters (76.4%) of female inmates were classified as minimum security. Just over 17% were classified as medium security and only 0.1% as maximum security. Approximately 1 in 5 (20.6%) male inmates were classified as maximum security, and 1 in 4 (24.1%) as medium security. Just over half were at the minimum security classification.

Although the majority of female inmates were minimum security, 26.6% of female inmates were held at maximum security correctional centres, 29.9% were held at medium security centres and 37.4% at minimum security centres.

Sexual victimisation

A sexual health survey that asked women prisoners about sexual forcing or coercion found that 59% said that they had been forced or frightened into doing something sexually that they did not want to do in their lifetime(Richters et al. 2008). Of these, 57% said that they did not tell anyone or seek help following the incident/s. Revictimisation was common: a third of women said they had experienced sexual coercion between 3 and 9 times, and a further 13% said it had occurred more than 10 times.

Mental health and substance abuse

Women in NSW corrections have significant levels of mental distress, particularly in relation to opioid and stimulant dependence, post-traumatic stress disorder, personality disorders and suicidal ideation (Indig et al 2010b). Further, across all categories of mental illness, women prisoners have much higher rates of mental illness (Butler & Allnutt, 2003).

Types of offences

The available research suggests women commit fewer and less serious crimes. Typically, drug offences, fraud and property theft are identified as "women's offences".[6] At the same time, some statistical analyses suggest that the violent offending among women is increasing (Cameron 2001). The ABS overview of national trends found significant increases in robbery, theft, assault and homicide.

For sentenced female prisoners in Australia, the most serious offence with the highest proportion has been illicit drugs, followed by acts intended to cause injury (Australian Bureau of Statistics, 2010). In NSW recent census figures show that the most serious offence among female inmates was in the illicit drug offence category (21.3%), followed by acts intended to cause injury. For men, this was reversed – for 17.8% the most serious offence was acts intended to cause injury, followed by illicit drug offences (14.0%) (Van Doorn & Geyer, 2011).

For women coming to the attention of NSW police shop lifting, assault, fraud and possession/use of drugs were the top four offences. The top four for men were domestic violence assault, possession/use of drugs, assault, and malicious damage to property. This analysis showed changes in female participation in offending during the ten-year period to June 2009. The numbers of female offenders increased significantly for breach of bail conditions and domestic violence assault[7] (up 14% and 12% respectively each year). Breach of apprehended violence orders and malicious damage to property also increased.

Women made up approximately half of offenders involved in prostitution and shoplifting and over a third of offenders involved in fraud. In contrast, men made up 98% of offenders involved in sexual offences, and over 90% of offenders involved in armed robbery with firearm and burglary (Holmes, 2010). Holmes concluded that more women offended, and their offending was of a more violent nature or against justice procedures than was the case ten years ago.

Increase in the numbers of women in prison

There appears to be a change in the overall profile of prisoners in Australia (sentenced and unsentenced), as well as some specific shifts for women. The most notable of these is the increased rate of female imprisonment over the last twenty years (Australian Bureau of Statistics, 2004a; Baldry, 2008; Department of Justice, 2007; M Mitchell, 2005). A number of reports and statistical analyses also suggest that the characteristics of prisoners has changed, with more mental ill-health, substance abuse and social disadvantage present, particularly among remandees.

Reviewing data collected between 1995 and 2002, the ABS calculated that the female imprisonment rate had more than doubled (58%), while men's imprisonment rate increased by 15%. One quarter was on remand. In 2010, the Bureau reported that the last ten years had seen an increase of 60% in the female prison population, compared to a 35% increase for men. Between the 2009 and 2010 Prisoner Census dates, the number of male prisoners increased by 1% (280) while the number of female prisoners increased by 5% (103) (Australian Bureau of Statistics, 2010). When sentenced prisoners only are considered this increase is even more pronounced – 1% for men, compared to an 8% increase in sentenced female prisoners. In NSW, between 1988 and 1999, the female prison

[6] It is important to note here that determining the most common types offences according to gender depends on which data sources are used for analysis. Data collected, for example, by the Drug Use Monitoring program, or "persons of interest" proceeded against by police, are more likely to reflect base-level patterns of offending, compared to data on prison populations, which reflect not just those offenders who come to the attention of police, but who are also subsequently sentenced by the courts (Forsyth & Adams, 2009).

7 It should be noted however, that caution needs to be exercised regarding this shift as it is not clear how dual arrest policies in relation to domestic violence are impacting these figures.

population increased from 209 to 432 (Select Committee on the Increase in Prisoner Population, 2000). Between 2000 and 2010, women as a proportion of the total NSW prison population increased from 6.7% to 7.5% (Australian Bureau of Statistics, 2010).[8]

In short, there has been a significant increase in the number of women in Australian prisons since 1995, and this increase is at a much faster rate than men, a situation that is not unique to Australia. Internationally, the rate of female imprisonment is also increasing (Corston, 2007; Gelsthorpe, 2010; Johnathan Martin, Paula Kautt, & Loraine Gelsthorpe, 2009). Of particular concern in both Australia and elsewhere is the increase, generally, in the remand population over the last 15 years or so, from 15% in 1998 to 21.4% in 2010, a figure that has been fairly steady over the last few years; however there are significant differences across jurisdictions (Australian Bureau of Statistics, 2010; King et al., 2005). In NSW, King et al. reported that between 1998 and 2004, the numbers of custodial remand prisoners increased from just over 1000 to approximately 1800. This increase has been particularly notable for women. Over ten years, the number of women in NSW prisons who were remandees grew from 15% in 1993 to 25% in 2003 (Corrective Services NSW., n.d.). In 2009, of the 854 female inmates over a quarter (26%) were on remand, compared to an overall percentage of 23% (Corrective Services NSW, 2010).

Vulnerable populations and complex needs

When providing services for women prisoners, it is especially important to note the needs of vulnerable populations and their complex needs. Two especially vulnerable populations – Indigenous women and women from a Culturally and Linguistically Diverse backgrounds (CALD) - and their needs are explored below.

Indigenous women

The complex links between social, economic, health and gendered issues are brought into greater focus when looking at a disadvantaged group such as Aboriginal women (Aboriginal Justice Centre, 2008; Cerveri et al., 2005). Indigenous women make up a large percentage of imprisoned women in NSW. Few qualitative studies have been undertaken to learn about the experiences and needs of Indigenous women involved in the criminal justice system (Bartels 2010b; Lawrie 2003). Indigenous women are thought to be overrepresented due to overpolicing of the Aboriginal community in general (Aboriginal Justice Centre, 2008; Bartels, 2010a).

Indigenous women's rates of sexual victimization are extremely high (Cervari et al. 2005; (Aboriginal Justice Centre, 2008). It can be difficult to ascertain how high the rates are as the barriers for reporting sexual victimisation are particularly salient for Indigenous women (Willis 2011). A study conducted by Lawrie (2003) found that Aboriginal women were particularly vulnerable to exposure to most of the issues listed above. Lawrie's findings indicate that Aboriginal women:

- Make up 31% of all female prisoners in NSW
- Are largely undereducated
- Suffer from high levels of unemployment
- Are predominately single mothers

[8] This figure was correct at the time of writing. Corrective Services NSW advises that there has been a decrease in the population since 2010. At end June 2012 there were 638 women in NSW correctional centres, representing less than seven percent of the total inmate population (CSNSW Inmate Census 2012). This represents a reduction from 650 in June 2011 and 746 in June 2010. It also represents a slight decrease in the percentage of the total inmate population. Of that population, 189 (29.6%) identified as Aboriginal.

- Are the primary caregivers to non-biological children
- Are the primary caregivers to older relatives
- Have a high level of exposure to the criminal justice system
- Have a history of juvenile offences
- 68% were drug affected when offence was committed
- 14% were alcohol affected when offence was committed
- 4% were under the influence of both drugs and alcohol when offence committed
- 70% were sexually assaulted as children
- 78% were victims of violence as adults
- 44% were sexually assaulted as adults (figures from Lawrie 2003)

When the women were asked about their experiences of sexual abuse, the vast majority believed that their drug dependence was directly associated with sexual victimization (Lawrie, 2003, p. 3). Many of these women were incarcerated due to drug crimes, so for this population, the causal relationship between sexual victimization and offending is indicated (Lawrie 2003). These statistics and the insights into the responsibilities that befall Indigenous women is a staggering view of the complexity involved in working towards assisting them in turning their lives around. Their imprisonment does not just impact on their own lives but as the primary caregivers to so many dependents within their families and beyond, their communities are also impacted by their absence and their associated drug and alcohol issues.

Lawrie's snapshot study provides the interconnection between issues such as education and employment and the need for vocational programs within the prison system. This is directly related to offending and the possibility of re-offending as "one quarter of women…stated their income came solely through the proceeds of crime" (Lawrie 2003, p. 3).

Women from Culturally and Linguistically Diverse (CALD) backgrounds

Just as with Aboriginal women, many women from Culturally and Linguistically Diverse (CALD) backgrounds in Australian prisons have expressed that they turned to crime because of their lack of education and employment (Easteal 1995). Barriers included language and cultural knowledge (Easteal 1995). Issues that concern the service provision for programs also centre on language and culture. Issues of sexual violence and trauma add another layer to the complexity in that speak explicitly or directly about these experiences can be difficult or not welcomed within particular cultural groups (Allimant & Ostapiej-Piatkowski, 2011).

Whiteacre (2006) examined the risk-needs-responsivity classification system in relation to race/ethnicity and finds a tendency toward classification errors for minority groups.

Child sexual abuse (CSA) and other forms of victimization

Australian studies

Child sexual abuse is relatively prevalent among the Australian population. In a review of seven Australian studies just over 1 in 4 women (27.5%) disclosed an experience of child sexual abuse (Andrews et al., 2002). In a 10-year cohort study of a nationally representative sample of students aged 14-15 years in Victoria to estimate child sexual abuse before 16[9] found a prevalence rate of

[9] Assessed retrospectively at the age of 24.

17% (Moorea et al. 2010). The last national victimisation survey that asked about child sexual abuse found that almost one million women (956,600) reported being sexually abused before the age of 15 (ABS 2006.

Although these figures are likely to underestimate the extent of sexual victimisation, compared to the general population of women, women in corrections report higher rates of sexual and physical victimization in childhood (Mazerolle et al., 2008; Teague & Mazerolle 2007; Warner 2001).[10]

There is little Australian research documenting the extent of sexual victimisation among women offenders. What has been done indicates prevalence figures of between 57% and 90%. In a random sample of 199 female prisoners in NSW, 59% said that they had been forced or frightened into doing something sexually that they did not want to do in their lifetime, and 57% of women said that they did not tell anyone or seek help following the incident/s (Richters et al. 2008). Revictimisation was common: a third of women said they had experienced sexual coercion between 3 and 9 times, and a further 13% said it had occurred more than 10 times. However, the NSW Inmate Health Survey (Indig et al., 2010b) found markedly lower rates of sexual victimisation among women, with 29% reporting that they had been subjected to at least one form of sexual violence since 16. The reasons for this are likely to be methodological: only one question was asked about sexual violence; only three forms of coercion/force were included (incapacitation was not one of these); and the survey was administered via telephone. Together these likely resulted in under-reporting.

Women in community corrections also demonstrate high rates of sexual victimisation. Research by the Queensland Crime and Misconduct Commission found that between a quarter and a third of women reported coerced, unwanted or forced sexual activity, including sexual intercourse (Mazerolle et al., 2008). The extent of sexual re-victimisation in the sample was very high for both males and females. Among the victims of CSA in this sample, 81 per cent subsequently experienced some form of sexual victimisation as an adult. Other work suggests even higher rates: a survey with female prisoners in Queensland estimated that prior to incarceration, 98% of women prisoners had experienced physical abuse and 89% had experienced sexual abuse (Kilroy, 2001).[11]

Aboriginal women have experienced higher rates of violence. The NSW Inmate Health Survey (Indig, McEntyre, Page J., & Ross, 2010a) found that the majority (81%) of Aboriginal women reported having ever been in a violent relationship, compared to 61% of non-Aboriginal women. They were just under twice as likely as non-Aboriginal women (42% compared to 24%,) to report having experienced sexual violence since age 16 years.

International studies

Moloney et al. reviewed the evidence on the extent of victimisation among women offenders and concluded that "empirical research examining the prevalence and severity of lifetime interpersonal violence is encountered by imprisoned women is scarce, contradictory, and subject to under-reporting" (K. P. Moloney, Van den Bergh, B.J. & Moller, L.F., 2009, p. 427). From these authors' perspective, Browne et al. carried out the most comprehensive assessment in 1999: they developed a comprehensive interview of structured behavioural questions for a representative sample of 150 female prisoners. They found that:

- Severe physical violence committed by a parental figure was experienced by 70%;

[10] Statistics for victimisation, and particularly sexual victimisation, are considered by many to be underestimate the actual extent of victimisation due to sample selection, the nature of survey questions and survey delivery (Australian Bureau of Statistics, 2002, 2003, 2004b; Lievore, 2003).

[11] A total of 100 surveys were completed. No further information about the survey questions is provided in this paper.

- Child sexual abuse in any form was experienced by 59% (more than half had occurred before the age of 10);
- Three-quarters reported physical violence by an intimate partner in adulthood;
- Three-quarters reported that they had experienced physical or sexual violence by other individuals (not including childhood and adolescent carers and intimate partner violence).

A recent review of the research to date, (which also includes the study by Brown et al.) McDaniels-Wilson and Belknap (2008) reported the following range of rates:

- Lifetime prevalence rates for rape, sexual abuse or molestation of 33%-55%
- Unwanted sexual physical contact from touching to rape (before 18 years) reported by 25%-56%
- Vaginal, oral or anal rape as a child (before 18) reported by approximately 40%; and
- Rape (attempted or completed) or sexual assault as an adult reported by 25%-43%.

In their own study, the authors measured a range of sexual violations[12] experienced by 391 study participants (between 18-69 years). In relation to CSA, they found that 51% of the women reported experiences ranging from nudity, exposure and kissing through to anal or vaginal rape, with rates ranging from 36%-45% in each of the five categories of behaviours. The authors conclude that many of women would have experienced multiple forms of sexual abuse from the same (or different) perpetrator. Of the women who had been abused, more than a quarter (26%) had reported between 3 to 13 *different* abusers. In relation to adult experiences of sexual violence:

- Almost three quarters (72%) reported sexual activity that involved sexual coercion (i.e. through emotional or verbal pressure)
- 44% of women reported illegal attempted penetration(i.e. rape, defined as using force, position of authority or alcohol/drugs to perpetrate offence);
- 60% reported illegal completed penetration, with 39% citing the use of drugs or alcohol to perpetrate and almost half citing the use of force;
- The average number of times women said these things had occurred was between 1.8 (multiple perpetrator rape) to 4.5 times (rape).

They also noted a significant number of women not identifying acts that met the legal definition of rape as rape (24%). McDaniels-Wilson and Belknap concluded that incarcerated women's sexual victimisation patterns differed to that from the general female population in their severity, frequency (i.e. revictimisation), and number of abusers.

In a study of 484 women aged 18-35 who were either sentenced or awaiting trial, Raj and colleagues found that (2008):

- 35% reported child sexual abuse (0-12 years);
- 14% reported adolescent sexual assault (13-17 years); and
- 22% reported sexual assault as adults (over 18 years).

This study also noted different patterns of victimisation, particularly in relation to the higher numbers of women identifying strangers as perpetrators in adolescent and adult experiences. They

[12] This is their terminology, and used to encompass a broader range of unwanted sexual activities than would be included in legal definitions. The Sexual Experiences Survey and a Sexual Abuse Checklist were the two instruments used in their study to capture the range of sexual victimisation experienced.

concluded that leaving home (usually as a result of childhood victimisation) might have meant greater exposure to unknown individuals.

These are only a selection of recent studies. Indeed, McDaniels-Wilson and Belknap (2008) referred to some 34 studies and reviewed 14 that demonstrated high levels of physical and sexual victimisation among incarcerated women. However, they also noted some weaknesses in this research base, namely the use of small samples, qualitative over quantitative research designs, and myriad definitions of sexual victimisation, making it difficult to compare studies. Despite these limitations, the authors concluded that in women's pathways to offending and reoffending, "victimization and trauma histories [are] risk factors" (McDaniels-Wilson & Belknap, 2008, p. 1091).

Mental illness and substance abuse disorders[13]

A greater number of people with mental illness are in the criminal justice system compared to the general community. In a review of the measurement and prevalence of mental disorders among prisoners, Ogloff and colleagues observed a fundamental change in the composition of the prison population over the last 50 years: "offenders who in the past were at the margins of custody (especially non-violent, recidivist and drug dependant offenders) are routinely imprisoned, and average periods of imprisonment have increased,"(2006, p. 8). Research in Australia with female prisoners or using key monitoring data such as that collected through the Australian Institute of Criminology's Drug Use Monitoring in Australia [DUMA] program has found a significant co-occurrence of different mental health issues (homonymic co-occurrence), mental health and cognitive impairment and mental health and substance use (heterotypic co-occurrence). This is also the case in other international jurisdictions (Farkas & Hrouda, 2007; Jordan et al., 2002)

Ogloff et al. attributed these trends in part to the process of deinstitutionalisation, particularly during the 1980s and 1990s. However, they warned that it is too simplistic to see this as the primary cause for increases in mental illness in the prison system. Two other factors are identified – the increase in drug dependency among offenders and the shift in "penal-welfare policy" in which the distinction between these systems' purpose and philosophy has blurred, thus affecting policies and decision-making across both arenas in relation to vulnerable populations.[14] These are pertinent observations given the association between victimisation and drug use, and the high proportion of women in the criminal justice system that are primary carers of dependent children.

The available national and international evidence on the prevalence of mental disorders among offenders suggests that:

- Mental illness is more prevalent among the remand population compared to sentenced prisoners;
- Despite the smaller numbers of women in prison, their rates of mental illness are higher than men's;
- The co-occurrence of mental illness with substance abuse is the rule rather than the exception;

[13] Substance abuse and dependency are not always thought of as mental disorders. The DSM-IV and the ICD both include substance abuse and substance dependency as specific diagnoses. As such, empirical studies on mental illness typically assess substance abuse and dependency.

[14] The authors here are alluding to the combination of the rise of neo-liberal policies here and elsewhere (such as the UK) in which social welfare and support became increasingly dependent on recipients meeting certain conditions, and if they did not, this invoked a criminal justice response, and the continued rise of law and order populist politics. This is most readily seen in the UK's Crime and Disorder Act of 1998. See particularly Garland 2001, Gelsthorpe, 2010 and Wacquant, 2009.

- A "relatively poor job" is done in appropriately identifying the needs of prisoners with mental illnesses prior to the time they enter the criminal justice system (Ogloff et al. 2006, p. 22); and
- Mental health screening across the justice system (i.e. police, courts and correctional services) has been "quite ineffective" (Ogloff et al. 2006, p. 22).

Ogloff and colleagues found that compared to male offenders, women demonstrate higher rates of: psychotic illnesses (e.g. delusional disorder) and schizophrenia; major depression; post-traumatic stress disorder; personality disorders; and anxiety disorders. For example:

- On general mental illness-
    - a UK study found that well over half (59%) of women in remand (*n*=382) had at least one current mental disorder, not including substance use disorders. When the latter was included, this rose to three-quarters (76%) having both and mental health and substance use disorders;
- In relation to schizophrenia and psychotic illnesses-
    - 4.2% of New Zealand women prisoners reported current (in the last month) schizophrenia and related disorders compared to 3.4% of remanded men and 2.2% for sentenced men;[15]
    - 14% of Australian female prisoners had experienced psychotic mental illnesses including schizophrenia; and
- In relation to depression-
    - A meta-analysis of 31 studies found higher rates of major depression among females (12%) than males (10%), although there was significant variability across the studies;
    - Australian research reported rates of depressive disorders of 7% for women and 5% for men.

Australian research

Australian research is in line with the international findings regarding the high prevalence rates of mental illness among the prison population.

The 2009 NSW Inmate Health Survey found that approximately half of the female participants had ever been assessed or treated by a medical practitioner for an emotional or mental problem. The most common mental health conditions diagnosed by the medical practitioner were depression (44.8%), anxiety (33.9%) and drug dependence (25.5%). In this survey women were more likely than men to:

- Have had a mental health diagnosis;
- Be admitted to a psychiatric unit and with longer periods of admission;
- Be using psychiatric medications;
- Report suicidal ideation and attempted suicide;
- Self-harm; and
- Report moderate to severe depression.

[15] Estimated *lifetime* prevalence in the general population is 1%.

The survey found that Aboriginal women were more likely that non-Aboriginal women to have been admitted to a psychiatric unit or hospital to be using psychiatric medications but were less likely to have received support, counselling or treatment for a mental problem from a psychologist or counsellor (Indig et al., 2010a). They were also more likely to have attempted suicide or self-harmed.

A 2003 survey on the prevalence rates for mental illness among NSW prisoners found that female prisoners had higher 1- and 12-month prevalence rates across all categories of mental illness (Butler & Allnutt, 2003).[16] This was particularly the case in relation to 12-month prevalence rates for non-sentenced prisoners. As the table below demonstrates, drug dependency and post-traumatic stress disorder were reported by approximately half of the women surveyed. Between a fifth and a quarter had a personality disorder diagnosis. Nearly a quarter reported depression and anxiety. High levels of mental distress were particularly the case for women on remand, and although the prevalence rates decreased among sentenced prisoners (with the exception of PTSD), the gender difference remains.

Table 1 Mental Illness among NSW prisoners (2003)

Diagnosis	Women	Men
Opioid dependency	53.4%	34.5%
Stimulant dependence	47.8%	27.8%
Post-traumatic stress disorder	43.6%	21.7%
Suicidal ideation	31.5%	15.3%
Impulsive personality disorder	31.5%	21.4%
Borderline personality disorder	30.9%	19.7%
Sedative dependence	28.6%	11.4%
Paranoid personality disorder	27.9%	19.8%
Suicide plan	24.2%	7.8%
Depression	23.6%	16%
Generalised anxiety disorder	22.4%	13.4%
Dependent personality disorder	21.2%	11.0%
Panic disorder	17.0%	7.3%
Manic episodes	7.9%	2.8%

Source: Butler & Allnut (2003)

[16] International classification of disease (ICD-10) categories included: Psychosis, neurasthenia, affective disorders, anxiety disorders, substance abuse disorders, and personality disorders.

Baldry et al. (2009) created a "criminal justice lifecourse" using linked data from a range of agencies.[17] The analysis showed that across the whole cohort (2,731 male and female prisoners) those with a single diagnosis (such as intellectual disability) had less convictions and custodial episodes compared to other groups with specific findings that:

- Those with co-occurring mental health and intellectual disability had the highest number of convictions;
- Women with co-occurring mental health disorders and alcohol and other drug use had a higher rate of custody than men;
- Women with co-occurring borderline intellectual disability and alcohol and other drug use had a higher rate of custody than men;
- Overall, indigenous women had more and a higher rate of episodes in custody than any other group.

Little research has specifically measured the extent of PTSD among prisoners (K. P. Moloney, van den Bergh, & Moller, 2009). A systematic literature review on the prevalence of PTSD among sentenced prisoners turned up 103 potentially relevant studies, however 71 studies did not measure PTSD (Goff, Rose, Rose, & Purves, 2007). Ultimately only four studies met the inclusion criteria and were based in the US, Canada, Australia, and New Zealand. Of these, only two included both male and female prisoners (one being Butler and Allnutt, cited above). Analysis of police detainee information from DUMA showed that women had higher levels of psychological distress in the last month compared to men (67% compared to 50%). This was particularly the case where mental illness was indicated (measured by psychiatric hospitalisation and/or current psychoactive medication use).

Substance use, abuse and dependency

As indicated above, substance dependency is prevalent among female prisoners. DUMA has been used to track the relationships between gender, mental health, drug use and crime (Forsythe & Adams, 2009; Loxley & Adams, 2009). The analysis also found statistically significant differences between male and female prisoners in relation to types of drugs used in the last month, with women more likely than men to use amphetamine/methylamphetamine and heroin. Women were also more likely than men to be taking benzodiazepines and antidepressants (Forsythe & Adams, 2009). Lifetime and regular use of these substances was also more prevalent among women (Loxley & Adams, 2009).

In relation to mental illness, drug use and offending, DUMA analysis found that both male and female detainees who had a mental illness were more likely to have used drugs; however women were equally likely to be drug dependant whether or not they had the indicator for mental illness (however we note that this is a very narrow indicator). High/very high levels of psychological distress were associated with a higher likelihood of having used illicit drugs in the past month, having a drug dependency, and having been charged in the last year (Forsythe & Adams, 2009).

In relation to child abuse, drug use and offending, the analysis found that women were more likely than men to have experienced at least one form of child abuse (49% compared to 34%). Sixty one per cent of these women also had experienced mental illness,[18] and for over half of women who

[17] These agencies included police, corrections, juvenile justice, Justice Health, courts, Legal Aid, mental health services, Department of Community Services, disability, and housing.

[18] The authors note that quite high numbers of people who had *not* experienced child abuse reported mental illness. However, we would caution that disclosures of victimisation are likely to be under-estimations.

had experienced childhood victimisation, there was a greater association (compared to men) with recent drug use, drug dependence and having been charged in the past year.

The intersection of sexual victimisation, mental illness and substance abuse

The literature was consistent in identifying three factors that characterise women in corrections: mental illness/poor mental health; alcohol and substance dependency; and histories of early interpersonal victimisation, particularly child sexual abuse. Based on what is known about the long-term consequences of trauma, these three characteristics would seem to be interrelated (Mullings, Hartley, & Marquart, 2004).

The role of child sexual abuse trauma in women's offending pathways

There is very little research that explicitly considers sexual abuse *trauma* and its relationship to women's offending pathways, or its impact on participation in offender programs(K. P. Moloney, Van den Bergh, B.J. & Moller, L.F., 2009). Despite the relatively consistent findings regarding the prevalence of victimisation, mental illness, substance dependency among female offenders outlined above, and that histories of sexual abuse are associated with greater involvement in the criminal justice system and worse outcomes upon release (McCartan, 2010), a causal role of CSA and other victimisation in offending pathways has not been examined: "the processes underlying this association have remained speculative due to the inherent difficulties in establishing a causal link empirically" (K. P. Moloney, Van den Bergh, B.J. & Moller, L.F., 2009, p. 428).

However, there is a significant evidence base describing the long-term impacts of child sexual abuse on women, namely: poor mental health; substance abuse; subsequent experiences of violence; homelessness; and sexual exploitation(V.L Banyard, Williams, & Siegel, 2001; Brewer-Smyth, 2004; Davis & Petretic-Jackson, 2000; Putnam, 2003; Kate Walsh, DiLillo, & Scalora, 2011). The intersection of these factors likely has a role in shaping women's offending pathways and their rehabilitation needs. There is some research with women in corrections that suggests that for the women themselves, trauma and the experience of violence by intimates and carers does have a distinct role, particularly in relation to drug use, which is then attributed to their offending (Lawrie, 2003). Salisbury found that child abuse (physical and sexual) was directly associated with a history of mental illness. Mental illness itself was associated with a history of substance abuse and current depression/anxiety. Symptoms of depression and anxiety and current drug addiction were the two factors that directly led to women's recidivism (prison admission). Indeed in this study, current depression/anxiety was strongly correlated with all other variables tested (child abuse, history of mental illness, current and past substance abuse and prison admission), suggesting that it "may play an integral role in women's pathways to recidivism"(Salisbury, 2007, p. 100).

In addition, much of the literature points to women's offending as based on social disadvantage (Covington & Bloom 2004; Scott 2004). Women are more likely to be the primary caregiver to dependent children. Indeed, for many women in the criminal justice system welfare is their main source of income. Where socially disadvantaged women cannot access social and/or economic support for their families, they may turn to illegal means to secure resources for themselves and their dependent children.

Summary

In the last two decades, there has been a significant increase in the number of women entering correctional facilities in Australia. A majority of the women in prison have extensive victimisation histories including childhood sexual abuse, intimate partner violence and violence from non-

intimates and carers. The rates far exceed those of women in the general community. Alongside sexual victimisation trauma, the majority of women in prison are socially disadvantaged and marginalised. The inability to gain or maintain employment, issues with parenting, drug and alcohol abuse and other mental health issues are likely to be related to their trauma histories.

The key messages arising from the literature reviewed so far are that:

- Women enter custody with less serious criminal careers than men (even though they may have more frequent episodes in custody);
- Women enter prison more disadvantaged than men, particularly in relation to: mental health, socio-economic status, being primary carers for dependent children, educational attainment; and
- The intersection of victimization, mental illness and substance abuse is typically located in, and exacerbated by, a context of diminished social capital (e.g. poverty; unemployment; social isolation; homelessness; violent or dysfunctional relationships), producing multiple pathways into the criminal justice system.

The following chapter describes the short and long term impacts of child sexual abuse.

2. The consequences of sexual abuse and multiple victimisation: "Complex trauma"

The adverse impacts of sexual victimisation have been extensively documented and are now recognised as comprising a range of coping strategies to a traumatic event. The dominant framework through which this range of responses is understood and organised has been through the construct of post-traumatic stress disorder (PTSD). However, PTSD was developed with survivors of single, or one-off, or relatively contained events. Many researchers in the fields of psychiatry, traumatology, and social work do not see PTSD as adequately capturing the effects of chronic and/or polyvictimisation.

As the previous chapter demonstrated, the nature of sexual victimisation experienced by women in prison typically begins early in life, is sustained, often occurs in circumstances of family instability and disadvantage, and is correlated with subsequent victimisation in adulthood. An extensive evidence base indicates that such victimisation experiences are strongly related to a range of mental health outcomes that often take the form of depression, addictive and self-harming behaviour, substance abuse, and dissociative disorders. Moreover, these adverse outcomes are rarely singular – co-occurring disorders are extremely prevalent among traumatised populations.

Currently, these co-occurring disorders are not included within a PTSD construct, but may be captured, through clinical assessment, by other diagnoses such as substance use disorders, borderline personality disorder, dissociative identity disorder, or antisocial personality disorder. Increasingly, an empirical and clinical research base is developing which uses "complex trauma" or "complex post-traumatic stress disorder" as a construct that more coherently captures the impacts of early onset victimisation on mental health, cognition, interpersonal relationships, and self-capacity.

Having reviewed the evidence on the mental health and other impacts of child sexual abuse, the prevalence of early sexual victimisation among female offenders, and the nature of their mental health needs, we would suggest that "complex trauma" is the best descriptor of the mental health needs of women in corrections. It arguably offers a more comprehensive and robust understanding of the relationship between trauma, mental health problems and drug addiction than "co-morbidity", or "dual diagnosis" in that it isa single framework to inform interventions across (at least) three domains of need: trauma support, mental health treatments and drug treatment.

This chapter briefly describes the long-term impacts of child sexual abuse before discussing "complex trauma" as the key framework for understanding women offenders' trauma needs

Adverse impacts of early sexual victimisation

The adverse impacts of child sexual abuse have been extensively documented (AIHW, 2007; Victoria L Banyard & Williams, 1996; Victoria L Banyard, Williams, & Siegel, 2003; Belsky & Vondra, 1989; Berlin, Appleyard, & Dodge, 2011; Bromfield, Lamont, Parker, & Horsfall, 2010; Browne & Bassuk, 1997; Cannon, Bonomi, Anderson, Rivara, & Thompson, 2010; "Characteristics of parents involved in the Queensland child protection system," 2008; Chiang, 2009; Classen et al., 2002; Coid et al., 2001; Stephanie Covington, 2008; Cross, 2001; DiLillo & Damashek, 2003; Patricia Easteal, 1994; Ehrensaft et al., 2003; Lori Haskell & Melanie Randall, 2009; Higgins & McCabe, 2000; Humphreys, 2007; Keel, 2005; Kim, Trickett, & Putnam, 2010; KPMG, 2009; Lamont, 2010; Macey, Giattina, Parish, & Crosby, 2010; McCloskey & Bailey, 2000; Messman-

Moore & Long, 2002).[19] Of particular relevance to this review are the impacts of child sexual abuse on mental health.

Mental Health

Child sexual abuse victimization leads to a range of issues around health and wellbeing well into adulthood. Adult women with CSA histories have been found to have a higher risk of mental health problems such as depression, anxiety, substance abuse and self-mutilation when compared to community populations (M. Cutajar et al., 2010; Henderson & Bateman, 2010; Horvarth, 2010; Mullen & Fleming, 1998).

Child sexual abuse alters "a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities" (Finkelhor 1987, p. 354 in K. Walsh, Fortier, & DiLillo, 2010). How victim/survivors learn to cope with the dynamic and impact of abuse, namely traumatic sexualisation, betrayal, stigmatization, and powerlessness can have an effect on the rest of their lives (Herman 1992). For instance, "avoidant coping" or more simply learning to cope with the abuse by avoiding dealing with it has been associated with trauma symptoms (Fortier et al., 2009). Survivors of child sexual abuse use a range of strategies to cope with these alterations such as psychological escape, socially withdrawing, and reframing. In the short term and depending on context, these can be effective ways of minimising distress. However, the available research shows that in the longer term, such strategies can ossify into avoidant coping strategies such as substance use; emotional numbing and self-harm with negative outcomes for mental health (Walsh et al. 2010) and on interpersonal relationships (Davis & Petretic-Jackson, 2000).

Avoidant coping may be signalled by drug and alcohol abuse and can lead to further victimization in adulthood. Studies have shown an association between childhood abuse and adverse relationship outcomes in adulthood, including intimate partner violence (IPV) (Victoria L Banyard & Williams, 1996; Berlin et al., 2011; Cannon et al., 2010; Coid et al., 2001; DiLillo & Damashek, 2003; DiLillo, Giuffre, Tremblay, & Peterson, 2001; Ehrensaft et al., 2003; Johnson, Sheahan, & Chard, 2003).

Past victimization may intersect with mental health issues often exacerbated by drug and alcohol abuse (Battle, Zlotnick, Najavits, Cutierrez, & Winsor, 2003; Sarteschi & Vaughn, 2010). Substance users with abuse histories (including child sexual abuse) reported higher rates of suicidal ideation and attempted suicide compared to users without such histories. This was particularly the case for those who had experienced multiple adverse experiences in childhood (Rossow & Lauritzen, 2002).

Revictimisation

Many studies indicate that prior childhood victimization may be a risk factor for subsequent victimization in the future (Christopher et al. 2007; Brewer-Smyth et al. 2004; Battle et al. 2003; Fagan 2001; Teague & Mazerolle 2007). Experiences of CSA in particular, have been found to substantially increase the risk of revictimisation in adulthood, with women who have experienced multiple forms of childhood abuse found to be most at risk. (Victoria L Banyard & Williams, 1996; Browne & Bassuk, 1997; Cannon et al., 2010; Classen et al., 2002; Coid et al., 2001; DiLillo & Damashek, 2003; DiLillo et al., 2001). Studies have consistently found that compared to participants who have not experienced abuse as children, women with histories of CSA are three times more likely to experience incidents of intimate partner violence, including physical assault and rape (Cannon et al., 2010; Coid et al., 2001; DiLillo et al., 2001; McCloskey & Bailey, 2000; Trask, Walsh, & DiLillo, 2011).

[19] The following section is part of an ACSSA research review on mothers' child sexual abuse histories and the intergenerational transmission of trauma in relation to their own children (Tarczon, 2012).

High-risk behaviours

As well as being at risk of experiencing violent interpersonal relationships (Davis & Petretic-Jackson 2000), women with a history of child sexual abuse victimization are more likely to engage in casual and unprotected sex while reporting less satisfactory sexual rewards and greater sexual costs (Lemieux & Byers 2008).

Post-traumatic stress or complex trauma?

Acute and post-traumatic stress

Traumatic events overwhelm the "ordinary human adaptations to life [and] generally involve threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992a, p. 33). The subsequent reactions to such experiences of terror, helplessness and vulnerability involve hyperarousal and vigilance, intrusion or flashbacks, and, as antidote to these states, numbing.

That sexual victimisation occasions post-traumatic stress responses is well established (for a summary of the impacts see Boyd, 2011). Over thirty years ago, Burgess and Holstrom termed the effects of sexual assault on victims Rape Trauma Syndrome in which the kernel of anxiety was "a subjective state of terror and overwhelming fear of being killed" (Burgess & Holstrom, 1974, in Burgess 1983, p. 100) and involved an acute or disruptive phase that could last from days to weeks characterised by general stress reactions and a second phase of a longer-term process of re-organisation lasting months to years. More recent work on the relationship between acute stress reactions and longer-term trauma responses supports these phased reactions (Elklit & Brink, 2004; A. Harvey & Bryant, 1999, 2002). Post-traumatic stress disorder is the psychiatric diagnosis given to this latter, more persistent form of trauma response.

Despite similarities in reactions across acute, sustained and long-term trauma responses (e.g. hyperarousal, avoidance, memory impairments), the clinical and empirical literature finds distinctions in the overall nature of trauma impacts arising from early, chronic victimisation:

> "[The post traumatic stress reaction] is what happens to some people after a single impact trauma. If you repeat it over and over, especially if it begins early on and one's development is formed in this environment, it gets a lot more complicated." (Herman, 2000)

Herman argues that PTSD is ultimately about the "memory imprint" of an event, about the ways in which the terrifying memory intrudes unsolicited into consciousness, results in hypervigilant, finely tuned startle responses to unrelated stimuli, and is ameliorated by techniques of avoidance. Treating PTSD focuses on the impacts of the past event and processing them such that the memory imprint is better integrated into the person's sense of self. Those working in the sexual assault field note that this is indeed possible for many survivors of a sexual assault, providing that there is also a sense of being able to affect one's own destiny (i.e. internal locus of control, high levels of sociability, skill at communicating with others and a social environment in which the self can be rebuilt safely).

Researchers have argued that PTSD defines only "limited aspect[s] of posttraumatic psychopathology", and does not reflect the range of symptoms abuse survivors experience such as unmodulated aggression, poor impulse control, and dissociative problems, or subsequent problems later in life such as substance abuse, personality disorders, affective disorders, and somatoform disorders (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Van der Kolk and colleagues concluded that:

> Despite the ubiquitous occurrence of numerous posttraumatic problems other than PTSD, the relationship between PTSD and the multiple other symptoms associated with early and prolonged trauma has received surprisingly little attention. In the PTSD literature, psychiatric problems that do not fall within its framework are generally referred to "comorbid conditions" *as if they occurred independently from the PTSD symptoms*. (2005, p. 390, emphasis added.)

The growing evidence about the particular symptomatology of complex trauma[20] is very relevant to this review not only because of the profile of female offenders, but also because of what complex trauma can suggest about the a) relationship between victimisation, mental health and drug use; b) how the dimensions of complex trauma may affect the capacity of women in corrections to engage in programs and c) the best therapeutic approaches for this population. The following section describes the complex trauma response and the adaptions of survivors.

The complex trauma response

Complex trauma differs from the "memory imprint" of PTSD in two aspects – the circumstances of the trauma event/s and the effects this has on core aspects of a person's sense of self (e.g. cognitions, mental health, emotional stability, and personality).

In relation to the first aspect, part of this is about the length, frequency, and severity of abuse. It is also about the contexts in which such abuse occurs. Child sexual abuse is fundamentally located within familial, care, and social networks, particularly for girls.[21] Within such contexts perpetrator tactics involve secrecy, complicity and threat. In other words, they are contexts of "captivity", in which perpetrators attempt to create accommodating or "willing victims" (Herman 1992, pp. 74-113). These two elements together – the nature of the abuse and the context in which it occurs – actively shapes the construction of the self – emotionally, cognitively, and relationally: repeated trauma in adulthood "erodes the structure of the personality already formed" whereas repeated trauma in childhood "forms and deforms personality", due to the many adaptations developed by survivors to cope with sexual abuse by a guardian figure (Herman, 1992, p. 96).

Research has emphasised the impact that early onset, repeated sexual abuse by a caregiver or guardian has on the development of attachment systems (Liotti, 2004; Van der Kolk et al., 1996). Forming primary attachments to care takers who are "either dangerous, or from [the victim's] point of view, negligent, [developing] a sense of basic trust and safety with caretakers who are untrustworthy and unsafe" and maintaining a sense of control in situations of unpredictability (Herman, 1992a, pp. 101-102), requires a range of adaptations and survival strategies such as denial, dissociation, fragmented/disordered attachment styles, self-blame, and fantastic assessments of the perpetrator (Briere & Spinazzola, 2005; Herman, 1992a; Luxenberg, Spinazzola, & Van der Kolk, 2001a; Van der Hart, Nijenhuis, & Steele, 2005; Van der Kolk et al., 1996; Van der Kolk et al., 2005).

Although these are often adaptive reactions at the time of experiencing abuse, in the longer-term they become maladaptive alterations in functioning. Based on clinical and empirical research, six "symptom clusters" are involved in a complex trauma response:

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[20] The literature typically uses "complex trauma", "complex post-traumatic stress disorder" and "disorders of extreme stress not otherwise specified [DESNOS]" to describe trauma responses to chronic or multiple victimisation.

[21] Nationally representative figures show that fathers, stepfathers and other male relatives made up half (51.6%) of perpetrators for girls, compared to one fifth (21.4%) of perpetrators against boys. Boys were more likely than girls to be sexually abused by individuals known to them other than family, family friends, or acquaintances or neighbours, such as doctors, coaches, and clergy.

- ***Altered self-capacities:*** dysfunctions in the areas of affect regulation (i.e. regulating emotional states and reactions), anger regulation, and behaviours and impulses (e.g. self-destructive behaviour, self-harming, excessive risk-taking, sexual involvement and suicidal ideation);
- ***Alterations in attention or consciousness:*** changes in memory function (e.g. amnesia) and the tendency to dissociation and depersonalisation;
- ***Alternations in self-perception:*** perceptions about one's self as a stigmatised, ineffective or damaged self, internalisations of shame, guilt and responsibility, and minimising harm;
- ***Alterations in relating to others:*** changes to the capacity to trust others, maintain personal safety and agency (e.g. revictimisation experiences or dominating relationships), or victimising others;
- ***Somatisation:*** experience of persistent physical illness and difficulties relating to the digestive system, chronic pain, heart and lungs, and urogenital systems (e.g. headaches, irritable bowl syndrome, high blood pressure, etc.); and
- ***Alterations in systems of meaning:*** changes to personal systems of meaning in relation to the world, one's purpose or self-efficacy within it, and the motivations of others. (Briere & Spinazzola, 2005; Herman, 1992b; Luxenberg et al., 2001a)

Table 2 describes the domains of complex trauma symptomatology, what they may involve and how they might be expressed. It also identifies social and cultural factors that can exacerbate these.

Currently, "complex trauma" or "complex PTSD" is not recognised by the International Classification of Disease or DSM-V. Reactions and behaviours such as dissociation, impulsivity, and substance dependency are described as, or within, separate and distinct diagnostic categories. However, when the profile and needs of women in the correctional system are considered, complex trauma is an extremely promising construct with which to understand the impact of child sexual abuse and how this interfaces with women's pathways into – and out of – prison. There are several reasons for this view:

1. It acknowledges that particular forms of victimisation – namely, those that begin early in life, are chronic, perpetrated by a caregiver, and which violate personal boundaries (such as child sexual abuse) – result in enduring changes to the self and its capacities. It provides a rationale or framework for understanding how diverse responses – e.g. dissociation, somatisation, risk-taking or depression – are related to the experience of trauma.
2. It captures the developmental impacts of childhood sexual abuse on attachment styles, emotional regulation, cognitive capacities and neural pathways development (van der Kolk, 1996).
3. It provides an understanding of the intergenerational transmission of trauma, both at an individual level and at a collective level. (L. Haskell & M. Randall, 2009)

Table 2 Complex Trauma response, expressions and relevant social factors

Symptom categories	Components	Expressions	Social & cultural factors
Alterations in Self-regulation and Impulses	Affect regulation Modulation of anger Self-destructive Suicidal preoccupation Difficulty modulating sexual involvement Excessive risk-taking	Self-harm Substance abuse & addiction Overwhelmed by anger Casual & unprotected sex Suicide plan Eating disorders	• Collective and intergenerational history of trauma • Low collective efficacy & community capacity • Social marginalisation • Social isolation • Poverty • Victim-blaming attitudes • Negative social reaction to disclosure • Perpetrator tactics to silence, threaten victims • Perpetrators not held to account • Being a client in multiple, poorly integrated systems • "Trauma blind" services & responses • Rape-supportive attitudes in the community • Structural inequality between men and women • Racism
Alterations in Attention or Consciousness	Amnesia Transient dissociative episodes Depersonalization	Clouded perception Feeling/being dazed Automation/being on "autopilot" Difficulty remembering appointments, discussions, events	
Alterations in Self-Perception	Personal ineffectiveness Changes in personal identity Disturbances in identity formation	Feelings of hopelessness & helplessness "Malignant" sense of self (contaminated; guilty; bad; self hatred)	
Alterations in Relations With Others	Inability to trust Revictimisation Victimizing others Perpetrator as omnipotent	Difficulty seeing danger signs/unsafe situations Confused boundary-setting Conflictual relationships Desire for a "rescuer"	
Somatization	Digestive system Chronic pain Cardiopulmonary symptoms Conversion symptoms Sexual symptoms	"Acid" stomach Irritable Bowel Syndrome Pelvic pain Headaches Unexplained symptoms (e.g. numbing, tingling)	
Alterations in systems of meaning	Fatalism World/people as malevolent Loss of hope Loss of belief	Lack of self-efficacy Despondency, despair Anger Apathy	

Source: Adapted from Herman (1992a, 1992b), Luxenberg et al. (Luxenberg et al., 2001a) and Haskell & Randall (2009)

Complex trauma and incarcerated women

Although there is little research that explicitly explores the connection between child sexual abuse and complex trauma outcomes in incarcerated women, findings suggest that women with child abuse histories score higher than women without such histories on affect dysregualtion, dissociation and somatisation measures (Zlotnick, 1997).

Jenks (2010) examined the relationship between child sexual abuse experiences, substance abuse, posttraumatic stress and complex trauma and its implications for the personality assessment inventory (PAI)[22]in a sample of incarcerated women. She hypothesised that the women with CSA histories would have significantly higher levels of overall psychopathology and higher levels of features reflective of Complex PTSD (C-PTSD), namely borderline features, negative self-perception, somatisation, depression, anxiety-related disorders, affect dysregulation, identity disturbance, self-destructiveness and traumatic stress. She also hypothesised that the severity of traumatic stress and CSA would be associated with higher levels of drug use. The analysis found that:

- Women with CSA histories scored significantly higher on overall levels of psychopathology;
- Women with CSA histories scored significantly higher on levels of drug use; and
- Higher levels of the features associated with C-PTSD were only partially borne out. When the various scales were combined there were statistically significant differences. However, when analysed separately only anxiety-related disorders, obsessive-compulsive disorders and traumatic stress were significantly higher.

This lack of resonance – particularly regarding affect dysregulation –was explained as being due to a) the small sample size; b) the already elevated levels of mental health problems among the sample of women with CSA histories, and c) the possibility that the measure used to assess this was not a valid measure for this population. Indeed, using the PAI tool to assess C-PTSD symptomatology may not be a good fit, something Jenks also acknowledges (see also Rideout, 2009).[23]

Complex trauma and Aboriginal women

A limited body of scholarship is available that suggests complex trauma as a useful construct for describing the impacts of sexual abuse on Aboriginal women and within Aboriginal communities (L. Haskell & M. Randall, 2009; Söchting, Corrado, Cohen, Ley, & Brasfield, 2007). It is more expansive than the PTSD construct and, through the notion of "disrupted attachments", acknowledges the trauma of colonisation and the attendant loss of land, culture and identity (Haskell & Randall, 2009). It also provides a framework through which drug and alcohol addiction, high risk behaviours, violence, are viewed as responses to trauma rather than pathologies and health problems.

The literature on culturally competent trauma interventions stresses the need for service providers' and practitioners' awareness and self-reflexivity about their own values and paradigms of knowledge/belief, particularly in relation to:

- The reliance on the individual as the locus of action and meaning;

[22] The PAI is a screening tool used in correctional settings for substance abuse disorders and/or mental health disorders. Jenks writes that although the tool itself is relatively sound, there is little research to guide its use with incarcerated women, particularly those with histories of child sexual abuse.

[23] Tools developed for this purpose are the Structured Interview for Disorders of Extreme Stress (SIDES) and the Self-report Inventory of Disorders of Extreme Stress (SIDES-SR). Additional instruments include the Traumatic Antecedents Questionnaire, the Dissociative Experiences Scale and the Inventory of Altered Self Capacities (Luxenberg et al. 2001a).

- The reliance on scientific knowledge compared to spiritual knowledge and meaning;
- Conceptions of authority and respect; and
- The political, historical and institutional sources of trauma.

Co-occurring disorders or complex trauma?

Given the absence of an over-arching construct for trauma-related behaviours, individuals are often diagnosed with a range of other disorders such as: major depressive disorder; anxiety; psychosis; borderline personality disorder [BPD],[24] dissociative identity disorder [DID]; substance abuse disorder; schizophrenia; conduct disorders; or oppositional defiant disorder, and behaviour such as self-harm, suicidal ideation, and substance dependency or misuse as symptoms of these.

This has significant impacts on treatment approaches, and about what is the most important element to address and at what point – the sexual abuse trauma, the mental health problem, or the substance use? Indeed, it is often the secondary (e.g. substance abuse) or tertiary (drug-induced mental illness) expressions of trauma that result in treatment and/or support. Screening for histories of abuse has not traditionally occurred within the mental health services (Huntington, Moses & Veysey, 2005). Often, the underlying trauma history is treated as a separate mental health need, is rarely integrated into treatment, and/or the complexity of symptoms results in multiple and changing diagnoses (Harris & Fallot, 2001).

Mental health and AOD service providers sometimes fear that trauma treatment means opening up a "pandora's box" of memories, and in-depth trauma counselling (Finkelstein & Markoff, 2004). However, as explained in the following section, in-depth trauma counselling should only occur in a context of stability and safety, where trauma reactions are manageable, where the survivor has a degree of mastery over her own reactions and emotions, has productive self-soothing strategies and is not in an environment that can be retraumatising. In other words, for women with mental health issues, active substance use, and high levels of trauma symptoms, the focus of trauma work is on stabilisation.

In order to better understand the connections between women's co-occurring mental health problems, substance abuse and victimisation histories, the US-based Substance Abuse and Mental Health Services Administration (SAMHSA) funded the Women, Co-Occurring Disorders and Violence Study.[25] This resulted in the development, implementation and evaluation of 9 "trauma-informed" programs.

Treatment, healing and recovery

Healing and recovery following exposure to traumatic events involves three core stages: stabilisation or establishing safety; processing trauma - the exploration and reintegration of traumatic memories into a personal narrative; and the positive reconnection with others (Herman 1992; Korn, 2009; van der Kolk, 2001).

These are explained in more detail in Table 3. These involve key aspects of mind, body, relationships and environment. These stages should not be considered as linear steps; the literature notes that individuals will move back and forth depending on circumstances. However, the purpose of the steps is about identifying what kind of therapeutic work can be done at which stage so that a

[24] A recent UK policy paper on women with borderline personality disorder in prison noted that approximately 20% of women in prison fulfill the criteria for BPD (Fossey & Black, 2010).

[25]The SAMHSA-funded Women with Co-Occurring Disorders and Violence Study (WCDVS) was one of the first large-scale studies to investigate promising models for treating women with complex problems. Four trauma-specific and integrated models of treatment for substance abuse clients with trauma histories, symptoms, or posttraumatic stress disorder (PTSD) were utilized in the study.

survivor can move more and more towards recovery. Although there is no "final" resolution or total recovery, healing from experience of trauma can be determined by the extent to which:

- Symptoms are brought within manageable limits;
- The survivor is able to bear the feelings associated with traumatic memories;
- The survivor has authority over the memories;
- Memory is a coherent narrative;
- Self-esteem has been restored;
- Important relationships have been re-established; and
- There has been a reconstruction of a coherent system of meaning and belief that encompasses the story of the trauma (M. Harvey, 2007).

In the context of singular traumatic events, these stages can be passed through relatively quickly. In the context of child sexual abuse and revictimisation however, moving too quickly to processing traumatic memories can increase distress and maladaptive coping strategies. Instead, the clinical and therapeutic literature recommends focusing on stabilisation through psychoeducation, symptom and affect management, and the development of alternative coping skills and strategies. In other words, the focus needs to be on increasing the capacity of survivors to be aware of and control their reactions to a range of stimuli, including flashbacks, extreme emotion states, and interactions with others. Importantly, this needs to occur within a safe and predictable external environment. A safe environment is one which supports and encourages this, and which does not recreate situations of humiliation, isolation, danger, unpredictability and disempowerment.

Supporting women with sexual abuse histories and complex trauma: Focusing on stabilisation

The establishment of safety is considered the starting place for all other interventions: no other therapeutic work can be undertaken until the individual has a sense of safety in themselves, a sense of capacity to manage that, and an environment that is able to support that. Herman (1992) warns against entering the second stage of memory exploration without first adequately establishing safety. This can result in repetitions of trauma and of telling about the trauma without being able to move towards reintegration and transformation about those experiences. For individuals who have experienced extensive victimisation and who are experiencing complex trauma symptoms, this first stage will be lengthy because they do not experience their own bodies and psyches as safe spaces, or as within their control.

Luxenberg et al. note that within this first stage, much of the initial therapeutic work is psychoeducational and that "physical needs, trust, safety, self-soothing and building of support networks, and not the trauma, should be the focus of the treatment. Therapy during this stage should be reparative not explorative" (2001b, p. 400). This involves:

- Providing clients with basic information about the effects of trauma;
- A rationale and explanation for specific symptoms;
- Developing capacities for self-care and self-soothing;
- Identification of supports within environment; and
- Identification of triggers in the environment.

Affect regulation and the management of symptoms (e.g. flashbacks, nightmares, sleep difficulties) are particularly important. Other aspects of this stage involve attention to physical well-being and bodily experiences, and the creation of scheduled and predictable routines.

Table 3 Therapeutic management of complex trauma

Phase	Focus	Tasks/goals	Approaches
Stabilisation and containment	Establishing personal safety	Restoring control over body Regulation of bodily functions such as sleep, eating, exercise& attention to basic health needs Tolerating and managing extreme emotion states Developing self-mastery and awareness Developing alternative coping skills Day to day safety and predictability	Psychoeducation – understanding traumas, identifying triggers; making connections between triggers and reaction Grounding and mindfulness Developing "safety plans" to manage feeling overwhelmed Learning to label/name flashbacks/triggers Early stages of dialectical behavior therapy
Processing trauma	Remembrance and mourning (Processing memories; self perception and relationship with other)	Deep exploration of memories; truth telling and grieving. The goal of this stage is to transform the traumatic memory so that it can be integrated into the survivor's life story	Prolonged exposure therapy Eye Movement Desensitization and Reprocessing therapy [EMDR]
Reintegration of self	(Reconnection with peers; meaningful work)	The stage involves: developing a new self; developing new relationships; the development of new goals; a sustaining faith; sharing responsibility; intimacy.	More general psychotherapeutic approaches

Source: Adapted from Herman (1992); Korn (2009); Luxenberg et al. (2001); van der Kolk (2001)

In terms of particular modalities of therapy such as cognitive processing therapy, eye movement desensitisation and reprocessing, and prolonged exposure, Luxenberg et al. recommend that these are best used in stage two of the recovery process. In addition, it is not clear whether therapies that work for PTSD are sufficient for complex trauma (Korn, 2009; Luxenberg et al., 2001b). For individuals with complex trauma responses, the literature stresses the importance of moving back and forth between Phases one and two. Pharmacotherapy would also be a complementary (but not of itself sufficient) treatment approach.

3. Key debates in women's offending and rehabilitation

A key purpose of this review was to advise CSNSW about how the effects of sexual victimisation interface with offending and reoffending pathways, and on that basis, advise on the directions that could be taken to address these effects within a correctional setting.

As noted in the executive summary and discussed in Chapter 1, a vast literature on women's offending has demonstrated three key things:

- Women enter correctional systems significantly more disadvantaged than male offenders in relation to mental health (including drug dependency), educational attainment, employment histories, and housing stability. Many are primary carers of dependant children;
- Their pathways into offending and the nature of their of their offences represent a distinct offending trajectory; and
- Sexual victimisation and multiple victimisation are prevalent among this population.

Both internal and external factors contribute to women's violent offending. External factors related to social disadvantage can lead to the commission of violent crimes by women. Violence may stem from poverty, lack of education and unemployment, homelessness and a history of exposure to family violence and child sexual abuse (Bottos, 2007; Carnovale, 2009; S. Miller, 2005). Internal factors can include the gendered socialisation imperatives around women and anger, which can "inhibit expressions of anger, thereby compelling them to internalize negative affective states" (Bottos 2007, p. 15). Mental illness or the mental destabilisation that occurs after prolonged substance abuse is another internal factor that may lead to violence by women. Feminist research also points to the defensive nature of women's violence. Women may react violently after prolonged exposure to intimate partner violence and/or sexual abuse, particularly if children are at risk. Further, women's violence is more likely to be "driven by self-defence and fear" (Swan et al 2008). Most violent offences by women are one-off events and few women are repeat violent offenders (Bottos 2007).

Feelings of powerlessness, hopelessness, and anger can combine with mental health issues and drug-related mental distress to result in the use of interpersonal violence. Qualitative and ethnographic research has explored the meaning of violent criminality for women, suggesting that for both men and women, their use of violence is shaped by the norms and expectations of gender and inflected with dimensions of race, class and inequality (e.g. J. Miller, 2008).

However, there is some debate about the extent to which the dominant approach to rehabilitation (that is, the Risk-Needs-Responsivity model) takes – and should take – these factors into account, either as a theoretical model of rehabilitation (e.g. Hannah-Moffat, 2009; c.f. Smith, Cullen, & Latessa, 2009) or in its application in correctional settings (e.g. Taylor & Blanchette, 2009).

This chapter offers a brief synthesis of the key areas of debate and research about how women's rehabilitation needs are best responded to, and what explanatory power gender should have in informing those responses. Two broad perspectives inform current research and debate: those that argue for universal or general causes underlying criminal behaviour (that is, they are the same for men and women, across ethnicities and across race), and those that see gender as a central dimension shaping criminal behaviour, social responses to it, and the desistance process.

Aetiology of offending

There are two broad views within the rehabilitative literature[26] regarding women's offending. The first is primarily psychological (with situational considerations). These are the Psychology of Criminal Conduct theory, Personal, Interpersonal, Community-Reinforcement theory (PIC-R) and Relational theory. The second is social, with psychosocial, sociological and feminist underpinnings. These theories are Pathways theory, Trauma theory, Addiction theory and Social Learning theory. These take into account gender, past child sexual abuse, current sexual/violent abuse, socioeconomic disadvantage, education, affiliations, substance use and trauma. There is also an emphasis on homelessness, unemployment and mental health issues. The difference in frameworks has an effect on how treatment programs are conceptualized and delivered. Psychological frameworks are concerned with individual level factors and sociological frameworks are more concerned with social level factors and how they impact on the individual.

Psychological frameworks for women's offending

Psychology of criminal conduct and personal, interpersonal, community-reinforcement theory

The psychology of criminal conduct (PCC) seeks a theoretical, research-based and practical understanding both of how people come to offend (and how some do not) and how people's level of involvement may vary over time, situations and circumstances. Rather than being a theoretical framework that seeks to understand women's offending, it can be thought of as "an *orientation* to the study of crime by identifying psychological correlates of crime" (Ward et al. 2009; 213, emphasis in original). It provides an overall approach to understanding why crime occurs.

The approach has been in development by Donald Andrews and colleagues. It is a relatively dynamic criminological theory that, over the last 15 years, has tested and integrated the key propositions of social learning, strain, and social control theories. This integrated theory is the personal, interpersonal, community-reinforcement theory. Some core assumptions underpin this theory in relation to:

- *Human behaviour:* that is outcome-oriented; that the outcomes that matter are in the near future; behaviour includes acts but also compliance/engagement with certain scripts or narratives.
- *Assessment of outcomes (and presumably future behaviour):* that it is cost/reward based.
- *Sources of influence:* that these operate at the level of the individual (an agentic, deliberate, intentional subject); at the level of relationships; or are unconscious, automatic, habitual, scripted, following a narrative.

The Personal, Interpersonal, Community-Reinforcement Theory (PIC-R) seeks to take into account personal characteristics, interpersonal relationships and situational contexts that are most likely to result in offending (Andrews & Bonta 2003). It is based on the notion that offending occurs in specific situational contexts as they interact with personal characteristics and are influenced by interpersonal relationships. The offending is the consequence of weighing up what Andrews and Bonta call "rewards and costs" (Andrews & Bonta 2003). Reducing offending involves recalibrating how an offender views their behaviours and their consequences (or cost/rewards) such that re-offending is less likely.

[26] There are many theories of crime, e.g. rational choice, routine activities, differential association, strain, labeling, lifecourse/developmental, social control. Many offer explanatory frameworks for crime prevention, which is not the same as reducing offending. Thus the qualifier "rehabilitative theories".

In their work developing the PCC, Andrews and Bonta have identified eight major risk factors that have been found to predict criminal conduct, with four psychological variables most closely associated with criminal conduct. The literature sometimes refers to these as the "The Big Four" (Andrews, Bonta, & Wormith, 2006), which are:

- A history of anti-social behaviour;
- Anti-social personality pattern;
- Anti-social cognition or thinking; and
- Anti-social associates.

Added to these are four "situational" or "circumstance variables", namely:

- Family and/or marital relationships;
- School and/or work engagement and performance;
- Leisure and/or recreation involvement; and
- Substance abuse.

Dynamic risk factors are "personal attributes and circumstances" (Andrews et al. 1990, p.24) which are open to modification, for example, drug use, anti-social behaviour and anti-social affiliations. The situational factors related to drug use, for example, may be the presence of a needle, which may be encouraging and appealing to a heroin addict (Andrews & Bonta 2003). According to those who developed the theory, it "considers factors that actively encourage or discourage deviant activity" (Andrews & Bonta 2003, p. 165). A great deal of importance is placed on an evidence base and this theory is designed to be both comprehensive and flexible, meaning that as new evidence regarding offending comes to light, it can be incorporated into PIC-R as variables related to offending.

Relational theory

Relational theory is based on the normative psychological development of women. It is thought that women's well being is related to their connections and valued relationships with others[27] (Covington 2007). It speaks to the idea that women receive a great deal of self worth and self esteem from their connections with others (Covington & Bloom 2004). This is a gender specific psychological framework for understanding how women's early relationships may affect their choices later in life. "Disconnection and violation rather than growth-fostering relationships characterize the childhood experiences of most women in the criminal justice system (Covington & Bloom 2004; 11). The limitation of relational theory is that it may ignore the need for women to foster independence. Relational theory is used in Pathways theory (discussed below) and acknowledges the need for connections to be healthy and respectful.

Social frameworks for women's offending

Gendered pathways is the predominant theory that attempts to specifically address women's offending. This theory also integrates other knowledge bases such as theories of addiction, trauma theory and relational theory. A large number of women are incarcerated on drug charges or theft charges associated with the monetary gain for the purpose of buying drugs (Moloney et al. 2009; Covington & Bloom 2004). In 2010 in NSW 15% of all women in prison were there on drugs charges and 16% on theft related charges (ABS, 2010). Drug use has been associated with posttraumatic stress disorder stemming from child sexual abuse and adult sexual abuse (VAADA 2010; Bottos 2007; Eliason 2006; Covington & Bloom 2004). Social marginality, mental health

[27] This does not imply that men's well being is not related to valued relationships

issues and homelessness are also factors associated with women's offending (Covington & Bloom 2004, p. 10). These can be exacerbated by lack of education and unemployment (Bottos 2007). Women who have children are often the primary caretakers of their children and where they are socially disadvantaged, they may turn to crime in order to provide resources for themselves and their dependent family (Moloney et al., 2009). Pathways theory also recognizes that "women's offending often develops through relationships with family members, friends and significant others" (Department of Justice, Victoria 2007).

Pathways theory

Pathways theory is concerned with shedding light onto the interconnected social disadvantages that can affect women and lead them to initiate offending (Covington & Bloom 2004; 10). Social issues such as class, gender and race are acknowledged as sites of critical concern to women's offending.

Kathleen Daly's (1992, 1994) work greatly contributed to the pathways perspective. She developed a multidimensional framework revealing how women's life experiences are shaped in the context of race, class, and gender. The research described five unique pathways to felony court based on review of court records from 40 women offenders (1992):

- *Harmed and harming* women. These women were abused or neglected as children, were often labeled as "problem" children, and acted out more frequently than women in other groups. Many women in this group also suffered from substance abuse and mental illness
- The *street pathway* women. This group was comprised of women who escaped abusive homes as children and adolescents and who subsequently became drug addicted. This group used criminal means to survive on the streets and support their addictions, often turning to prostitution, theft, or drug dealing.
- The *battered* women pathway. Women whose abuse was primarily from violent intimate partners. Daly concluded that their appearances before the court were directly caused by their experiences with domestic abuse.
- The *drug-connected* women. These women were identified as being addicted to drugs and involved in manufacturing and/or distributing drugs in the context of an intimate or familial relationship. The onset of drug use for drug-connected women in Daly's sample was relatively recent in comparison to street women.
- "*other"/economically motivated* women. These women committed crimes for economic gain either because they were economically marginalized or were simply greedy. Daly (1992) found these women unique because they lacked any notable abuse history, were not drug-addicted, and were not violent. Other researchers have argued that the offending context for this group of women more closely resembles male offending patterns than gendered causal pathways (Reisig, Holtfreter, & Morash, 2006).

More recent qualitative and quantitative research suggests a number of key domains that create pathways to reoffending that differ from that of male offenders, namely mental health, intimate relationships, self-esteem, self-efficacy and parenting stress (Van Voorhis, Salisbury, Wright, & Bauman, 2008).

Overall there is a strong empirical association between victimization, depression, addiction, and criminal behaviour with women inmates, illustrating a clear antisocial trajectory. Male offenders also display these connections (e.g., co-occurring substance abuse and depression disorders), however as found by Cutajar and colleagues in their 45-year follow up study of male and female

victims of child sexual abuse and subsequent victimization or offending, the overall connections between these needs were much less pronounced compared with women inmates (2011).

However, the precise interactions between these factors are less well-developed. In the US Salisbury attempted to empirically map the pathways of 313 women probationers in Missouri, specifically in relation to whether a gendered criminal pathway to recidivism for women offenders could be demonstrated. Four path models were tested:

- a model of "traditional" risk/need factors using Andrews and Bonta's (2003) Personal, Interpersonal, and Community-Reinforcement (PIC-R) theory. Variables in this model included: criminal history, antisocial family, antisocial home environment, antisocial attitudes, and antisocial friends.
- Two gender-responsive models. These models included risk/need factors that were hypothesized to be critical in establishing criminal routes for women based on the pathways perspective. The first gender-responsive model, included measures of child abuse, mental illness history, substance abuse history, current depression/anxiety, and dynamic substance abuse (the child abuse model). The second model used measures of relationship dysfunction, self-efficacy, adult victimization, current depression/anxiety, and dynamic substance abuse. This was considered a "relational model".
- A social capital/desistance model based on recent empirical research conducted with women offenders. Risk/need factors included in this hypothesized pathway were educational strengths, relationship dysfunction, familial support, self-efficacy, and employment and financial difficulties. This model was informed by both gender-neutral and gender-responsive frameworks.

Her analysis showed her mixed support for the first pathway. On the one hand, the hypothesis that major antisocial modelling mechanisms in women's lives would facilitate continued antisocial behaviour was supported - antisocial family, antisocial friends, and antisocial home environments all either had significant direct or indirect effects on prison admissions. However, prior criminal behaviour and antisocial attitudes were not relevant in explaining a pathway of women's recidivism.

In relation to the "child abuse model" although child abuse was not directly related to prison admissions, it was an indirect influence through its psychological *sequelae* and created five unique paths to recidivism for women. Symptoms of depression and anxiety and current drug addiction were the two factors that directly led to women's recidivism. She concluded that "although childhood abuse was not criminogenic in and of itself, it appeared to be an etiological precursor to more identifiable criminogenic risk factors" (Salisbury, 2007).

In the "relational model" self-efficacy, current depression/anxiety, and current/dynamic substance abuse were all significantly associated with admissions to prison within two years of the initial interview. Relationship dysfunction and adult victimization did not exhibit meaningful correlations with recidivism. Path analysis revealed that each risk/need factor in the model either directly or indirectly affected recidivism and indicated strong support for the relational perspective of women's offending: "Women who experienced painful, unsupportive, and unsatisfying intimate relationships where they had little personal voice or power were at indirect risk for engaging in continued offending behaviour". Salisbury concluded that dysfunctional relationships established trajectories to recidivism through increased risk of victimization as an adult, reduced self-efficacy, depressive and anxious affect, and addictive behaviour.

Trauma theory

The "interaction between trauma, trauma outcomes and criminality has been established…" (Moloney et al 2009) however an empirical causal relationship has been difficult to establish. Post-traumatic stress disorder (PTSD) is a "response to violence" (Covington & Bloom 2004) whether it is experienced or witnessed. PTSD prevalence in imprisoned women's populations in Australia exceeds the general population by a factor of ten (Moloney et al 2009). Women with a history of child sexual abuse are more likely to find themselves in re-victimizing relationships in adult life. The violent offences committed by women are often "directed to intimate partners who inflicted years of abuse on them" (Eliason 2006; 3).

Addiction theory

Addiction has serious repercussions on cognitive, emotional and social functioning. The link between women's drug use and criminal behaviour has been well established (VAADA 2010; Bottos 2007; Eliason 2006; Covington & Bloom 2004). Drug and alcohol use is believed to be a maladaptive coping strategy that numbs the effects of trauma for women who have experienced violent and/or sexual abuse and dysfunctional families and partnerships (Moloney et al. 2009). Cobbina (2009) found that women's "desire for approval and acceptance by their peers and male intimate partner" (Cobbina 2009, p. 37) might also initiate drug use. Incarcerated population surveys indicate that more women than men are addicted to drugs (Eliason 2006). Women are also more likely to commit offences in order to acquire the money to buy drugs.

Social learning theory

Most offences committed by women are not violent. However there are some violent offences committed by women and social learning theory seeks to explain this violence. Although social learning theory is not specific to women, it holds that "modelling is central to development" (Bottos 2007; 13). In other words women learn violence in their childhood from their families and the relationships around them. This learning is reinforced when violence is seen and experienced as a successful avenue to desired outcomes (Andrews & Bonta 2003).

The above theories, although not exhaustive, include an illustrative example of the ways that women's offending has been conceptualized. In order to understand how to affect change in women who have offended, it is important to understand why they offend. Psychological and sociological explanations seek to acknowledge the individual and the social conditions that may initiate offending behaviour.

Limitations of theoretical frameworks

The theories briefly outlined above are important to service provision in women's prisons because they are intricately tied to offender and rehabilitation programs.

The limitations of relational theory as a stand-alone theory related to women's offending is that it cannot explain why not all women with dysfunctional or violent relationships or abusive childhood experiences offend. It is also important to attend to the diversity in women. Although relational theory indicates a normative psychological development for women based on connection, it would be dangerous to assume that women are all the same (Kubiak & Arfken, 2007). Hannah-Moffat (2010) indicates that to refer to women as a homogenous group can lead to the policing of gender expectations when women act outside what is considered the norm. Certainly many women would benefit from programs that teach independent living skills. As indicated in Pathways theory, women are often inculcated into a lifestyle of crime through their intimate partners.

The Psychology of Criminal Conduct and Personal, Interpersonal, Community-Reinforcement Theory (PIC-R) are theories that are used all over the world to understand women's offending as well as a basis towards the classification and rehabilitation of prisoners. This is because it is a 'general' theory of offending, with a 'universal' set of variables to indicate the possibility of criminal behavior in individuals that have been empirically tested – predominantly with male offender populations. That is, Andrews and Bonta (2003) have theorized male offending while labeling it general offending. There is no acknowledgment of the male offender perspective on their theory and this remains a major limitation in applying this theory to women's offending as well as to claims of universalism. For instance, understanding the offending patterns of Indigenous and CALD women within this framework is lacking.

Non-criminogenic needs are not considered as being directly related to offending. Examples of what Andrews and Bonta (2003) consider non-criminogenic needs within this model are gender and a history of sexual trauma (Blanchette & Brown 2006; Ward et al. 2009). Evidence suggests, however, that trauma, particularly post-traumatic stress disorder brought on by sexual victimisation, is a constant and proximal lived experience that affects the survivors' ability to live freely from intrusion, hyper-arousal and constriction (Herman 1992). The idea that PIC-R cannot fully account for women's offending is consistent with the literature that indicates that although empirical evidence and practice evidence show support for the PIC-R theory as applicable to male offenders, for female offenders, PIC-R has not been empirically tested with large samples so its effectiveness remains unknown (Blanchette & Brown 2006; Holtfreter & Cupp 2007).

Regarding pathways theory Hannah-Moffat (2010) provides a caveat: the danger of essentialising women within this framework and that "gender responsive penality is situated within a narrow politics of difference" (Hannah-Moffat, 2010, p. 193). This is also a criticism in regard to relational theory. It is dangerous to assume that gender responsivity is the be all and end all of policy implementation in prisons. She argues that it is important to consider the intersectionality of gender with other forms of oppression, such as race, class, religion and sexuality. Another limitation of Pathways theory speaks to the needs of transgender and non-gender conformist people who may be discriminated by the facets of gender responsiveness that rely on adherence to strict gendered norms (Horan 2010). Pathways theory is a positive step towards providing women in prison support that speaks to their needs, however, some commentators have noted that the paradigm is still one of correctional management rather than an alternative that may suit the needs of women more effectively (Hannah-Moffat, 2010).

Addiction theory and trauma theory are not able to form a framework for understanding women's offending individually. However they can be used in conjunction with Pathways theory that describes some of the challenges faced by women who are trauma affected and turn to alcohol and/or drugs to self medicate.

From an epistemological point of view the tension regarding both the "gender neutral" and the "gender-specific" debate is that while the PIC-R has been tested over many years, and thus has empirical, statistical weight, the small sample size that female offenders represent means that research on that population has tended to be qualitative and where statistically analysed, results have not been robust. Of the evidence base attempting to demonstrate a difference in women's offending trajectories compared to men, Salisbury noted that there is considerable debate between the "what-works" and "gender-responsive" scholars when it comes to women's risk and needs and that both the risk and need principles have yet to be firmly established with female offender populations.

Perspectives on Rehabilitation

The field of research on rehabilitation for female offenders is characterized by debates about the most effective ways to deal with multiple forms of disadvantage. For most involved in this debate, the notion that women's offending patterns and risks for re-offending and rehabilitation needs are different to men's is the point of departure (K. Blanchette & Brown, 2006). What is at stake is the need to reduce recidivism and how that might best be achieved through rehabilitation. Three theories of rehabilitation are presented below: Risk-Needs-Responsivity, Gender Responsive Framework and Good Lives Model.

Risk-needs-responsivity

The risk-needs-responsivity (herein RNR) model of offender rehabilitation, takes as its central idea, that offender treatment can reduce recidivism when it is directly targeted at criminogenic factors[28] (Andrews & Bonta 2003). The theoretical framework is one of risk assessment and risk management and is operationalised via a classification system that calculates each offender's risk 'score' based on actuarial measures (Holtfreter & Cupp, 2007)of dynamic and static risk factors[29].

Dynamic risk factors (such as drug use) are open to rehabilitative efforts and static risk factors (such as past criminal convictions) are not open to be changed. Actuarial risk assessments are considered more accurate predictors than clinical assessments

Risks (of misconduct and recidivism)

Risk factors are comprised of static (unchanging) and dynamic risk factors, which when changed, are associated with shifts in criminal conduct (also considered criminogenic needs). Risks measures have been identified through data collection using cross-sectional research, uniwave longitudinal research and multiwave longitudinal research on offenders and their behaviour patterns (Andrews, Bonta, & Hoge, 1990). The findings are used to create the actuarial risk measures that can be used to predict offenders' likelihood of re-offending and treatment needs. This is done through the use of the assessment tool, the Level of Services Inventory Revised (LSI-R). For example a study may indicate that anti-social attitudes are always present in relation to violent crimes. Anti-social attitudes then become a measure of recidivism and are considered a risk. Measuring dangerous behaviour, past violent acts and psychopathy as well as other variables occurs through psychological assessment tools.

The risk assessment tools are based on the predictive factors (identified through both longitudinal and retrospective studies) that are known about a specific population, in this case, male offenders (M. Mitchell, 2005). There is significant debate about the predictive factors for women. These are not as clear due to the relatively recent interest in female inmates and the lack of research in this area (P. Easteal, 2001; Hardyman & Van Voorhis, 2004; M. Mitchell, 2005). Risk, in this context, has been validated for men, however it has not been successfully validated for women. The implications of this for the resonance of the RNR approach are not clear. There is a growing understanding the risk is gendered (Hannah-Moffat & Shaw, 2001) and that the greatest risk for women in prison is not for escape or violent misconduct (as it is for men), but is related to self-harm and suicide. The studies presented below demonstrate that LSI-R may not be not be appropriate for determining women offenders' risk of re-offending.

[28]Criminogenic factors are dynamic and static risk factors related to offending behaviour. Dynamic and static risk factors are defined above.

[29] Actuarial measures are predictive factors for offending based on quantitative statistical assessments rather than clinical or manual assessments.

Holtfreter and Cupp (2007) looked at the empirical research on risk assessment tools for female offenders that has been published over the last 20 years. Their meta-analysis indicated a number of concerns with the use of RNR classification tools for women. These included:

- Sample sizes varied and women remain under represented in samples;
- A number of studies included questionable external validity, for example a few of the studies were conducted on specific populations by design (i.e. Native American) which may not be generalizable to female offenders;
- The measures for recidivism in many studies varied from any new offences through to re-incarceration;
- Women's risk (of recidivism) scores were lower than men's but women's risk was not being measured correctly;
- LSI-R was more accurate for men than women except when women's offending resembled men's (one study indicated embezzlement for women was not related to poverty nor abuse histories); and
- Many of the studies concluded that RNR worked for women even when they had not tested it on subgroups (i.e. women) or the study populations were made up of 92% men

Holtfreter & Cupp (2007) concluded that more research is required to more accurately understand the predictors for female offenders.

Davidson and Chesney-Lind (2009) used quantitative and qualitative methods in an attempt to assess the usefulness of risk assessment instruments in determining risk level and program provision to successfully rehabilitate female offenders. In-depth interviews revealed "the gendered links among physical and sexual abuse, drugs, and crime" which are missed by a risk and needs assessment (Davidson & Chesney-Lind, 2009). They conclude that female offenders do not seem to fit into an "otherwise seemingly objective method of assessment" (Davidson & Chesney-Lind, 2009, p. 221). Reisig, Holtfreter and Morash (2006) found in their study that risk assessment tools "misclassif[y] a significant portion of socially and economically marginalized women with gendered offending contexts" (Reisig et al., 2006, p. 384).

Hardyman and Van Voorhis (2004) indicated women's victimization histories, mental health issues, poverty and gendered health needs played an important role in offending and must be operationalised for the purposes of risk assessment (pg. ix). Van Voorhis et al (n.d.) who studied the validity of measures in the Level of Service Inventory-Revised (LSI-R) for paroled women, concludes that "a combination of gender neutral and gender-responsive items make up the optimum prediction of offender recidivism" (Van Voorhis, Salisbury, Bauman, & Wright, n.d.).

Hollinger et al (2003) found in their study that the risk/needs assessment criteria applied to a population of female prisoners indicated that women tend to score higher on financial and emotional/personal domains. The study concludes that the risk/needs inventory when applied to minority groups, for instance ethnic groups or female prisoners may lack validity (Holsinger, Lowenkamp, & Latessa, 2003). In other words, the system may not actually be measuring risk accurately for minority groups due to the instrument having been designed for the majority group (male offenders). Or more accurately, claims that the RNR framework is gender neutral are unlikely as "the bulk of research used to support claims of gender neutrality is based on males" (Holtfreter & Cupp, 2007, p. 363)

Harer and Langan (2001) conducted a study of 24,000 female and 177,000 male prisoners. They found that violent offences committed by women could not be predicted by the current risk assessment tools because they are based on actuarial measures of men's predictive factors for

violence. They argued that there need to be "correctional policies requiring separate classification systems for men and women" which reflect the lower risk of predicted violence perpetrated by female offenders. The transferability of this finding to the Australian context may be limited; the need for separate classification systems for men and women has been recognised and implemented in several jurisdictions (including NSW)

The evidence base on the usefulness of RNR for the rehabilitation of female offenders challenges the notion that "male or female, black or white, the predictive criterion validity of assessments of major risk factors will be evident in a variety of contexts" (Andrews et al., 2006, p. 16).

Need

If the risk principle refers to the potential for re-offending, the need principle relates to the identification of where to target rehabilitation efforts to reduce that potential. The need principle seeks to determine which behaviour or attitude (anti-social attitude, drug addiction, violent outbursts) requires a cognitive shift. For RNR, needs are related to the offence committed and are therefore called criminogenic needs (Bonta & Andrews, 2007). Need can also refer level of educational attainment, employment history, debt and financial issues, and housing instability.

This system may very well work for male offenders. However it may mean that female offenders with the greatest need for support services related to sexual violence, family disconnection and exploitative relationships participate in programs which do not suit their actual risk nor meet their actual needs. Bonta and Andrews (2007) state that "Offenders have many needs deserving of treatment but not all of these needs are associated with their criminal behaviour" (Bonta & Andrews, 2007, p. 5). This is where the disjuncture occurs between RNR and a more gendered understanding of female offenders. However, research findings regarding what constitutes risk and/or need for women are unclear. Interpretation of the results or their implications are also unclear. There can sometimes be a tendency to see the hypothesis being posed as if gender predicts offending, or child sexual abuse predicts offending. But, as the work of Salisbury and Van Voorhis shows, the question is rather how factors such as child sexual abuse are correlated with mental health, drug use, and subsequently how are these relate to offending. While CSA may appear distal, as the chapter on trauma showed, CSA has a complex, and enduring relationship with many adverse behaviours (many of which are considered relevant for offending).

A number of studies indicate that female offenders' needs requiring rehabilitative intervention may be very different to men's. For example Shearer (2003) states that "female substance abusers experience different types of mental health problems than males" (Shearer, 2003, p. 46) and therefore require different treatment modalities. Shearer goes on to say that women's substance abuse is usually tied to a traumatic history such as sexual abuse.

The importance of framing a sexual abuse history as a need for female offenders is echoed by Sorbello, Eccleston, Ward & Jones (2002). They conducted a review on the treatment needs of female offenders and found that for women inmates, the treatment of non-criminogenic needs can be relevant within the prison system. This is because issues such as a history of child sexual abuse and adult sexual abuse "often lie at the core of why women offend" (Sorbello, Eccleston, Ward, & Jones, 2002, p. 199). Again, this indicates a gendered facet to 'needs' that is ignored in dominant frameworks like RNR. Lowenkamp, Holsinger and Latessa (2001) add that even if an abuse history is not directly operationalised as a risk/need "it is quite possible that a history of abuse may have implications for the style and mode of the delivery of correctional treatment" (p. 548).

Additionally, in treating the substance abuse issues for women in prison, it has been suggested that self esteem, depression and the need for positive relationship modelling are important factors to address (Langan & Pelissier, 2001). Parenting skills are also important for women and not frequently addressed in male programs (Shearer, 2003), in which case it would addressed through the responsivity component.

Those researching women's offending argue that in not addressing women's specific needs, the RNR model fails to capture some of the nuanced gender specific needs related to women's offending pathways and rehabilitation needs. According to Easteal (2001) this lack of fit between the system and the inmates can lead to women prisoners acting out or developing further behavioural problems that draw greater risk classifications which in turn exacerbate needs rather than address them.

Responsivity

The responsivity principle relates to how the treatment should be delivered. As the name suggests, this principle determines how the therapist delivering the treatment responds to the learning style and personality of the offender. The responsivity factor has two branches; specific and general. This is not a very comprehensively developed component of the model, however it remains the component used to defend against claims of gender neutrality (outlined in the 'Risks' section above). General responsivity refers to "the use of cognitive social learning methods to influence behaviour". Specific responsivity is the component that attends to the unique needs of the individual, such as learning styles and general personality. It is also claimed to respond to gender, race and other unique individual traits (McDaniels-Wilson & Belknap, 2008). However, as demonstrated above, many researchers question the validity of the measures as they apply to women, hence the responsivity principle may also require more gender specific consideration (Davidson & Chesney-Lind, 2009; Holtfreter & Cupp, 2007).

In fact there is very little evidence that RNR is suitable for the classification, and therefore rehabilitation, of female offenders. Even meta-analysis conducted by the authors of the theory that look to identify what works for female offenders includes the caveat that "it did not look at gender as a specific responsivity consideration" (Dowden & Andrews, 1999, pp. 449-450).

Gender Responsive Rehabilitation

The Gender Responsive Framework (GRF) for the rehabilitation of female offenders is a direct response to the growing number of women in correctional settings and seeks to address "the realities of women's lives through gender-responsive policy and programs…[that are]…fundamental to improved outcomes at all criminal justice phases" (Covington & Bloom, 2004, p. 3). GRF, just like RNR, is more than just an approach to rehabilitation. However, it is not a treatment model in the way RNR is. It is a framework that informs management ideology. By making the female gender the focus, the policies and practices that flow from that ideology underpin how prisoners are treated, how staff are trained and how programs are administered. The major principles of GRF are:

- Recognise that men and women require different penal policies and environments – criminal conduct is gendered;
- Respect and safety are key to women's program readiness;
- Acknowledge women's relational needs and recognise the need for women to create healthy and respectful relationships;
- Programs that address substance abuse, trauma and mental health can be achieved through collaboration and integrating services;

- Design programs to address socioeconomic disadvantage; and
- Create transitional pathways with collaborative services.(Covington & Bloom, 2004)

These principles acknowledge that the successful rehabilitation of women in prison depends on more than just a focus on individual pathology. The framework takes into account the "structural and social causes of crime" (Covington & Bloom, 2004, p. 2) and seeks to acknowledge the complexity of addressing female offending and rehabilitation. This includes the knowledge that many women within the prison complex are victim/survivors of sexual and physical violence (Covington & Bloom, 2004; P. Easteal, 2001).

A study conducted in Maui, by Van Voorhis and colleagues (2008) was designed to test the use of gendered risk items within the RNR framework. They maintained the traditional list of risk factors in the RNR classification tool, but also added female gendered risk items to the list. They were trying to assess whether building a bridge between RNR and GRF would create a risk classification tool that would more accurately predict female prisoner's risk classification score for prison misconduct and re-offending.[30] The study was conducted with approximately 200 female offenders. The instruments used for data collection were:

A "Face Sheet" which is a 29 item interview "designed to capture important information on women's criminal and psychosocial history, as well as their general demographic, economic and medical characteristics" (Van Voorhis et al., n.d., p. 29).

The Level of Service Inventory-Revised (LSI-R) that identifies dynamic risk and need (criminogenic factors).

A Self-Report Supplementary Survey was also used. The Self-Report component tries to get at that data which is not traditionally included in the LSI-R, such as:

- Child abuse
- Adult physical and emotional abuse
- Relationship dysfunction
- Parental stress

The scales that were found to be effective in identifying additional dynamic risk factors when tested on female probationers in Missouri in another study by Van Voorhis et al. (n.d), were also included in the Self-Report Supplementary Survey. These are:

- Mental health history
- Symptoms of depression
- Poverty
- Housing safety
- Anger
- Family conflict
- Family support
- Educational strengths (Van Voorhis et al., n.d.)

This research found that gender-specific factors are predictive of women's offending. In the case of institutional settings these are: "child-abuse, loss of personal power in relationships, family

[30] Note that LSI-R is generally not used to make security classifications in Australia.

support, parental stress, family conflict and current symptoms of depression and psychosis" (Van Voorhis et al., 2008, p. 14). Traditional predictors are relevant to women's reoffending with the most salient of these for women being drug and alcohol use, mental health issues, accommodation, education, employment and economic concerns. Although the factors such as self-esteem and self-efficacy are not considered criminogenic, it may assist in creating readiness in female offenders to deal with their offence behaviour if they are also supported in "self-esteem, self-efficacy, family and relationship support, and financial and educational assets" (Van Voorhis et al., 2008, p. 14)

The physical environment of a prison setting effects those most strongly who have a history of child sexual abuse and mental health issues (Van Voorhis et al., 2008). This supports Easteal's (2001) work with women in prison settings who identified the environment as re-traumatising, particularly around the use of strip-searches, high security settings, and the inability to secure support services related to physical and mental health needs.

Van Voorhis et al (2008) conclude that there are gendered risk factors and gendered protective factors for women's misconduct and recidivism and that a combination of gender-neutral (RNR) and gender-responsive (GRF) items make up the optimum prediction of offender recidivism (Van Voorhis et al 2008).

Table 4 Risk and protective factors for women's recidivism

RISK FACTORS FOR MISCONDUCT AND RECIDIVISM FOR FEMALE OFFENDERS	PROTECTIVE FACTORS AGAINST MISCONDUCT AND RECIDIVISM FOR FEMALE OFFENDERS
Poverty, un/der employment, lack of education and homelessness	Family support
Substance abuse	Education
Antisocial associates	Self-esteem
Parental stress	Self-efficacy

(Van Voorhis et al., n.d., p. 64)

Female offenders' ability to complete programs was also tackled by Martin, Kautt and Gelsthorpe (2009) who used a multivariate statistical technique to determine why female prisoners were not completing general offender programs.

Their hypothesis that men's and women's compliance predictors will vary quite significantly was reflected in the findings (J. Martin, P. Kautt, & L. Gelsthorpe, 2009). In their study of 1064 female and 10228 male offenders, they found that the greater the number of general offender programs women attempted, the less compliance in completion they demonstrated (J. Martin et al., 2009). They conclude that women's compliance with programs is normative, meaning that "the offender's investment in the programme and its goals as well as her belief in the legitimacy of the sentencing authority" is a motivating factor (J. Martin et al., 2009, p. 882). So we have a gendered understanding of women as relational as well as having a normative response to authority. Further, Dowden and Andrews (1998) found that women responded most positively to programs that targeted families and relationships. It was these programs that had an effect on reducing female offenders' recidivism.

Limitations to consider

A gender responsive framework is another step in a process towards acknowledging women as qualitatively different to men in both their offending behaviour and their responsiveness to rehabilitative interventions. However there are also inherent limitations in a Gender Responsive Framework. Hannah-Moffat (2010) provides a discussion on these limitations in her work on

female offenders. She writes that there is the danger of essentialising women within this framework and that "gender responsive penality is situated within a narrow politics of difference" (Hannah-Moffat, 2010, p. 193). This is also a criticism levelled at the use of relational theory. It is dangerous to assume that a Gender Responsive Framework is the be all and end all of policy change required in women's prisons. It is important to understand women's diversity by acknowledging the intersectionality of gender with other forms of oppression, such as race, class, religion and sexuality (Hannah-Moffat, 2010).

Another limitation of GRF speaks to the needs of transgender and non-gender conformist people who may be discriminated against by the facets of gender responsiveness that rely on adherence to strict gendered norms (Horan 2010).

GRF is a positive step towards providing women in prison support that speaks to their needs, however, it has been noted that the paradigm is still one of correctional management rather than an alternative that may suit the needs of women more effectively (Hannah-Moffat, 2010).

The evidence presented is based on small samples, however, there is reason for concluding that women's participation and completion of programs (and therefore recidivism) may be heavily influenced by their specific needs as women. By providing gender relevant programming, gender-specific staff training and a more secure and nurturing environment, women's motivation to complete general offender programs that reduce recidivism, may be heightened. By offering programs that target women's needs, based on relational theory of female psychological development, means greater readiness and motivation by female offenders to complete programs. Further research in this area is needed to test these specific hypotheses.

Although GRF incorporates Trauma Theory as a component, gender is the main focus. In Section 2 of this report, we will consider the application of Trauma Theory that contains a component of gender as an alternative approach. This approach might best be conceptualised as a Trauma-Informed ideology.

Good Lives Model (GLM)

The Good Lives Model (GLM) of rehabilitation is a theory of positive psychology (Ward & Brown 2004). The theory was formulated as a corrective to the risk focus of RNR. This means that where the RNR system seeks to identify risk and treat it, the Good Lives Model seeks to identify strengths and enhance them. A brief look at the basic critique of RNR by the proponents of GLM makes clear the ideological differences between the two theories (Table 5).

Table 5 Comparison of RNR and GLM by Ward et al.

RISK-NEEDS-RESPONSIVITY	GOOD LIVES MODEL
Motivating offenders by concentrating on transgressive behaviour	Motivating offenders by concentrating on their strengths and how to build a better life by desisting from crime
Deprioritises the role of narrative identity and agency in the process of change	Prioritises agency and encourages the viewing of oneself as achieving positive change
Obsolete view of human nature	Belief that people seek out meaningful and fulfilling lives
Ignores the need for a therapeutic alliance and the need to clinically target self-esteem and personal distress	A sound therapeutic alliance means engaging with human issues that are not criminogenic, such as self-esteem and personal distress.
Psychometric tool that seeks to identify offender risk profiles and traits	Seeks to identify offender as "embedded in various social and cultural systems that facilitate and constrain their behaviour" (T. Ward, Collie, & Bourke, 2009, p. 303)
One-size-fits all paradigm (claims of universality while claiming to be responsive to individual traits)	The GLM can be customised to identify the strengths of each individual and is therefore responsive to individual needs.

The theory of positive psychology for offenders comes from the belief that deficit based models (which identify the 'bad' behaviour for correction) have little long term impact, whereas positive psychology (related to resilience and capacity building) imply a long term benefit (Yates & Masten, 2004). Ward and Brown argue that "the management of risk is a necessary but not sufficient condition for the rehabilitation of offenders" (T Ward & Brown, 2004, p. 244). They consider this a conceptual issue around the best way to reduce recidivism.

The Good Lives Model is also about the realities of the therapeutic alliance and how to equip offenders with the ability to psychologically deal with any obstacles they encounter when they are released. Although not a gender specific theory of rehabilitation, it takes as central, the requirement to treat the unique needs of offenders based on the strengths they require for well-being. This is achieved through a consultation and case management approach for each offender.

The theory is based on the idea that enhancing primary human goods[31] will give offenders the tools they need to combat the psychological and material conditions that led to offending. This is done by attending to the internal (psychological) and external (material) obstacles to achieving the primary goods associated with a fulfilling and productive life, free from crime. Humans strive to make their lives meaningful; therefore all human action is a function of the achievement of primary goods. "Primary goods emerge out of basic needs while instrumental or secondary goods provide concrete ways of securing those goods" (T Ward & Brown, 2004, p. 246).

For offenders, primary human goods are also the goal, the problem according to Lindsay et al (2007) is that offenders use distorted thinking to achieve these goals, which they pursue through anti-social behaviour. It is also possible that the offender lacks the skills and aptitude to attain human primary goods in ways other than criminally. A GLM of rehabilitation would seek to "construct a balanced, prosocial personal identity in offenders" (Lindsay, Ward, Morgan, & Wilson, 2007, p. 39) and to teach the skills and aptitude required to live a crime free life. The motivation for change is a significant aspect of this theoretical model of rehabilitation. The motivation of the offender toward distorted and criminal behaviour within this model is explained by their criminogenic needs and dynamic risk factors (for example, anti-social attitudes, anti-social associates). The GLM helps them to construct prosocial primary human goods goals by identifying the prosocial pathways to these goals and how their identity can be defined by the prosocial, while encouraging supports from organisations, programs, friends and family to act as external motivators toward their adaptive functioning (Lindsay et al., 2007).

The point is to make the journey of rehabilitation result in a positive outcome by way of the setting of realistic goals. Concentrating on one primary good is suggested (T Ward & Brown, 2004). The achievement of this in addition to attention paid to the risk for re-offending (offending programs) creates a holistic and strengths based approach to offender rehabilitation which views dynamic risk factors as "distortions in the internal and external conditions required for the acquisition of human good" (T Ward & Brown, 2004, p. 244).

The GLM has been used predominately for the rehabilitation of sex offenders (Lindsay et al., 2007). This does not diminish the capacity of the theory to be conceptualised as a process through which female offenders can be rehabilitated.

The danger with GLM is that it can be used to only focus on the individual rather than on the social processes that lead people to offending. However, the positive psychology approach is in line with positive reinforcement, rather than negative reinforcement and there is a consideration of both internal and external factors for desistance that should give equal weight to internal

[31] Primary human goods are "actions, states of affairs, characteristics, experiences and states of mind" (T Ward & Brown, 2004, p. 246) that are not particularly related to instrumental goals, but are an end in themselves.

psychology and external social conditions. As GLM is a broad approach to rehabilitation, it is important to make explicit, how it could be operationalised in a prison environment for the rehabilitation of female offenders. This operationalisation has not yet been carried out, and a program would need to be designed specifically for female offenders with GLM as the theoretical framework.

Table 6 How the different theories correspond

THEORY OF OFFENDING	THEORY OF REHABILITATION
Relational theory	Gender responsive
Psychology of criminal conduct	Risk-needs-responsivity
Personal, interpersonal, community-reinforcement theory	Risk-needs-responsivity
Pathways theory	Gender responsive & Good lives model
Trauma theory	Gender responsive
Addiction theory	Gender responsive
Social learning theory	Gender responsive & Risk-needs-responsivity

The presentation of the issues outlined so far leads to some emerging tensions. The Risk-Needs-Responsivity (RNR) model and the Gender Responsive Framework (GRF) model are very different concepts and their application would most certainly indicate different outcomes. The studies conducted in Maui and Minnesota (Van Voorhis et al., n.d.; Van Voorhis et al., 2008), which evaluated the incorporation of elements from both frameworks into the classification and rehabilitation of women prisoners, offers a bridge between RNR and GRF.

4 Addressing women's victimisation histories in correctional settings: Issues and approaches

Compared to the research base on women's offending pathways and rehabilitation needs, the research on best practice in supporting women with their trauma histories in correctional settings is limited. There is even less accessible information about the approaches correctional systems themselves are taking. In reviewing the literature it became apparent that there are a number of challenges in provided trauma support within these settings. These include: the coercive nature of the prison environment; the retraumatising impact of certain operational practices; and the high cycling of women through the criminal justice system.

Beyond these challenges, there is also the underlying tension about, on the one hand, the extent to which the penal system should be a therapeutic agent (e.g. Baldry, 2009), and on the other, the reality that women offenders have high rates of victimisation and enter the prison environment with significant trauma needs. Indeed, the reality is that sexual victimisation appears to be central to women's pathways into the criminal justice system. Despite the difficult questions about the role of the penal system, there remains an imperative to consider the ways in which this system can support healing and recovery for women offenders.

This chapter discusses:

- The challenges identified in the literature in supporting women with their trauma histories; and
- Approaches being used in Australia and internationally to support women offenders with their trauma histories.

Key challenges in addressing trauma in correctional settings

Challenge 1: The prison environment

The ability of prisons to respond effectively to women's sexual assault histories is restricted by the nature of the prison environment, which is based upon an ethos of power, control and surveillance (Bloom, Owen & Covington, 2003) – often for the purpose of maintaining security as well as punishment. Moloney & Moller (2009, p. 432) support this point, arguing that "punitive penal systems based on male norms routinely uphold institutionalized values of containment and subordination" (see also Easteal, 2001, p.92). Yet prison can also function as a time of respite for some women offenders. The following section discusses the key issues that affect the practicality and safety of addressing sexual abuse trauma in an institutional environment like prison.

Many current operating principles of prisons are in direct conflict with the needs of victim/survivors of sexual assault, as well as in conflict with women's broader health, well-being and treatment needs (Bloom et al, 2003). For example, while regaining a sense control over one's life is considered fundamental to healing from sexual abuse by dominant therapeutic frameworks, prisons typically reduce women's autonomy and can recreate the dynamics of abusive relationships (Bloom et al., 2003; Covington & Bloom, 2006; Covington et al., 2008; Dirks, 2004; Pollack & Brezina, 2006).

Disclosure and Safety

Exposing vulnerabilities, such as sexual abuse, within an environment that is hostile to healing may be at odds to prisoners' personal safety needs (Pollack & Brezina, 2006). For example, there

are issues with disclosing sexual abuse to authorities who may not be considered trustworthy from the perspective of the women, particularly because of negative encounters with them in the past. Similarly, the use of group therapy approaches can be particularly problematic in a prison setting, as group therapy requires a safe and trusting environment. Yet other inmates can use information within the prison system as currency, and information pertaining to traumatic experiences may be used against the inmate at a later point in time. As Pollock notes, "in a prison environment, trusting other women with such information…is extremely problematic" as the "prison subculture of non-disclosure and lack of trust" (1998, p. 100) is in tension with the desired dynamics of group therapy. Thus, disclosure of traumatic experiences such as sexual assault in a prison environment may directly impact the safety and well-being of an inmate during their period of incarceration.

In seeking to assist women from CALD backgrounds, attention needs to be paid to the importance of professional interpreters (Allimant & Ostapiej-Piatkowski, 2011). The use of other prisoners to interpret creates barriers for disclosing and does not attend to language issues effectively (Allimant & Ostapiej-Piatkowski, 2011). Information within prisons can be used as currency and therefore a disclosure of sexual assault carries a high level of risk and retraumatisation.

This suggests that the open discussion of traumatic experiences is not always appropriate for women in prison. Consequently, it may be argued that providing a means of creating a safe and supportive prison environment may be a more appropriate strategy for addressing issues associated with having a history of sexual assault. This is commonly referred to as "trauma-informed" practice and policy (Covington & Bloom, 2006). Covington and Bloom define trauma-informed practice as practices that:

> Take the trauma into account; avoid triggering trauma reactions and/or retraumatising the individual; adjust the behaviour of counsellors, other staff, and the organization to support the individuals' coping capacity. (2006, p. 17)

Pollack and Brezina (2006) provide an additional criterion for trauma-informed practice, suggesting that women be able to participate in their own treatment plans – that is, that women should be afforded autonomy over their therapeutic experience/s. This may be achieved, for example, by allowing women prisoners to determine what aspects of their discussions in one-on-one counselling will be officially recorded (Pollack & Brezina, 2006, p.127), thus ensuring a level of control over who in the prison community has knowledge of specific traumatic experiences, and reducing the power dynamics between prisoner and staff (Pollack & Brezina, 2006).

Covington and Bloom (2006) argue that it is imperative for the criminal justice system broadly to ensure their practices and procedures are trauma informed. This is particularly so for women's prisons where, as documented earlier, the overwhelming majority of prisoners have a history sexual and other abuse. Within the prison environment, standard procedures provide a lucid example of the re-traumatising nature of the prison environment and culture (Covington & Bloom, 2006). These procedures may be considered to be sexually abusive (Covington & Bloom, 2006) and place women, particularly victim/survivors of sexual assault, at risk of further trauma. Examples of these procedures include strip searches (Sisters Inside, 2004), pat searches (Moloney et al., 2009), surveillance by male staff (Pollack & Brezina, 2006), and by staff controlling sexual access to their intimate inmate partners (Blackburn et al., 2008).

Whose needs?

The prison (broadly as an institution) has been designed with male prisoners and their behaviour(s) in mind (Moloney et al, 2009). Many "standard" procedures are based upon the

actions of, and risks posed by, male prisoners. Given that female prisoners are, overall, less violent, pose less of a risk to safety, and are designated as high need (ABS, 2004; Salomone, 2004), it is questionable as to whether many of these operating practices are in fact necessary or appropriate in a women's prison.

It is also worth noting here that due to the relatively small number of women prisoners (in comparison to their male counterparts) "the lack of multiple facilities often makes the question on housing assignments moot" (Bloom et al, 2003, p.19), as only higher security facilities are available (see also ABS, 2004). This inappropriate assessment of risk, or lack of appropriate security-level facilities, and consequent placement of women in high security settings is particularly problematic for women with sexual abuse histories. It results in them being exposed to practices, which aim to monitor and control the behaviour of inmates, in order to manage and reduce their perceived risk and this risks re-creating abuse dynamics.

Challenge 2: Re-traumatising practices

The use of strip searches in prison provides a key example of a re-traumatising practice (Easteal, 2001; Covington & Bloom, 2006) that can be addressed through policy and institutional change. Strip searches are broadly considered as constituting a sexually abusive and re-traumatising practice within current literature. That is, they are (or can be) a form of sexual abuse in and of themselves, and/or may serve to reproduce or cause women to "relive" past experiences of sexual and physical abuse. For example, a female prisoner and sexual assault victim/survivor cited in Pereira (2001, p. 188) describes her experience of prison strip-searches "as similar to sexual assault. I felt the same helplessness, the same abuse by a male in authority, the same sense of degradation and lack of escape". This suggests that strip-searches reproduce the dynamics of sexual assault (Pereira, 2001; Pollack & Brezina, 2006). Consequently, strip-searches can be re-traumatising, and have been linked to post-traumatic stress disorder, none of which is conducive to women successfully engaging in therapeutic work (Pereira, 2001, p.188).

International and domestic studies indicate the use of strip-searching in prisons is not able to fulfil its function as a security process (Aretxana, 2001; Cerveri et al., 2005; Fergus & Keel, 2005; Penfold, Turnbull, & Webster, 2005). This is because the detection rate from strip-searches remains exceedingly low (Penfold et al., 2005). It is also difficult to argue that strip-searching is an effective penal policy as it is re-traumatising and violating particularly for women with a sexual abuse history (P. Easteal, 2001). A balance can be struck between the need to maintain a drug and weapon free prison population and implementing trauma-informed processes and procedures (S. S. Covington & B. E. Bloom, 2004; Penfold et al., 2005).

Consequently, it may be appropriate to cease the use of strip searches in women's prisons – particularly given their limited success in uncovering contraband items, which is used to justify the practice (Easteal, 2001:106). As Wybron and Dicker (2009, p. 16) note, of the 41,728 strip searches conducted at the Brisbane Women's Correctional Centre between 1999-2002, only 2 searchers uncovered any significant contraband. In Victoria at the Dame Phyllis Frost Centre in 2001-2002, of the nearly 18,900 strip searches, only one item of contraband was detected (Cerveri et al., 2005; Fergus & Keel, 2005). That is an extremely low 0.005% detection rate. At Barwon Prison in the same time period, from the 12,893 strip-searches completed, only 21 items were found (Cerveri et al., 2005). Again, a low detection rate of 0.16% indicates that strip searches are not able to fulfil their security imperatives. Further, a qualitative study carried out in six UK prisons found that prison staff (both uniform and plain clothes) were nominated by other prison staff and prisoners a likely pathway for drugs into prison (Penfold et al., 2005).

Alternatively, the search process may be modified to reduce exposure, for instance by having the woman remove only half of her clothing at any given time. Others have suggested that the use of

same sex guards to conduct the searches may reduce their traumatic nature. However, some women prisoners in Estela's (2001) study indicated that they in fact *preferred* to be strip-searched by male guards, and were concerned about the "sexual motivation" of the female guards in conducting the searches. These comments suggest that same-sex strip searches do not necessarily reduce the traumatic nature of this practice. Further, while gendered power relations may be reduced through the use of a same-sex guard, the relationship between the guard and prisoner is a hierarchical one regardless of gender (Wybron & Dicker, 2009). Together this research suggests that overcoming the trauma and disempowerment by moderating the procedure used is limited, particularly for victim/survivors, and it is preferable to cease and replace re-traumatising practices.

Box 2 Alternatives to strip-search

A Home Office report on tackling drug markets in prisons recommended the following measures:

- Passive drug dogs
- X-ray machines
- Closed circuit television
- Good staff (Penfold, Turnball & Webster, 2005)

Recommendations also included clearly and frequently communicating the penalties of drug trafficking and use in prison. This extends to family and friends who visit inmates (Penfold et al., 2005). However caution should be observed in the style of communication utilized to transmit this message.

The recommendations concerning the use of x-ray machines have been introduced in ACT Corrections. The Women in Prison Advocacy Network (WIPAN) released a report indicating that x-ray machines are less intrusive and re-traumatising. They are also thought to be safe as they release only a low dose of radiation (Bogdanic, n.d.) However caution would need to be paid when considering pregnant inmates. A study conducted in the US as far back as 1985 attests to the safety and efficacy of x-ray machines in detecting contraband in prisons (Sexton, 1985).

Challenge 3: Cycling through prison

Another key challenge in addressing women's experiences of sexual victimization in a prison setting relates to the often short-term or transitory nature of women's time in prison. As described in Chapter 2, a significant proportion of women prisoners are on remand. Research by Baldry and colleagues (2009) found that women had a higher rate of custodial episodes per year compared to men and that these were of shorter duration. The researchers concluded that there was a greater "rate of cycling in and out of prison", particularly for women with complex needs (Baldry et al., 2009). This raises a number of issues. First, it is questionable as to whether any meaningful therapy can be undertaken in short timeframes. Further, many women may enter prison on remand, and will thus be housed in (generally) high security settings for a short period of time, without access to the therapeutic programs available to convicted prisoners, and once their case is heard, might simply be released with time served. Finally, high frequency cycling into and out of prison can increase feelings of uncertainty and instability in relation to housing, childcare, and family connections. Entry into the prison environment itself is disorienting whether through the distress or aggression of others, or due to withdrawal from drugs.

Similarly, mental health crises, episodes of self-harm, suicide attempts and violent outbursts can also heighten feelings of distress and uncertainty. In addition, as the previous chapter noted, substance use is a way of dissociating from traumatic memories. Detoxification can mean the unwelcome and uncontained intrusion of these memories (in Plugge, Douglas, & Fitzpatrick, 2006, p. 57).

The point here is not that remand presents practical impediments to supporting women with their trauma needs in terms of service provision, but that the transition into and out of remand is a time of extreme disequilibrium and to that end a time of significant unsafety and retraumatisation for women.

Is the provision of trauma support possible within prison?

Given these challenges, is it possible to provide trauma support within correctional settings, and if so, how should this be done? Some authors (Pollack & Brezina, 2006; Baldry, 2008) have gone so far as to suggest that engaging in meaningful therapy or treatment for *any* issue – whether it be sexual abuse history/trauma, mental health issues or substance abuse – is virtually impossible in a prison setting, as prison:

> Is not and cannot be, a therapeutic community; it cannot serve both punishment and therapeutic purposes because they are antithetical and prison's primary focus is security not therapy. Prison by its very nature, excludes normal society, promotes prison living skills and actively erodes community living skills.(Baldry, 2008, p. 9)

Having said this, it is important to note that, whatever the philosophical mismatch noted by Baldry, prison can provide stability and respite for female offenders, many of whom come to prison with significantly poor health (when compared to the general population). Although the prison environment is in many ways extremely detrimental to women with sexual abuse histories it is nonetheless a relatively stable environment that presents an opportunity to engage women in therapy. UK research with women in prison identified both positive and negative ways in which prison impacted their health (Plugge et al., 2006).[32] Over a three-month period following reception into prison, women's health status (subjectively measured) improved.[33] The level of drug use decreased, and they were much more likely to have accessed drug and alcohol services (from 9.3% before prison to 47.2% after three months). A number of women in this study who had drug abuse histories noted real improvements to their health and general functioning. Tongeren & Klebe suggested that "some women have found prison to be more stable and safer than their lives before incarceration"(2010:50), suggesting that women may be successfully engaged in treatment and counselling within a prison environment.

However, it is also crucial to remember that establishing and maintaining safety is the first and fundamental aspect of trauma recovery. The possible stability that prison can provide is only ever a) temporary and b) artificial. As one women stated: "Personally, I see prison as a false environment. You haven't got nothing to worry about in here" (Plugge et al., 2006, p. 50). The stress of obtaining drugs, housing, dealing with police and court cases are temporarily abated. Thus, a window of opportunity becomes present, and women prisoners have, in overseas studies, nominated "programming aimed at repairing and recovering from trauma…as one of their most important programming needs"(Dirks, 2004, p. 109). The question is how to best do this in light of the challenges discussed above and the literature on trauma and recovery, which suggests that it would be extremely risky to begin any deep therapeutic work in a prison setting.

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[32] This research involved 505 women recruited from two remand centres in England. Interviews were conducted at three points in time. By time three (three months), 112 of the remaining 120 women participated.

[33] The authors note that this was the case only for those women who used drugs prior to coming to prison. Nevertheless, three quarters of the sample fell into this category.

Further, programs dedicated to dealing with family violence and sexual assault are designed with English speaking populations in mind, and therefore are not always available to CALD women in prison. This is a population who encounter barriers to accessing information and services within prisons. US research has suggested that the operational environment creates further barriers by ignoring the needs of CALD women prisoners and therefore becomes an agent of discrimination (Hannah-Moffat, 2010). Work and education programs that are culturally specific need to be offered in order that CALD women can also break out of the cycle of offending (Covington & Bloom 2004).

The following sections identify the key approaches and strategies that have been implemented or have promise.

Addressing women's trauma histories in correctional settings: Current approaches

In a review of responding to sexual assault within institutional settings generally, Clark and Fileborn observe that:

> Fully addressing sexual assault within institutions requires more than enhancing policies that specifically address sexual assault. Rather, to provide adequate responses to victim/survivors of sexual assault, institutions need to address fundamental operating principles and procedures to provide environments that are conducive to women's safety and wellbeing. (2011, p. 14)

While we would not suggest that *no* therapeutic work could be done in a prison environment, it is clear from the current literature that the cultural and operating environment of women's prisons may impede efforts to engage in meaningful therapeutic work with prisoners, and that responding to, and supporting their trauma needs requires more than just providing for counselling. On the basis of the literature, two frameworks provide the overall "scaffolding" to inform trauma support for women offenders. These are:

- A Gender-Responsive Framework; and
- A Trauma-Informed Framework.

Chapter 2 provided a summary of the principles of a gender-responsive framework to women's management in custody. As we noted, this framework is primarily about understanding women's offending pathways, the roles that gender, violence and social marginalisation play in these pathways, and what this subsequently tells us about correctional programming. While it is attentive to trauma and its impacts, it is not a mental health or therapeutic framework. Hence, we would suggest at this stage the integration of both frameworks to inform CSNSW's next steps.

The following sections:

- summarise current approaches in correctional policy development for women prisoners generally; and
- describe a trauma-informed approach for a range of interventions.

Good practice in women's prisons

In 2011, the Australian Institute of Criminology published a literature review on good practice in women's prisons (Bartels & Gaffney, 2011). This was an important undertaking, because, as the review notes, correctional facilities and practices have been premised on the needs of male prisoners; "accordingly many prison models do not provide women prisoners with the support,

services and requirements they need to achieve their rehabilitative goals" (Tomison in Bartels & Gaffney, 2011, p. iii). Broad developments in Australian jurisdictions include:

- Acknowledging that there are gendered pathways into offending;
- Creating safe, non-threatening environments;
- Improving court processes and using bail and non-custodial sentencing options;
- Improving programs' gender-responsivity; and
- Acknowledging the centrality of women's relationships with others.

These national (and international developments) are summarised in Table 7 In addition to these broader policy shifts, six further domains of practice were considered including prison systems and architecture, correctional programs, physical and mental health, and women prisoners' parental responsibilities. Table 7 summarises the key findings and good practice recommendations for these areas. These practices address a range of issues that are relevant for women offenders, and a number of programs have been found to improve outcomes for women (e.g. longer program retention, lower rates of substance use and improved mental health). Table 8 provides a summary of what national and international developments in relation to good practice.

An important aspect not included in this review is the place – and promise – of trauma-relevant programs and practices. In the chapter dealing with correctional programs, it is noted that each of the women's institutions in Canada offers counselling services for survivors of abuse and trauma (the use of which is completely voluntary) and that "treatment readiness for correctional programming targeting criminal behaviour is increased when women offenders have access to counselling to help them deal with issues of trauma" (Bartels & Gaffney, 2011, p. 35; see also CSC website). No further information is provided for this assessment. Further, trauma-informed initiatives and approaches are not expanded upon – other than noting recent debate on its centrality for women's correctional programs (see p. 52). In other words, although there is a growing implementation of the broad developments mentioned above, there is less recognition of what a trauma-informed framework is and how it is relevant to supporting women offenders.

Table 7 Summary of good practice in prisons for women offenders (adapted from Bartels, 2010)

Domain	Key issues/developments	Examples of good & promising practice cited
Women's prison systems and architecture	• Geographic and community isolation is often more pronounced for women's prisons & needs to be addressed • Architecture historically based on surveillance and security	• Shift towards self-standing "cottage-style" living units • Style of living that is as close as possible to independent and family-friendly living in the community • Enhance capacity for Indigenous prisoners to develop & maintain cultural links (without isolating, or stereotyping Indigenous women) • Use of environmental factors known to promote wellbeing (e.g. natural light, fresh air, colour & space) • Cell design to maximise control of personal space, privacy & dignity • Intermediate-care accommodation for women requiring temporary additional support or respite from "self-care environment" • Consideration of electronic rather than physical surveillance systems
Women's prison system management and operation	• Management philosophies and operating standards are informed by and reflect an understanding of women's needs	• Segregation of female prisoners from male prisoners • High ratio of female to male staff • Careful management of male corrections staff interaction with prisoners (e.g. not sole escorting officer) • Training for corrections staff about the needs of women in prison • Staff model gender-responsive values • Preference for female specialist staff (e.g. doctors) • Offending behaviour programs delivered in women's prisons are validated for use with female offenders • Routine and structured days, which encourages sense of stability, order and purpose • Throughcare and pre-release service delivery model/s based on strong engagement with, and support of, community sector • Self-management is an explicit and embedded value
Corrections programs	• Lack of reviewed evidence about "what works" for women • Risk-based assessment tools need to be normed on women and culturally diverse populations • Slow emergence of programs specifically designed for women	• Development of training modules for women such as substance use • Gender and culturally appropriate reintegration support • Programs are holistic and integrated, addressing multiple need areas simultaneously • Continuum of care models (e.g. case conferencing and case management) to provide "wrap around" services within and beyond prison • Vocational training for meaningful employment opportunities and multiple learning pathways/modalities • Parenting and mother-child programs to encourage stability between mothers and their children
Security issues and classification systems	• Women tend to be misclassified (usually overclassified) • Given women's offending profiles relative to men's, prison management systems should reflect their generally lower security risk	• Wherever possible cottage style accommodation • Female remand prisoners placed in general cottage accommodation and/or not automatically classified as maximum security prisoners • Use of gender-specific and validated screening, classification and needs assessments tools • Use of transitional and "half-way" facilities that provide a broad range of services and support

	• Traditional measures for KPIs are less relevant for women's prisons	
Physical and mental health	• High rates of mental ill-health and substance abuse • Higher mortality rates post-release compared to male prisoners • High proportion of offenders that are drug related	• Holistic service models that encompass psychological intervention, drug treatment and other services • Intensive, specialised services for women experiencing severe mental illness and other complex issues • Integrated, social model of health care delivery, with a health promotion focus • Use of drop-in services to enable women to develop trust in staff and the program before participating fully • Promotion of dignity and safety for women prisoners • Continuity of care across prison staff, medical and allied health, and social care services • Trauma counselling services that are culturally appropriate and safe
Women prisoners' parental responsibilities	• Significant numbers of women offenders are also primary carers to their children • Maintaining positive connections between women offenders and their children is key to positive outcomes	• Provision of gynaecological and obstetric services • Provision of residency programs for women and their children, both full-time and occasional • Equipment, toys, bedding etc. is safe and in appropriate condition • Purpose built areas for family visits • Parenting programs • Separation policies and practices are designed and implemented to provide emotional and practical support for mothers • Post-release programs provide support to mothers seeking reunification with their children • Use of child-care facilities/centres in the community to enable women to attend educational and employment programs, and which mothers can continue to use once released

Table 8 Current approaches to addressing sexual victimisation in correctional settings

State/ Country	Framework	Trauma informed	Evaluations	Gaps/Comments
ACT, Australia	Risk management	No (Cottage style accommodation is responsive to women's accommodation needs.)	No	Although there is a specific policy in relation to female prisoners in regard to cottage style accommodation at the Alexander Macon chi Centre, there are no specific women centred policies ("Alexander Maconochi Centre," 2010). There is no mention of trauma or the specific needs of trauma survivors. Recent policy on strip-searching relates to Corrections Management Bill 2008. The Bill was voted in 15:1 to extend powers of correctional staff to strip search female prisoners on grounds of 'prudence' (*Debates of the Legislative Assembly for the Australian Capital Territory*, 2008).
NT, Australia	Risk management	No	The most recent evaluation of NT prisons recommended research into women centred policies. These have yet to be addressed	There are no specific policies related to female prisoners. Their staff recruitment advertisement does not include any mention of the need to be trauma informed or any training related to trauma. They do however include the need to be culturally sensitive to Indigenous culture.
QLD, Australia	Gender responsive	No	No	There is no mention of trauma in women's policy but QCS have developed strategies to deal with women's needs including the specific needs of Indigenous women (*Improving outcomes for women offenders: Women offenders policy and action plan 2008-2012*, 2008). Evaluation required to determine the effectiveness of their gender responsive programming and policies.
SA, Australia	Risk management	No	No	SADCS literature, such as annual reports, do not present yearly statistics separately for both genders (*Department of Correctional Services, South Australia: Annual Report 2009-2010*, 2010). There is little recognition within SADCS documents to suggest they are responding to gender or trauma. A recent AIC report indicates that gender responsive service delivery for SA women's prison is on the agenda (Bartels & Gaffney, 2011).
TAS, Australia	Risk management	No	No	There is no indication of a women's policy in Tasmania. There are specific programs run for women, however these are not trauma informed and there is no discussion of accommodation needs for women, nor a gendered understanding of female offending or issues related to child and adult sexual abuse history.
VIC, Australia	Gender responsive	Yes	Preliminary evaluation undertaken in 2009, however implementation of Better Pathways was less than two years prior to the evaluation and	Awaiting current evaluation to identify gaps.

			re-offending rates are not possible to determine (Evaluation of the Better Pathways Strategy, 2009).	
WA, Australia	Gender responsive	Yes	No, however an Inspection of the Boronia Women's Pre-Release Centre has been conducted	Lack of evaluation means gaps cannot be identified, however an inspection of the Boronia Pre-release Centre for women indicates the women-centred policies are having a meaningful effect on reducing recidivism and successful transitions from prison to the community by female prisoners. The inspection did however reveal a lack of culturally appropriate policies for Aboriginal women and identified the need for these to be put into place, particularly considered that Aboriginal women make up 30% of the prison population.("Report of an Announced Inspection of Boronia Pre-release Centre for Women," 2009). Of note is that therapeutic programs are not offered to women on remand (Department of Corrective Services, 2009)
INTERNATIONAL				
Canada	Gender responsive	Yes	Yes	Evaluations have produced some mixed results. Changes need to be whole-of-system. This means not just staffing female prisons with female staff but working to alter the staff culture to respond to women's needs. It is also important to change the "delivery capacity of management" (Fair, 2009, p. 8)
Denmark	Gender Responsive	Unknown	Unknown	Only the most violent female criminals are housed in prisons. All other female prisoners are housed in mixed sex units that accommodate children. This is done to replicate society as closely as possible and is considered effective practice.
Germany	Gender responsive	Unknown	Unknown	Germany is considered most progressive in their delivery of services for female prisoners. They offer excellent accommodation for women with children and their facilities offer many benefits such as a piano room and large gardens (Fair, 2009). They also have family friendly visiting policies that allow families to remain in touch.
New Zealand	Risk management	No	Unknown	The prisons utilized by women in New Zealand are designed the same way men's prisons are designed. The processes and policies used to manage female offenders a again, the same as men's.
Spain	Risk management	No	Unknown	Spain has a type of hybrid system of management of female offenders(Fair, 2009). Some facilities are built specifically, whereas others are tacked onto men's prisons. Female prisoners in Spain receive fewer resources than men and are not eligible for drug and other offender programs
Sweden	Risk management (& family friendly)	No	Unknown	Women are housed in facilities originally built for men. Although Sweden has child positive policy towards female prisoners who are mothers (there is an overnight facility where children can stay with mothers), children born to women in prison can only stay with their mothers up until they are 12 months old (Fair, 2009). Sweden has a 'leave' system for prisoners to spend time with family, which is considered very important.
United States	Risk management	No	No	The US is not directly responsive to the needs of women. They do not have family friendly policies towards the

				visitation of children. This is demonstrated by the cramped and harsh facilities put aside for family visitation. Prisons housing women were originally built for men. However examples such as Arizona in which the state responded to accusations of infringements towards prisoners by guards is promising.

Trauma-informed care and practice

A recent development in the Australian mental health context is a trauma-informed approach for working with individuals in the mental health system. Trauma informed organisations, programs, and services are based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience, and which traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive, effective and avoid re-traumatisation (Mental Health Co-ordinating Council). In the US context trauma informed approaches and principles are more developed. This has been regarded as a paradigm shift for those services and systems that support individuals with mental health and substance use disorders. Trauma-informed can be contrasted with more traditional approaches to these populations, as demonstrated in Table 9.

A second distinction refers to trauma-informed and trauma-specific services. Trauma-specific services are designed to treat the actual consequences of sexual or physical abuse trauma. They include a variety of therapies and techniques (such as grounding techniques, desensitisation therapy, and behavioural therapies) in a way that is consistent with the need for respect, information, connection, and hope for clients. It is important to recognise the adaptive function of "symptoms" and the need to work in a collaborative, empowering way with survivors. All trauma-specific service models need to be delivered in a context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections (Jennings, 2004; Morrison 2008).

Trauma-informed services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. A trauma-informed system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence place in the lives of people seeking services. Trauma-informed services work in tandem with trauma-specific services (Morrison 2008).

A trauma-informed system is characterised by:

- safety from physical harm and re-traumatisation;
- an understanding of clients and their symptoms in the context of their life experiences and history, cultures and their society;
- open and genuine collaboration between provider and consumer at all phases of the service delivery;
- an emphasis on skill building and acquisition rather than symptom management;
- an understanding of symptoms as attempts to cope;
- a view of trauma as a defining and organising experience that forms the core of an individual's identity rather than a single discrete event; and
- a focus on what has happened to a person rather than what is wrong with a person. (Jennings, 2004)

Tables 10 provides a list of resources and models for transforming organisations to develop a trauma-informed approach to health and allied health service provision. Tables 11 and 12 provide information about evaluated trauma specific and integrated interventions.

Table 9 Comparison of traditional models and trauma-informed service models (Harris & Fallot 2001)

Traditional services and systems	Trauma-informed services and systems
Traumatic stress is not viewed as a primary event in defining people's lives.	Traumatic and violent events are central, primary events impacting everything else in the lives of victim/survivors. Assumes the impact of trauma is all-encompassing.
Problems/symptoms are discrete/separate, and require a separate source of support and/or intervention.	Problems/symptoms are inter-related responses or coping mechanisms to deal with trauma.
A hierarchical approach: clinical staff and administrators are trained to respond to trauma survivors in a specific way. Clinical personnel are seen as the experts who assign diagnoses to treat a condition. The focus is on being objective and distant. This approach is based on power imbalances.	Shared power/decreased hierarchy: everyone is trained to respond to individuals in distress, and about the impact of trauma in the lives of clients. This approach emphasises the importance of viewing clients' responses through the lens of trauma and attempts to equalise power imbalances in relationships.
Primary goals are defined by service providers and focus on symptom reduction.	Primary goals are defined by the person or family who is homeless and focus on recovery, self-efficacy and healing.
Reactive: Services and systems are crisis-driven and focused on maintaining high liability.	Proactive: Services and systems focus on preventing further crises and avoiding retraumatisation. At the systemic level, policies and practices are adjusted to avoid re-traumatising.
Sees clients as broken, vulnerable, damaged and needing protection from themselves. Agencies and providers are responsible for fixing the problem.	Understanding that providing clients with the maximum level of choices, autonomy, self-determination, dignity, and respect is central to healing - based on a philosophy of holistic healing and resilience. The agency is responsible for creating an environment conducive to healing and becoming a partner in a process defined by the individual

In a trauma-informed model all staff members – including administrators – are trained to respond to individuals in distress (Prescott et al., 2008). Education and training of staff regarding traumatising practices is also important (Pollack & Brezina, 2006). Staff lacking awareness of the impact of past sexual abuse may, for example, misinterpret women's resistance to traumatising practices as an attempt to "make trouble", and the individual may consequently be reprimanded (Easteal, 2001, p. 106). This has substantial ramifications for workforce development. However, these ramifications have been found to be "cost effective" in the US. Research has found that trauma-informed services with trauma-specific services available have better outcomes than "treatment as usual". For example, adults have been found to experience a decrease in psychiatric symptoms and substance abuse; improved daily functioning; and a decrease in trauma symptoms, substance abuse, and mental health symptoms (Hopper, Bassuk, & Olivet, 2007). Trauma-informed services also appear to be cost effective (Domino et al., 2005), and both providers and consumers report positive outcomes (National Centre for Family Homelessness, n.d.).

Table 10 Resources for developing trauma-informed service systems

Developing Trauma-Informed Service Systems and Organisations				
Model	**Focus**	**Intended audience**	**Intended setting**	**Information source**
Creating Cultures of Trauma-Informed Care	Culture change	Providers, State service systems	Public sector human service systems, Provider agencies, Individual services & programs	Fallot & Harris 2009 http://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf
Creating Trauma-Informed Systems of Care: Facilitating Recovery in Mental Health Services Settings		Direct care staff, Senior & middle managers	Public sector, mental health provider agencies	See Jennings 2008 Models for developing trauma-informed behavioural health systems http://www.uwgb.edu/bhtp/tools/developing_trauma.pdf
Developing Trauma-Informed Organizations: A Tool Kit		Policymakers, Program directors	Corrections, Domestic violence agencies, SA* treatment & MH provider agencies (specific focus on Women; Co-occurring SA & MH disorders)	For purchase see http://www.healthrecovery.org/toolkit/
National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings	Organisational leadership for Reduction of seclusion & restraint practices	Senior & middle managers	Child, youth, adult, & forensic MH facilities	This training was provided through an organization auspiced by the National Association of State Mental Health Program Directors in the US. For information see http://www.nasmhpd.org/index.aspx
Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse	Workforce development	Direct care staff, management, and clinicians in all settings	Child-serving, Child residential, Domestic Violence, Crime victims, Corrections, SA treatment programs Customizable focus for each setting	This is delivered by the Sidrian Institute. See here for information: http://www.riskingconnection.com/rc_about.html
The Sanctuary Model	Systems/cultural change	Organizational leaders	Acute care inpatient for adults & children; Child residential; Community based programs; Juvenile Corrections; SA programs for women, children & adolescents	This was developed by Bloom. See here for more information http://www.sanctuaryweb.com/sanctuary-model.php
Women and Addiction: A Gender-Responsive Approach		Clinicians, Counsellors, Program directors State service systems	Public and private SA treatment, mental health services, criminal justice settings, Targeted for Women, SA, MH	This was developed by Covington. See here for more information: http://www.ncbi.nlm.nih.gov/pubmed/19248395

* SA= substance abuse; MH= mental health; SMI= Serious mental illness; DV= Domestic violence

Table 11 Trauma-specific interventions for women with co-occurring problems

Models	Core concepts/assumption	Program elements	Intended audience	Settings	Measures	Outcomes
Trauma Recovery and Empowerment (TREM) • 24-33 structured group sessions weekly • 75 min • 8-12 women	Some current dysfunctional behaviours may have started as legitimate coping responses to trauma Repeated trauma in childhood deprives people of the opportunity to develop skills for adult coping Trauma severs connections to oneself, family, and community Repeated trauma results in feelings of helplessness and an inability to advocate for oneself	Basic education about physical and sexual abuse and how current behaviours are linked to this A reframing of symptoms as coping responses Strengths based approach to coping responses Skills acquisition for self-regulation, boundary maintenance and communication Basic education about sexuality Creation of healing community Development of feelings of competence in self perceptions	Women, MH, SA	Residential & non-residential SA & MH programs Corrections Homeless populations Domestic Violence programs	Severity of problems related to SA Psychological symptoms Trauma symptoms	EVALUATED (3 quasi-experimental studies) 2 studies found significantly greater decreases in problem severity at 6 and 12-month follow ups 2 studies found significantly reduced psychological symptoms 1 year after the intervention All 3 studies found reduction in trauma symptoms at 1 year follow-up
Trauma affect regulation: Guide for education and therapy (TARGET) • 10-12 sessions	Post-traumatic symptoms product of an ingrained, but reversible, biological change in the brain's alarm and information processing systems and the body's stress response systems. Repeated trauma results in reacting to all types of current stressors as survival threats Not designed to necessitate exposure therapy/recall, but can prepare people for this phase	Strengths-based psycho-educational program to manage and regulate extreme emotion states and promote self- efficacy. Seven skills: Focus; recognizing triggers; emotion self-checking; evaluating thoughts; defining goals; options; and making contributions	Men and women Young adult; adult.	Residential; Outpatient; Juvenile justice settings Women's prisons MH and SA services	Severity of PTSD symptoms PTSD diagnosis Negative belief related to PTSD Severity of depression and anxiety Self efficacy related to sobriety Emotion regulation Health related functioning	EVALUATED (2 randomised control studies; 1 quasi-experimental study) 1 study found improved emotion regulation and post-traumatic beliefs at posttest and follow-up, leading to additional improvements in dissociation and affectively-modulated coping and relational involvement. Decrease in PTSD diagnosis at follow up Greater improvement in beliefs about PTSD Participants maintained level of self-efficacy related to sobriety at 3 and 6 month follow up. Great improvement in emotional

					regulation and health related functioning

Source: Adapted from Moses, Reed, Mazelis, and D'Ambrosio (2003)

Table 12 Integrated interventions

Models	Key information	Intended audience	Settings	Measures	Outcomes
A Woman's Path to Recovery		Adult women	Inpatient; Residential; Outpatient	Alcohol Drugs Mental health Quality of life Social functioning	EVALUATED 1 pre (intake) and post treatment study (2 month after intake) Participants showed: significant decreases in self-reported substance use; significant global clinical improvement from midtreatment to posttreatment; significant decreases in self-reported impulsive and addictive behavior;
Seeking Safety (Morrissey et al., 2005)	A quasi-experimental treatment outcome study was conducted from 2001 to 2003 at nine sites of multiple programs	Adult women with co-occurring disorders		Substance use problem severity, mental health symptoms, and trauma symptoms were measured at baseline, and follow-up data were analyzed with prospective meta-analysis and hierarchical linear modeling.	A total of 2,026 women had data at the 12-month follow-up: 1,018 in the intervention group and 1,008 in the usual-care group. For substance use outcomes, no effect was found. The meta-analysis demonstrated small but statistically significant overall improvement in women's trauma and mental health symptoms in the intervention relative to the usual-care comparison condition. Analysis of key program elements demonstrated that integrating substance abuse, mental health, and trauma-related issues into counseling yielded greater improvement, whereas the delivery of numerous core services yielded less improvement relative to the comparison group. A few person-level characteristics were associated with increases or decreases in the intervention effect. These neither moderated nor supplanted the effects of integrated counseling.

Women's Integrated Treatment Helping Women Recover(HWR): A Program for Treating Addiction	The three fundamental theories underlying the model are: relational-cultural theory, addiction theory, and trauma theory Counsellors use a strengths-based approach with a focus on personal safety to help clients develop effective coping skills, build healthy relationships that foster growth, and develop a strong, positive interpersonal support network	Adult women with co-occurring disorders	Criminal justice or correctional settings	Substance use Aftercare retention and completion Reincarceration	EVALUATED 1 experimental study From baseline to the 12-month postparole follow-up, women in the intervention group had a larger decrease in drug use than their counterparts in the comparison group, after controlling for ethnicity, marital status, and employment Retention in the first episode of residential aftercare treatment following parole was longer for women in the intervention group than it was for women in the comparison group. Women in the intervention group were more than 4 times as likely as women in the comparison group were to successfully complete this aftercare treatment episode following parole. A smaller percentage of intervention group than comparison group women were reincarcerated during the 12 months following parole. During this time, intervention group women were 67% less likely than comparison group women to be reincarcerated, after controlling for ethnicity, marital status, and living situation

Promising trauma-specific treatment for women in the criminal justice system

As indicated in these tables there are a range of models, toolkits and modules that have been used for organisational change and workforce training to develop trauma-informed responses. There are also a number of trauma-specific treatments that are appropriate for correctional settings. Several of these have been evaluated and have had good outcomes for clients:[34]

- **TARGET** (follow up periods at 3 and 6 months):
  - Some improvement in severity of PTSD symptoms
  - Decrease in numbers of PTSD diagnoses at post-treatment
  - Some improvement in symptoms of depression and anxiety
  - Maintenance of self-efficacy in relation to sobriety
  - Improvement in emotional regulation
  - Improvement in health related functions
- **Seeking Safety** (6, 9, 12 month follow up)
  - Significant decrease in substance use
  - Significant improvement on measures of trauma symptoms
  - Improvement in psychopathology symptoms (control group worsened)
- **TREM** (6 and 12-month follow up)
  - Significant reduction in drug addiction severity at 6- and 12-month follow-ups
  - Some indication that the reduction in symptoms of mental illness was significantly greater in the intervention group than in the comparison group at 12-month follow-up.
  - Significant reduction in trauma symptoms compared to non-intervention group
- **Helping women recover**:
  - Decrease in substance use and depression
  - Fewer trauma symptoms, including anxiety, sleep disturbances, and dissociation
  - Continued improvements in the areas of trauma symptomatology and depression at each follow up period
  - High numbers of clients who successfully completed the program reported remaining drug and alcohol free, as well as conviction-free, during the program

These treatment models have been implemented in a range of US settings, are designed for stablisation, containment and the establishment of safety. However it is also important to provide individual counselling in crisis situations (for example, an incident of sexual violence, which has occurred in the last two-four weeks prior to reception at prison) or for women on longer sentences where their mental and physical well-being is sufficient to support more exploratory processing (although care would be required here), where there is stability within their correctional trajectory, and where the physical environment is conducive to supporting a sense of safety. Individual

[34] This is a brief summary of the key findings. We can provide more information about study design and results if necessary.

counselling may still be warranted outside of these situations, but may be primarily focused on stablisation and containment.

Provision of therapy in prison

While our focus thus far has been on the general operating and cultural environment of prisons, it is important also to consider the role of service and program delivery, the challenges in providing services in a prison setting, and the conditions under which they are most efficiently and effectively delivered.

In terms of providing counselling or other therapy services specifically to address issues of sexual abuse trauma, Pollack and Brezina (2006) suggest that it is imperative for such services to operate independently of the prison, and that such services are not "tied up to a mandate to punish and control" (2006, p. 122). For instance, counselling should not be 'pushed upon women who may not be ready to deal with painful issues in their lives' (Dirks, 2004, p. 109), nor should a refusal to engage in therapy be used against women (such as at parole hearings). Prison staff such as prison guards should not also be responsible or involved in therapeutic processes, as the member of staff is in a position of power over the prisoners' experience in the institution. This may hinder disclosure or open discussion of trauma history, for example, out of fear of what the staff member could do to them, such as changes in medication or treatment, being moved to a higher security level, being placed in solitary confinement and so on (Buchanan, 2007). Prison culture often dictates that staff are not to be trusted (Easteal, 2001), and it is difficult to imagine how meaningful therapy could occur in the context of such hostile relations.

The adoption of a holistic approach to addressing women's needs has been advocated broadly in the literature both on women in prison and in therapy more generally (Sorbello et al., 2002; Salomone, 2004; Covington, Burke, Keaton & Norcott, 2008). It is important to note here that sexual abuse history also intersects with myriad other factors to result in an offending pathway, such as socio-economic status, race, homelessness, unemployment and so forth. Therefore, it is necessary to address a range of factors in order to reduce reoffending.

It was noted earlier that prisons have been designed around the risks and needs of male prisoners. It is perhaps unsurprising then that the programs offered in prisons have also been designed primarily around the needs of male prisoners, and are often merely "tinkered" with or directly imported into women's prisons. Ensuring that programs offered to women (therapeutic or otherwise) are designed to reflect the needs of women, as opposed to simply "adjusting" or completely replicating programs designed to meet the needs of men is necessary, as "successful treatment with women requires an understanding that there are differences between the experiences of men and women" (Covington et al., 2008, p. 390).

Some authors have argued that it may be more beneficial to focus on developing women's strengths and resilience rather than direct therapy work helping them "recover" from their sexual abuse trauma (as prison is not the right environment to do this). Pollock (1998, p. 200) draws our attention to the fact that 'the most successful treatment has active elements rather than being just a "talking cure". Such "active elements" may involve a focus on developing transferable "real life" skills while in prison, such as educational or employment based training, or focus on developing women's strengths and independent coping capacity (Pollock, 1998, p. 200).

Bringing together trauma-informed and gender-informed approaches

There are two ways that policy and process can move forward in the provision of services for female inmates. There is gender responsivity and trauma informed service provision. What might be a better way to move forward is to create a holistic or ecological response to women that seeks

to provide them with the environment, staffing and programming needs as they relate to gender and trauma. This takes into consideration that although gender is important, it can be used to essentialise and discriminate against women who do not embody or operate in gender normative ways (Hannah-Moffat, 2010). Trauma informed services can be considered gender neutral, in that they deal with the trauma of sexual violence. Trauma informed services can also be beneficial to those who do not have trauma in that the services are about safety and respect.

Complex Trauma and Transitional Support: Beyond prison

In order for women to transition from a prison environment back into society, a transitional support process is required. The following section considers issues related to transitional support including how to incorporate the knowledge that most women in corrections have been victimized and re-victimised throughout their lives (P. Easteal, 2001; M. Mitchell, 2005; Turner, 2010). This is a presentation of issues in understanding transitional practices as they relate to domestic and international studies on women's post-release needs as well as recommendations created through the evaluation of transitional programs.

An understanding of complex trauma requires a view that what sits behind the offense behaviours of many female prisoners can include a traumatic or several traumatic incidents experienced in childhood or adulthood, including sexual and physical abuse. The most common manifestations of traumatic experiences are post traumatic stress disorder, suicide ideation, substance abuse and addictions, borderline personality disorder, self-harming such as cutting, burning, disassociation and re-enactment through abusive relationships (Jennings, 2004, p. 5).

There are two dimensions for supporting those who experience complex trauma - trauma-specific and trauma-informed. Trauma-specific services deal directly with:

- trauma symptoms, specifically issues such as disassociation, intrusion and hyper-arousal that are characteristic of post-traumatic stress disorders;
- the memories of abuse and how to understand what may seem like maladaptive coping behaviours but are actually adaptive functions that need to be changed in support of new environments and contexts; and
- the long-term sequelae of sexual victimization such as substance abuse or parenting problems.

Trauma-informed services are not dealing with childhood or adult sexual and physical abuse trauma directly, rather they are designed to "accommodate the vulnerabilities of trauma survivors" (Jennings, 2004, p. 15). This indirect approach allows the focus to be given to other issues such as substance abuse, housing support or vocational training without retraumatising the victim/survivor through processes, environments or staff interactions (Hannah-Moffat, 2010). This is achieved by evaluating the systems and processes victims/survivors of trauma will face through the transition process with a view to incorporate an understanding of how a history of exposure to violence may affect help seeking behaviours and engagement with those services and processes (Morrison, 2009).

Some guidelines that may assist in the implementation of trauma informed transitional support include:

- An ongoing consideration of workforce. This includes recruiting people who are willing and able to advocate for women on their behalf.
- Being cognisant of the vicarious trauma that staff can suffer when working with trauma survivors. Ongoing support and training for workers in this field is required.

- The trauma victim/survivor must be involved in the planning and implementation of transitional case management plan.
- Systems must be integrated and coordinated. Case management appears to offer the best paradigm to assist releasees' entry into various services. However it is important not to overload the releasees with multiple appointments that may be difficult for them to fulfil.
- Procedures must be evaluated with a view to avoid retraumatisation and reduce the impacts of trauma (Jennings, 2004, p. 9)

Much of the literature concerning best practice models for transitional support remains free from the considerations of complex trauma. However, by building a bridge between the complex trauma literature and theories concerning offender readiness and offender motivation, empirically sound models that validate women's trauma histories can be formulated. The effort toward trauma informed practices means that women's needs and the needs of correctional facilities are one and the same; namely to support women to stay out of prison by meeting their specific needs.

What does transitional support do?

"Prisoner re-entry to community begins at the point of admittance to a prison" (Seiter & Kadela, 2003, p. 368). Information and communication by corrective and community services are vital to the success of prisoner re-entry as the anxiety associated with "not knowing"'creates tension and the conditions for re-offending (Baldry, McDonnell, Maplestone, & Peeters, 2002; Carnaby, 1998; S. S. Covington & B. E. Bloom, 2004; Fox et al., 2005). "Not knowing" concerns issues of release, maintenance of public housing, obtaining public or private housing, support services, drug programs, custody of children and employment opportunities. Therefore a targeted re-entry focus upon reception into the prison means that disclosures of sexual trauma at any stage of incarceration can be used to connect the woman with therapeutic support upon release (Berman, n.d.; Cobbina, 2009; W.H.O., 2009; WHO, 2009).

As discussed in other sections of this report, therapeutic work dealing directly with complex trauma may in fact do more harm than good in an environment that does not provide safety, nurturing and hope as its main goals. The notion of trauma-informed services as described by Jennings (2004), relates to services that do not treat symptoms or disorders directly related to sexual violence trauma. They do, however, "avoid inadvertent retraumatisation and will facilitate consumer participation in treatment" (Jennings, 2004, p. 15). Therefore the work of transitional support workers is to help women to build a safe and stable reality outside of prison, where they can be linked with therapeutic settings that can allow them to move to Stage 2 of trauma recovery (as described in the previous chapter).

Transitional support processes and staff can also be responsive to Stage 3 of trauma recovery. Stage 3 relates to reconnection, and therefore fits with the function of transition into a post-release environment. By viewing transitional support through a trauma informed lens, processes can be built around the knowledge that women benefit from connectedness and respectful relationships (Brown & Ross, 2010a; S Covington, 2008a; S. S. Covington & B. E. Bloom, 2004). They require support in reconnecting with children and their families. They will need to be connected to housing support, substance abuse programs, employment providers and educational opportunities (Ogilvie, 2001).

Most importantly for women with complex trauma who have been released from prison, is to be assisted in connecting with services that can address child sexual abuse and adult sexual abuse experiences through trauma-specific services. This is because trauma-specific therapy cannot easily be undertaken in a prison environment, however once released, women can be assisted to deal

directly with the causes of their trauma. This is of course predicated on their desire to do so and releasees should never be forced to undertake therapeutic trauma counselling unless they choose.

This assistance to create a stable and safe life outside of prison is one of the most important processes that correctional institutions can undertake. It may be an often difficult task to assess who exactly is responsible for this task (Ogilvie, 2001). If, as Ogilvie states, the imperative of corrections is to punish, rehabilitate, deter and denunciate, the very act of imprisoning people leaves only rehabilitation as a focus. "Genuine rehabilitation simply *cannot* be undertaken solely within the prison environment and *must* be undertaken at the post-release phase" (Ogilvie, 2001, p. 5). The imperative of rehabilitation post-release, coupled with the notion that if women are returned to the unstable environments in which they originally offended, they will have little chance of remaining crime free (Brown & Ross, 2010a) is central to desistance (Maruna, 2001). Birgden (2008) identifies two main issues in relation to offenders and rehabilitation, these are, community safety and offender rights. By supporting releasees in reaching their goal of a secure environment and services to assist them in getting their lives back together, both of these issues are given equal priority and therefore equal chances of success.

There are a number of areas that can be attended to in an effort to create transitional policies and processes that are trauma informed. The following examples draw from qualitative studies examining the impact of transitional systems that do not meet women's needs. In particular, the following criteria have emerged as important for the provision of effective transitional support.

- Information and communication;
- Reconnection;
- Mentoring & Social Capital;
- Consistency and Reliability (staffing considerations);
- Trauma Recovery;
- Housing; and
- Vulnerable populations;

These issues have been summarised in Appendix C. The following deals specifically with trauma recovery.

Trauma recovery

Reconnection can also include connecting women to support services that can assist in Stage 2 of trauma recovery. Namely trauma specific services which deal directly with trauma experiences and the symptoms and disorders associated with complex trauma. This may include one-on-one counselling, group therapy, drug and alcohol programs, relationship programs and parenting programs that can act as a continuation and intensification of support in a stable environment.

Due to the complexity of needs and the reality of women's ability to engage in any number of programs while attending to child custody, relationship, housing and employment issues it is suggested that transitional support is "premised on effective case management and programming for offenders from their point of entry" (Berman, n.d., p. 2). Designing a case management system that is responsive to possibly competing goals can alleviate the danger of overburdening women with responsibilities.

Connecting women to trauma specific services includes a concern for the design of processes relating to transitional support and through-care. It is important to maintain a relationship with

women that does not include the same characteristics as surveillance ("Women in prison summary," 2010). Transitional support is not the same as parole and other criminal justice requirements and should not seek to recreate that paradigm.

A transitional support worker acts as a gateway to the safe and helpful environments that are crucial in the trauma and healing process. Transitional support and through-care that matches the needs of women with complex trauma can be delivered via a case management framework within which rehabilitation interventions can be delivered (Turner, 2010). Case managers and workers need to be trained in women's specific needs and their practices must be trauma informed. Trauma informed service delivery ensures that no staff, process or policy re-traumatises their clients.

Transitional support and through-care begins upon reception into prison and can continue for as long as a year post-release. Identification of client needs include whether they have short, medium or long-term needs, whether they require assistance with housing, employment, education, relationships, custody, parenting, substance abuse, mental health and complex trauma.

Transitional services and through-care are really frameworks for supporting women to support themselves. In terms of the function of transitional support services, they are really to assist the releasee to experience their own ability to get on with life without engaging criminal behaviour. This may be a challenging time but it is also the time when releasees can benefit from exercising their agency and autonomy while being supported. Indigenous women require culturally specific transitional support programs that foster strong links to external Indigenous organizations (Bartels, 2010b). In order for the greatest outcomes to be achieved, transitional services need to be trauma-informed and be able to link women with trauma-specific service providers.

PART B: An evidence-informed framework to inform interventions for women with sexual abuse histories

Introduction

Part B provides a summary of the findings in relation to the research questions. It also suggests a conceptual framework that integrates these findings and their implications for interventions (see Figure 1).

Key messages from the review

The impact of a history of sexual victimization on women's offending pathways

A causal relationship between victimization and offending is not demonstrated by the literature. This does not mean however that sexual victimization is not a pervasive factor in the lives of women offenders. That the majority of women within correctional systems have significant victimisation histories, including child sexual abuse (CSA), has been consistently demonstrated across national and international research literature. The research findings have been mixed, however, on the extent to which the relationship between a history of victimisation and women's offending is causal due to the methodological differences in, and limitations of the studies. This subsequently has led to debate about how such victimisation histories should be accounted for within empirically validated rehabilitation systems such as the Risk-Needs-Responsivity framework (RNR).

However, in terms of the questions at hand about how CSA trauma interfaces with women's offending, their wellbeing while in custody and their rehabilitation prospects, there is a complex interrelationship between early onset, prolonged victimisation; poor mental health; and substance abuse, as described below:

- **Histories of early onset lifecourse victimisation.** Women offenders typically have extensive victimisation histories, characterised by: sexual victimisation in childhood, adolescence, and adulthood; repeat victimisation; multiple perpetrators; and intimate partner violence. This is prolonged, intentional victimisation often perpetrated by those in care giving roles (Jennings 2004) (See Part A, Chapter 1);
- **Early onset child sexual abuse and lifecourse victimisation is correlated with a complex of mental health symptoms beyond PTSD.** A growing evidence base shows that the type of victimisation experienced by a significant proportion of the women in correctional settings results not simply in "more severe sequelae of single incident trauma, but in [outcomes] that are qualitatively different in their tendency to affect multiple affective and interpersonal domains" (Cloitre et al. 2009, p. 7). Increasingly, developmental trauma, disorders of extreme stress not otherwise specified [DESNOS] and Complex Post Traumatic Stress Disorder [C-PTSD] are being used to describe these outcomes (see Part A, Chapter 2).
- **A significant number of women in correctional settings demonstrate mental health issues, including substance abuse, at a higher rate than, and different to, male prisoners**. Both male and female offenders have higher rates of mental illness compared to community populations. Further, compared to male offenders, women demonstrate higher rates of: psychotic illnesses (e.g. delusional disorder) and schizophrenia; major depression; post-traumatic stress disorder; personality disorders; anxiety disorders; and substance abuse. Co-occurring disorders are the rule rather than the exception. (See Part A, Chapter 1)

In other words, three relationships overlap: the relationship between early onset, prolonged victimisation and serious mental health problems; the relationship between being in the correctional

system and having a victimisation history; and the relationship between being in the correctional system and having a mental health diagnosis.

Victim/survivors of early onset, prolonged victimization employ a range of strategies to cope with the terror and disempowerment of such victimization, such as dissociation, self-medication, suicidal ideation, self-harm, and running away. This interlocking nature of victimization, mental illness and substance abuse is typically located in, and exacerbated by, a context of diminished social capital (e.g. poverty; unemployment; social isolation; homelessness; violent or dysfunctional relationships), producing multiple pathways into the criminal justice system, often with detours through mental health system involvement, statutory care systems (as both children and parents). Empirical research testing the "gendered pathways" theory[35] suggests that a history of child abuse, including sexual abuse is strongly correlated to a history of mental illness, current depression/anxiety, and substance misuse. Further, current depression and anxiety, and current substance misuse have been associated with women's recidivism (Salisbury 2007).

How can the correctional system best address women's sexual abuse histories?

The trauma literature has identified that the path from trauma to healing and recovery involves several phases: 1) stabilisation and safety (of both self and environment); 2) remembrance and reintegration; and 3) reconnection with self and others. A basic tenet of this literature is that processing trauma memories and in-depth therapeutic remembrance cannot occur in the absence of safety. There are a number of challenges involved in providing therapeutic counselling for sexual abuse that inhibit the establishment of safety. These relate to: the penal environment; retraumatising practices; the manner in which women "cycle" through the correctional system; and the risk of therapeutic interventions becoming "risk-reduction" interventions and part of correctional programming.

Potential risks in addressing sexual abuse trauma therapeutically in a corrections settings

Several concerns were identified in relation to whether therapeutic interventions specifically addressing women as victim/survivors of child sexual abuse (and other victimisation) could be appropriately implemented in correctional settings. Such concerns include: the nature of the prison environment; the presence of coercive and retraumatising operational practices; and the tendency for women to cycle rapidly through the correctional system. These factors can make sexual abuse counselling a risky undertaking. These issues are summarised in Table 13 below.

The correctional environment, and particularly custody, presents significant tensions for endeavours to address women's trauma histories. On the one hand are the issues summarised by Table 13; on the other, entering custody can present a period of stabilisation for some women. Whatever the ideological mismatch between correctional settings and trauma intervention, it remains the case that high numbers of women experiencing psychological distress as a result of victimisation histories are increasingly entering the correctional system.

[35] This refers to the body of research exploring women's particular pathways into the criminal justice system. The research, which has often been retrospective and qualitative, identified histories of abuse, mental illness, poverty, substance abuse, and relationship dysfunction as key factors influencing women's offending trajectory. A smaller body of work has sought to empirically test the salience of these factors. See for example the work of Salisbury (2007; 2009).

Table 13 Challenges in providing sexual abuse counselling in correctional setting

Challenge	Risks
Prison environment's emphasis on control, surveillance, and prisoner management contrasts with the principles of trauma counselling	The prison setting cannot meet the requirement of safety on several fronts: • Lack of control, arbitrary rules, and unequal power dynamics can replicate the experiences of sexual abuse, and can result in retriggering memories, flashbacks and coping mechanisms such as suicidality, self-harm, and dissociation. • Where sexual abuse counselling is not transparently independent from the corrections complex, intimacy and punishment become mixed up, also replicating the victim-perpetrator dynamic. • Informal rules among inmates (don't talk, don't trust, don't feel) can inhibit disclosing sexual abuse and its impacts, or can result in that knowledge being exploited by others.
Coercive control practices	Practices such as strip-searches can intimidate, humiliate and retraumatise women prisoners. Disciplinary, rather than trauma-informed, responses to coping strategies (such as self-harm) further retraumatise survivors. They can undermine and undo efforts in other parts of the correctional system that aim to support women with their trauma needs.
Rapid cycling through the CJS	Transitioning into a period of custody involves elements that increase feelings of destablisation and loss of control, increasing trauma symptoms, or could retraumatise women. These elements include: • Withdrawal from drugs • Placement of children into statutory or other care arrangements • Loss of housing • Placement with others experiencing substance withdrawal and mental distress Rapid cycling or being on remand reduces eligibility for specific types of programs, meaning that access to supports can be limited.
Therapeutic intervention co-opted by "risk-reduction" framework	Emphasis on psychological impacts of violence decontextualizes victimization from issues of power, inequality, racism, and social vulnerability. Psychological and emotional needs due to impacts of trauma could turn into risk factors for (re)offending; healing and recovery end up as a factor of rehabilitation

Sources: Baldry (2009); Easteal (2001); Hannah-Moffat (2004); Pollack & Brezina (2006)

The key approach for correctional settings: Establishing safety

Healing and recovery following exposure to sexual abuse involves three core stages: establishing safety; exploration and reintegration of traumatic memories into a personal narrative; and reconnection with ordinary life (Herman 1992). These involve key aspects of mind, body, relationships and environment, as described in Table 14. Although stages should not be considered as linear steps and individuals will move back and forth depending on circumstances, these steps help to guide what kind of therapeutic work can be done at which stage so that a survivor can move towards recovery. Based on the issues identified so far, our view is that correctional settings are best placed to assist women with sexual abuse histories to establish safety and develop skills to manage psychological triggers and reactions that can be barriers for program participation.

The establishment of safety is considered the starting place for all other interventions. No other therapeutic work can commence until the individual has a sense of safety in themselves, a sense of capacity to manage that, and an environment that is able to support that. Herman (1992) warns

against entering the second stage of memory exploration without first adequately establishing safety. This can result in repetitions of trauma and of telling about the trauma without being able to move towards reintegration and transformation about those experiences.

For individuals who have experienced extensive victimisation and who are experiencing complex trauma symptoms, this first stage will be lengthy because they do not experience their own bodies and psyches as safe spaces, or as within their control. Within this first stage, much of the initial therapeutic work is psychoeducational: "physical needs, trust, safety, self-soothing and building of support networks, and not the trauma, should be the focus of the treatment. Therapy during this stage should be reparative not explorative" (2001b, p. 400). This involves:

- Providing clients with basic information about the effects of trauma
- A rationale and explanation for specific symptoms;
- Developing capacities for self-care and self-soothing;
- Identification of supports within environment; and
- Identification of triggers in the environment.

Affect regulation and the management of symptoms (e.g. flashbacks, nightmares, sleep difficulties) are particularly important. Other aspects of this stage involve attention to physical well-being and bodily experiences, and the creation of scheduled and predictable routines.

The most appropriate stage in an offender pathway to participate in support programs for victimisation

The trauma of child sexual abuse and subsequent victimisation is a core feature of women's offending pathways and not an easily separable issue for them to manage. Indeed, the complex trauma literature indicates that the trauma of early onset, repeated sexual victimisation by trusted others is integral to survivors' sense of self and their self-capacities.

Both a trauma-informed framework and a gender-responsive framework suggest that supporting women with trauma can and should be integrated into correctional practice, from reception to release. As indicated above, supporting women with their trauma histories is itself a staged approach, beginning in the first instance with safety and stabilisation, and moving towards reintegration. Thus, it is not so much a question of what is the most appropriate stage for a support "program", but rather, what is the most appropriate *form of support and intervention* at what stage of women's entry into prison and their transition back into the community?

Based on the clinical and empirical research with women who have similar characteristics to those in prison (i.e. co-occurring diagnoses; CSA histories), and the scholarship on the tensions of doing therapeutic work with women in correctional settings, safety and stabilisation is the most appropriate form of support for a significant part of the correctional timeline, particularly for those women in custodial environments. This is not only because of the issues therapy in prison presents, but also because the type of support required by individuals experiencing complex trauma necessitates a focus on stabilisation first. As an individual moves through the corrections pathway, and in light of their health, mental health, and other treatment needs, therapeutic interventions could shift to more exposure-based therapy.

Thinking about the issue as "what form should the support take" rather than "when should support be provided" not only reflects recovery as process, it also fits more easily within the continuum of care/throughcare philosophy, which is increasingly influencing approaches to women offenders (Sheehan, 2011). This philosophy is characterised by:

- Assistance and support to offenders whilst in custody or under supervision in the community;
- Whole of sentence planning;
- Integrated Case management;
- Provision of seamless service to avoid duplication and/or isolated work practices;
- Effective working partnerships; and
- Provision of consistent interventions across community and custody which are proven to be effective in reducing recidivism (Baldry, 2007)

Post-release support was not a focus of the review. However, it warrants consideration. Developing a sustainable and integrated approach of addressing women's CSA histories would benefit from an examination of how the overarching timeframes of recovery, and of entry/transition/release, could articulate with each other – both conceptually and at the level service provision, partnerships, and case management approaches. In other words, it is important to understand how the prison journey (broadly, entry through to release) can support, enable – or at the very least not undermine – the trauma and recovery journey. There may well be important synergeies across both journeys that could be enhanced.

Table 14 Stages of recovery (Herman 1992)

	Phase	Focus/aim
1	**Establishing safety** (Stabilisation; containment and symptom reduction)	The focus is on the stablisation and containment of trauma It involves: restoring control over body and self-care: attention to basic health needs; regulation of bodily functions such as sleep, eating, exercise; management of symptoms of trauma (e.g. startle response, anger/rage). This needs to be supported by the development/presence of a safe environment. A safe environment is one which supports and encourages the above, and which does not recreate situations of humiliation, isolation, danger, unpredictability and disempowerment.
2	**Remembrance and mourning** (Processing memories; self perception and relationship with other)	Deep exploration of memories; truth telling and grieving. The goal of this stage is to transform the traumatic memory so that it can be integrated into the survivor's life story.
3	**Reconnection** (Reconnection with peers; meaningful work)	The stage involves: developing a new self; developing new relationships; developing a sustaining faith.

Source: Adapted from Herman (1992).

Supporting Aboriginal women and women with complex needs and/or a particular combination of needs

A limited body of scholarship is available that suggests complex trauma is a useful construct for describing the impacts of sexual abuse on Aboriginal women and within Aboriginal communities (L. Haskell & M. Randall, 2009; Söchting et al., 2007). It is more expansive than the PTSD construct and, through the notion of "disrupted attachments", acknowledges the trauma of colonisation and the attendant loss of land, culture and identity (Haskell & Randall, 2009). It also provides a framework through which drug and alcohol addiction, high-risk behaviours, and violence, are viewed as responses to trauma rather than pathologies and health problems.

The literature on culturally competent trauma interventions stresses the need for service providers' and practitioners' awareness and self-reflexivity about their own values and paradigms of knowledge/belief, particularly in relation to:

- The reliance on the individual as the locus of action and meaning;
- The reliance on scientific knowledge compared to spiritual knowledge and meaning;
- Conceptions of authority and respect; and
- The political, historical and institutional sources of trauma.

In addition, some literature suggests that a trauma-informed approach links well with other approaches to working in Indigenous communities, in which the individual and collective impacts of trauma can been addressed (Green, 2011).

Women offenders are highly likely to be experiencing a range of co-occurring difficulties – e.g. mental health, substance misuse and addiction, parenting difficulties. Such individuals are often diagnosed with a range of other disorders such as: major depressive disorder; anxiety; psychosis; or borderline personality disorder (BPD).[36] This has significant impacts on treatment approaches, and about what is the most important element to address and at what point – the sexual abuse trauma, the mental health problem, or the substance use? It is often the secondary (e.g. substance abuse) or tertiary (drug-induced mental illness) expressions of trauma that result in treatment and/or support. Often, the underlying trauma history is treated as a separate mental health need, is rarely integrated into treatment, and/or the complexity of symptoms results in multiple and changing diagnoses (Harris & Fallot, 2001). However, the research is increasingly finding that integration is key.

Evaluative research with women who have co-occurring disorders and who have experienced violence has found that integrating trauma awareness and issues into drug and alcohol treatment programs has resulted in better outcomes on a range of measures such as program completion, symptom reduction and abstinence (see Tables 11and 12, in Chapter 4)

What support is currently available to women in other correctional systems?

In a recent review, good practice developments in Australian jurisdictions included:

- Acknowledging that there are gendered pathways into offending;
- Creating safe, non-threatening environments;
- Improving court processes and using bail and non-custodial sentencing options;
- Improving programs' gender-responsivity; and
- Acknowledging the centrality of women's relationships with others. (Bartels & Gaffney, 2011)

Six further domains of practice were considered including prison systems and architecture, correctional programs, physical and mental health, and women prisoners' parental responsibilities. These practices address a range of issues that are relevant for women offenders, and a number of programs have been found to improve outcomes for women (e.g. longer program retention, lower rates of substance use and improved mental health).

An important aspect not included in the review by Bartels and Gaffney is the place of trauma-relevant programs and practices. It is noted that each of the women's institutions in Canada offers counselling services for survivors of abuse and trauma (the use of which is completely voluntary)

[36] A recent UK policy paper on women with borderline personality disorder in prison noted that approximately 20% of women in prison fulfill the criteria for BPD (Fossey & Black, 2010).

and that "treatment readiness for correctional programming targeting criminal behaviour is increased when women offenders have access to counselling to help them deal with issues of trauma" (Bartels & Gaffney, 2011, p. 35; see also CSC website). However, no further information is provided for this assessment. Further, trauma-informed initiatives and approaches are not expanded upon – other than noting recent debate on its centrality for women's correctional programs (see p. 52). In other words, although there is a growing implementation of the broad developments mentioned above, there is less recognition of what a trauma-informed framework is and how it is relevant to supporting women offenders.

A framework to address sexual trauma histories in correctional settings

Based on the literature, interventions to support women with sexual abuse histories involves:

- A focus on stabilisation (developing a sense of safety and bodily integrity);
- An understanding of how the effects of trauma associated with CSA are involved in other life domains (e.g. in relation to alcohol, drugs and addiction; aggression and violence; education, training and employment; readiness; and parenting); and
- Support for these interventions through policies, practices and workforce development that:
    - Understand the long-term impacts of victimisation and trauma on survivors;
    - Understand the roles of victimisation, socio-economic disadvantage, relationships, and gender in women's offending pathways and rehabilitation needs.

Supporting or counselling female offenders with CSA histories in correctional settings should include at minimum:

1. The establishment and maintenance of women prisoners' personal, interpersonal and environmental safety, as this is the most crucial element of trauma-focused interventions; and
2. A whole-of-system approach within which to locate the safety principle, and to support the work of corrections and treatment personnel.

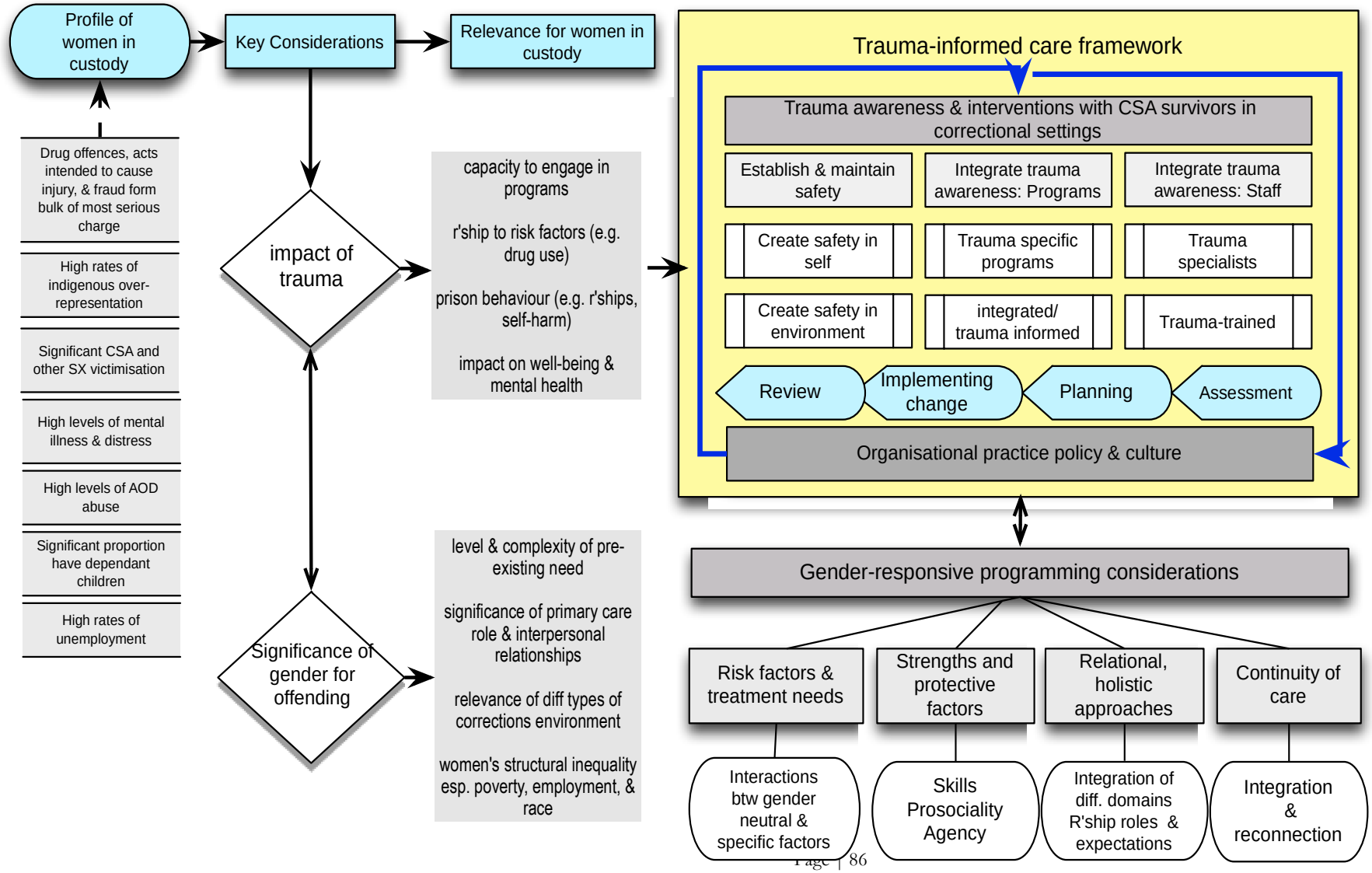
The point made here is two-fold: first, that addressing CSA trauma and providing women with therapeutic support needs to reflect the "stages of recovery" model developed in the traumatology literature; and second that such support should be embedded within a broader organisational approach to trauma and its impacts.

It would also be beneficial to bring a gender-specific lens to correctional programming for women, in light of:

- the emerging evidence that "gender-neutral" rehabilitation frameworks fit women offenders better when assessment tools are supplemented by "gender-specific" factors (e.g. Van Voorhis et al. 2010);
- the impact of acute needs on the RNR framework is unknown, but worthy of consideration; (Andrews, Bonta, Wormith, 2006); and
- methodological problems with how information regarding mental illness and sexual victimisation have been measured in studies that test the validity of, for example, the LSI-R (as noted by Rettinger & Andrews, 2010).

In other words, precisely how a CSA history and its impacts interact with prison misconduct, women's risk of re-offending, and programming needs is empirically under-researched; however, what is available is suggestive that such history is a relevant factor.

Figure 1 Conceptual framework for addressing CSA histories in a prison setting



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We have developed a conceptual framework to inform how CSNSW might take steps in considering altering current policy and practice to address women's sexual trauma histories (see Figure 1). The elements of the framework are described below.

The conceptual framework

1. Acknowledging the profile of women in custody

Addressing women offenders' trauma needs begins with acknowledging the overall profile of the women who are in custody. Relative both to male offenders and to women in the general community, and as described throughout this report, this population is characterised by:

- Significant rates of child sexual abuse and other forms of victimisation within relationships;
- High levels of substance abuse;
- High levels of mental illness and distress;
- High rates of unemployment and financial stress;
- High rates of housing instability;
- Histories of statutory care; and
- Significant proportion with dependant children.

Further, Aboriginal women comprise at least a quarter of women in custody. Women also tend to have different offending profiles compared to men, with drug offences, acts intended to cause injury, and fraud forming bulk of "most serious charge" among women.

2. Key considerations: What is the significance of trauma and gender for women's offending and needs in custodial settings?

The factors named above are well recognised by correctional systems both here and in countries such as the UK, Canada and the US. However, there is less consistency in naming the connections between these factors, and, subsequently, their implications for managing women offenders, and for women's experiences of, and within, custody.

This lack of consistency or clarity is reflective of broader debates and shifts within the traumatology, mental health, and clinical treatment fields. It is only in the last two decades that a more holistic understanding of trauma and its impacts on mind, body, and engagement with the social world has been demonstrated in the research literature, and more recently still that it has gained traction in human service systems (i.e. mental health, drug and alcohol treatment. homelessness and housing, child welfare, social welfare services). Although significant proportions of the clients in these systems have trauma histories (and are often multi-service users), many of these services and organisations are only at the beginning stages of placing trauma as central to their clients' service needs.

Another reason for this may relate to the lack of consensus within the criminological research about the significance of gender and gender difference on women's offending pathways. However, taking a step back from offending specifically, and looking to the issues of mental illness, sexual victimisation, unemployment, homelessness, and health, gender – particularly gender inequality – is a key social determinant underpinning these experiences (Krug, Mercy, Dahlberg, & Zwi, 2002; WHO, 2005). Thus from a public health perspective, "gender" as a composite of social location, collective norms, and individual experiences, is an active dimension in prevention and intervention responses for improved outcomes in mental health, experiences

of violence, and social marginalisation. It is not clear why gender (as we describe it here) would not also be an active dimension within correctional programming.

While there is ample research that describes a consistent profile of women offenders and the long-term impacts of trauma, there is not currently an empirical evidence base that consistently demonstrates that gender-specific needs or trauma needs are causally related to offending, predict offending, or that targeting these needs reduces re-offending.

Thus, in light of what is available (and how it has been synthesised in part A), this step is about debating, discussing and developing a shared understanding across CSNSW policy, operations, and service provision in relation to the following questions:

- Regarding trauma
    - How should the impact of child sexual abuse trauma (other victimisation) be understood in terms of:
        - An individual's capacities and functions (e.g. cognitive, affective, personality);
        - Its interactions with other life domains such as relationships, parenting, housing, mental health;
        - Its interactions with and/or manifestations as difficult, challenging, or harmful behaviours.
    - To what extent should understanding and working with the impacts of trauma be recognised as "core business" for a correctional system?
- Regarding gender
    - How is "gender" to be understood across the organisation? To what extent does it reflect a socio-ecological understanding of gender, gender difference and gender inequality (i.e. that gender is both an individual experience and something located across community, culture and society?
    - How significant is gender in shaping the profile of women offends and their offending pathway?

Relevance of trauma for custodial settings

The next aspect of the framework builds on the previous process to ask how the impacts of child sexual abuse trauma may be particularly relevant for women in custody. As examined in the review, early onset, chronic sexual victimisation results in trauma symptomology involving dissociation, problems with affect regulation, maladaptive self-soothing mechanisms, and interpersonal difficulties.

These aspects of trauma can negatively impact:

- Program readiness, for example:
    - Capacity to engage in the program and with program staff due to dissociative or aggressive behaviours;
    - Capacity to integrate and utilise program material (in terms of cognition and memory);
    - Capacity to stay engaged with program.
- Prison behaviour, for example:

- Self-harming behaviours to manage extreme emotions;
- Suicide attempts; or
- Other disruptive or challenging attempts at managing re-triggering incidents, anxiety, hyper-arousal or hyper-vigilance.

Other ways that trauma may be relevant relates to the type of treatment program women are in, particularly those where trauma has been shown to overlap with the program area – e.g. substance abuse.

Acknowledging the centrality of trauma and its impacts has consequences for treatment and intervention approaches (e.g. drug treatment). It also has consequences for any therapeutic intervention in relation to the women's victimisation. Evidence indicates that trauma, the possibility of rehabilitation, and wellbeing are unlikely to be separate or sequential issues for women offenders. Indeed, evidence for improving outcomes suggests *treatment integration* in which substance abuse, mental health, and trauma symptoms are integrated in therapeutic interventions (Morrissey et al. 2005) results in better outcomes for clients.

3. Locating therapeutic work with women offenders within a trauma-informed care framework

As stated earlier, therapeutic work with women offenders regarding their trauma needs should be located within an overall framework. A trauma-informed care and practice framework has emerged as a very useful approach for service systems, staff, and clients.

This framework has come primarily out of the North American mental health care system, in recognition of the high prevalence rates of sexual and physical abuse among mental health clients. Individuals for whom trauma services are aimed are increasingly being understood "not as a subgroup or an anomalous or special population of clients, but as encompassing nearly *all* persons served by public mental health and substance abuse service systems" (Jennings, 2004, p. 8).

A trauma-informed approach involves looking at all aspects of programming and service provision though a "trauma lens" (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009), not just those directly addressing the impacts of trauma. Its focus is to create organisations, programs, and services that reflect the basic understanding of the role of violence in the lives of people seeking mental health and addictions services (Harris & Fallot, 2001; Mental Health Coordinating Council, n.d). Principles of trauma-informed care include:

- Understanding trauma and its impacts;
- Promoting safety;
- Ensuring cultural competence;
- Supporting control, choice and autonomy;
- Sharing power and governance;
- Integrating care;
- Healing happens in relationships; and
- Recovery is possible.

Types of interventions are grouped as being:

- Trauma-specific: that is, interventions designed to directly address trauma and its impacts. As noted throughout this report, such interventions would primarily be within the stabilisation phase for women who are entering the correctional system. Such interventions are about increasing an individual's capacity to be safe within themselves by: being able to identify and manage emotions, triggers, flashbacks; understanding what trauma is, how it affects the mental, emotional, spiritual, physiological and cognitive self; understanding the role of trauma in mental illness, substance addiction, and interpersonal difficulties; and developing skills and strengths for alternative coping responses to trauma.
- Trauma-informed: that is, interventions that do not directly target managing the effects of trauma, but are aware of: the connection between trauma and other maladaptive behaviours; the impact of trauma on capacity to fully participate in treatment programs (rather than interpret lack of engagement as a lack of motivation, for example); the importance of choice, autonomy and participatory decision-making with survivors.

In the diagram, there are two overall aspects to be considered: the work with CSA survivors themselves and organisational practice, policy and culture.

In relation to interventions with CSA survivors, the following is suggested:

- ***Use the "stages of trauma and recovery" model to understand both impacts of and treatment responses to trauma***. As noted earlier, for women in prison, their trauma histories are likely to be extensive and knotted up with a range of negative behaviours such as substance abuse and negative outcomes such as mental illness, as well as deeply affecting their capacity for emotional self-regulation. Thus safety – physical, existential, and environmental is paramount as the basis for the next stages
- ***Provision of trauma-specific interventions.*** The literature on complex trauma advocates trauma-specific interventions such as capacity-building survivors to understand reactions to trauma, to identify their own reactions and triggers and to have plans and strategies in place to manage them (psycho-education), and mindfulness and body-oriented therapies. See Table 11 for examples of evaluated interventions.
- ***Integrate trauma awareness into other programs:*** As noted throughout, other treatment programs such as substance abuse, positive parenting, anger management and so on would likely benefit from having an trauma component integrated into them. See Table 12 for examples of evaluated interventions.
- ***Integrate trauma awareness in staff capacity:*** There are two ways staff can have a trauma awareness – one is through directly providing trauma-specific interventions (i.e. being a trauma specialist as with sexual assault counsellors) and by being trauma-informed as providers non-trauma specific programs, or as operational staff.

In relation to organizational policy and practice, becoming trauma informed can involve a change management approach in regards to daily operations; policy and resourcing priorities; staff selection and recruitment; staff training and leadership. An organisation-level element is importance both for the safety of offenders and for the confidence of correctional staff, for whom a more informed perspective on the impacts of trauma and the relevance of gender difference could enhance offender management and interaction.

In this diagram four domains are described:

- ***Assessment:*** of current policies and procedures; of operating environment; physical space; level of knowledge among staff

- ***Planning:*** for where current practice can be altered; identifying champions within the work environment. Creating working groups, convening discussion groups. Creating shared understanding among different parts of the organisation.
- ***Training and workforce capacity:*** Developing training information and modules that best addresses both information needs and capacity of workers to undertake training. Training that is skills focused. Creating support among leaders for time given to training.
- ***Review:*** It is important to review at different points to understand the challenges, strengths, and obstacles are bringing a trauma informed perspective to the organisation. This may be particularly the case for the correctional settings where a number of Trauma Informed Care principles may not be applicable. It is envisaged that the review process here will be very important.

The table below is not intended to be prescriptive, but to highlight the importance of embedding interventions that would address sexual abuse trauma within higher level guidelines and strategies. These have been suggested by the literature, which comes primarily from the North American context. Although there are some differences, both frameworks advocate high level policy statements/positions; workforce capacity and training; guidelines; reflexive monitoring and practice; and research and evaluation. A list of resources and toolkits is provided in the table also.

Importantly, work done around trauma-informed care will have relevance for male prisoners also.

Table 15 Organisational strategies for trauma-informed interventions

Trauma-informed	Useful resources
Policy statement in relation to how trauma is to be understood and addressed within the organisation Workforce orientation, training, support, competencies and job standards related to trauma, e.g. • understanding of, and sensitivity to, issues of violence, trauma, and coercion; • incorporate relevant skill sets and job standards; and address prevalence and impact of traumatic events; • basic education about the traumatic impacts of sexual and physical abuse and other interpersonal violence to increase sensitization to trauma-related dynamics and the avoidance of retraumatization; • direct care and clinical staff should be educated in a trauma-informed understanding of unusual or difficult behaviors, the maintenance of personal and professional boundaries, evidence-based and emerging best practices in the treatment of trauma, and in vicarious traumatization and self-care. Systems integration/coordination among systems dealing with persons with trauma histories Trauma screening and assessment upon entry into system Procedures to avoid retraumatization and reduce impacts of trauma, e.g. • Training on dynamics of retraumatization and how some practices could mimic original sexual and physical abuse experiences. • Specific policies to create safety; acknowledge and minimize the potential for retraumatization; address trauma history in treatment and discharge plans; respect gender differences; and provide immediate intervention to mitigate effects should interpersonal violence occur Research and data to explore prevalence and impacts of trauma, assess status of services, and support implementation of evidence-based and emerging best practice trauma treatment models. From Jennings, (2004)	*Blueprint for Action: Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services (Compiled by Ann Jennings)* The Trauma-informed Toolkit: • Provides recommended practices to assist service providers and/or organizations to increase their capacity in delivering trauma-informed services. http://www.trauma-informed.ca/home.htm **Available on the internet as PDFs** *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol* Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D. July, 2009 • Has a selection of useful questions for organisations to ask re the principles of TIC. *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services* Ann Jennings, Ph.D. (2004). **Selected websites:** National Center for Trauma Informed carehttp://www.samhsa.gov/nctic/ Trauma Centre http://www.traumacenter.org/ Mental Health Co-ordinating Council www.mhcc.org.au/

4. Consideration of the relevance of a Gender Responsive Programming

In the North American context, a Gender Responsive Programming framework [GRP] has emerged to reflect what is known about women's offending pathways. Developed primarily by Covington and Bloom, and empirically tested by Van Voorhis and colleagues, a GRP framework attempts to identify needs predictive of reoffending that are specific to women (e.g. depression/anxiety, child abuse, adult victimisation, anger, self-efficacy).[37] Empirical studies have found that integrating gender responsive factors into the dominant Risk-Needs-Responsivity framework, under appropriate conditions, achieved strong levels of predictive validity. More broadly, the GRP framework aims to provide an overall approach to managing women offenders. It emphasises: respect and safety in correctional environments and programming; women's relational needs; the interconnections between mental health, substance abuse and trauma; and women's structural socio-economic marginalisation (see Part A, Chapter 3 for a review of the literature on gender and rehabilitation). In the UK context, "woman-centred" approaches are being advocated, which reflect many of the tenets of GRP.

The GRP framework is important to the questions this review is concerned with. It reflects the research conducted with women offenders about their pathways and, increasingly, is being tested for validity as a programming tool. However, a GRP framework is not sufficient to answer questions about the role of trauma in women's offending pathways or about how to shape therapeutic interventions with women to address their histories of sexual victimisation. In a GRF framework, a victimisation history is often one of, but not central to, women's distinct needs. Yet the clinical literature on trauma strongly suggests that the trauma of childhood and prolonged victimisation is profoundly connected to complexity of need.

Gender responsivity is defined as "creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's lives" (Covington & Bloom, 2004, p. 3). Its approaches are based on the research evidence about women's particular offending patterns, and advocates a strengths-based approach that takes into account violence and abuse, poverty, race, class and gender inequality as factors shaping women's rehabilitation needs.

The Gender Responsive Framework (GRF) seeks to address "the realities of women's lives through gender-responsive policy and programs…[that are]…fundamental to improved outcomes at all criminal justice phases". The major principles of GRF are:

- Recognise that men and women require different penal policies and environments – criminal conduct is gendered
- Respect and safety are key to women's program readiness
- Acknowledge women's relational needs and recognise the need for women to create healthy and respectful relationships
- Programs that address substance abuse, trauma and mental health can be achieved through collaboration and integrating services
- Design programs to address socioeconomic disadvantage
- Create transitional pathways with collaborative services. (Covington & Bloom, 2004)

[37]This is not to suggest that such factors are not experienced by or relevant for male offenders. Rather, the issue is whether such factors predict re-offending.

These principles and how they connect to the current rehabilitation framework is ultimately for CSNSW's consideration. As noted through out the review, whether risks/needs are demonstrably different for women compared to men is under debate. Nevertheless the presence of trauma histories, their complex sequelae and the overall circumstances of disadvantage for women offenders has been demonstrated through out the research. It may be that looking at risk/needs through the lens trauma may shed light on how the different needs are present within women's profiles, and what their particular relationships are relative to men.

In summary

The framework that we have described is not intended to be prescriptive or to provide recommendations about actions. Rather it points out that, based on the review of the literature two broad directions emerge to assist corrections in managing and rehabilitating female prisoners. The first relates to addressing, on the one hand, the status of women within such settings as victim/survivors. In this view, addressing sexual abuse histories requires two broad types of intervention: those that directly address the impacts of trauma; and those that integrate an understanding of trauma into their design and delivery. The second direction relates to addressing the role, relevance, and extent of gendered differences in offending and rehabilitation.

It is also important to note that these directions and the way that we have combined them into a single framework is not intended to replace other approaches and frameworks such as RNR or through care. We would hope instead that our conceptual approach could be overlayed onto these current approaches such that points of resonance and articulation become clear and can be developed into practical actions.

References

Aboriginal Justice Centre. (2008). Circles of Support: towards Indigenous justice: prevention, diversion & rehabilitation. Canberra: Aboriginal Justice Centre & ACT Council of Social Services Inc.

ABS. (2010). *Prisoners in Australian, 2010*. Canberra: Australian Government Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mediareleasesbytitle/1F2BD14CF87EE4AFCA25751B001AC5FA?OpenDocument.

AIHW. (2007). The burden of disease and injury in Australia 2003. Canberra: Australian Institute of Health and Welfare.

. Alexander Maconochi Centre. (2010), from http://www.cs.act.gov.au/custodial_operations/types_of_detention/alexander_maconochie_centre

Allimant, A., & Ostapiej-Piatkowski, B. (2011). Supporting women from CALD backgrounds who are victims/survivors of sexual violence: Challnges and opportunities for practitioners. *ACSSA Wrap 9, Australian Institute of Family Studies*, 1-15.

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: rediscovering psychology. *Criminal Justice and Behaviour, 17*(1), 19-52.

Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct* (Third ed.). Cincinnati: Anderson Publishing.

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency, 52*(1), 7-27.

Andrews, D. A., Guzzo, L., Raynor, P., Rowe, R. C., Rettinger, L. J., Brews, A., & Wormith, J. S. (2012). Are the Major Risk/Need Factors Predictive of Both Female and Male Reoffending? *International journal of offender therapy and comparative criminology, 56*(1), 113-133. doi: 10.1177/0306624x10395716

Andrews, G., Gould, B., & Corry, J. (2002). Child sexual abuse revisited. *The Medical Journal of Australia, 176*(10), 458-459. Retrieved from http://www.mja.com.au/public/issues/176_10_200502/and10179_fm.html

Aretxana, B. (2001). The sexual games of the body politic: Fantasy and state violence in Northern Ireland. *Culture, Medicine and Psychiatry, 25*, 1-27.

Australian Bureau of Statistics. (2002). Information paper: Measuring crime victimisation Australia: The impact of different collection methodologies. Canberra: Author.

Australian Bureau of Statistics. (2003). Sexual Assault Information Development Framework. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2004a). Crime and justice: Women in prison *Australian Social Trends*. Canberra, ACT: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2004b). Sexual assault in Australia: A statisitcal overview. Canberra: Author.

Australian Bureau of Statistics. (2010). Prisoners in Australia. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2011). Corrective Services March quarter 2011. Canberra: Australian Bureau of Statistics.

Baldry, E. (2007). Throughcare: Making the policy a reality.

Baldry, E. (2008). The booming industry: Australian Prisons. In Debate (Ed.). NSW: School of Social Sciences and International Studies.

Baldry, E. (2009). *Prisons and vulnerable persons: Institutions and patriarchy.* Paper presented at the Australia and New Zealand Critical Criminology Conference 2009, Melbourne.

Baldry, E., McDonnell, D., Maplestone, P., & Peeters, M. (2002). *Ex-prisoners and accommodation: what bearing do different forms of housing have on social reintegration of ex-prisoners?* Paper presented at the Housing, Crime and Stronger Communities Conference, Melbourne.

Baldry, E., with McComish, C., & Clarence, M. (2009). *Punishing the vulnerable: Women with mental health disorders and cognitive disabilities in the NSW Criminal Justice System* Paper presented at the Sisters Inside Conference, Brisbane.

Banyard, V. L., & Williams, L. M. (1996). Characteristics of Child Sexual Abuse as Correlates of Women's Adjustment: A Prospective Study. *Journal of Marriage and the Family, 58*, 853-865.

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2001). The long-term mental health consequences of child sexual abuse: an exploratory study of the impact of multiple traumas in a sample of women. *Journal of Traumatic Stress, 14*(4).

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The Impact of Complex Trauma and Depression on Parenting: An Exploration of Mediating Risk and Protective Factors. *Child Maltreatment, 8*(4), 334-349.

Bartels, L. (2010a). Indigenous women's offending patterns: A literature review. In C. R. Council (Ed.), *Research and Public Policy Series*. Canberra: Australian Institute of Criminology.

Bartels, L. (2010b). Diversion programs for Indigenous women *Research in Practice*. Canberra: Australian Institute of Criminology.

Bartels, L., & Gaffney, A. (2011). *Good practice in women's prisons: A literature review*. (41). Canberra: Australian Institute of Criminology.

Battle, C. L., Zlotnick, C., Najavits, L. M., Cutierrez, M., & Winsor, C. (2003). Posttraumatic stress disorder and substance use diorder among incarcerated women. In P. Ouimette & P. Brown, J (Eds.), *Trauma and Substance Abuse: causes, consequences, and treatment of comorbid disorders*. Washington DC: American Psychological Association.

Belsky, J., & Vondra, J. (1989). Lessons from child abuse: The determinants of parenting. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 153-202). New York: Cambridge University Press.

Berlin, L. J., Appleyard, K., & Dodge, K. A. (2011). Intergenerational Continuity in Child Maltreatment: Mediating Mechanisms and Implications for Prevention. *Child Development, 82*(1), 162-176.

Berman, J. (n.d.). Women offender transition and reentry: Gender responsive approaches to transitioning women offenders from prison to the community. In N. I. o. Corrections (Ed.): Centre for Effective Public Policy.

Berry, P. E., & Eigenberg, H. M. (2003). Role strain and incarcerated mothers. *Women & Criminal Justice, 15*(1), 101-119.

Brewer-Smyth, K., Worbert Burgess, A., & Shults, J. (2004). Physical and sexual abuse, salivary cortisol. and neurologic correlates of violent criminal behavior in female prison inmates. *Biological Psychiatry, 55*(1), 21-31.

Blackburn, A. G., Mullings, J. L., & Marquart, J. W. (2008). Sexual Assault in Prison and Beyond. *The Prison Journal, 88*(3), 351-377. doi: 10.1177/0032885508322443

Blanchette, K., & Brown, S. L. (2006). *The assessment and treatment of women offenders*. West Sussex: John Wiley & Sons Ltd.

Blanchette, K., & Taylor, K. (2009). Reintegration of female offenders: perspectives on "What Works". *Corrections Today, 71,* 60-64.

Bloom, B., Owen, B., & Covington, S. (2003). Gender-responsive strategies: research, practice, and guiding principles for women offenders. Washington DC: National Institute of Corrections, .

Bogdanic, A. (n.d.). Strip searching of female prisoners in Queensland. In W. i. P. A. Network (Ed.). New South Wales: Women in Prsion Advocacy Network.

Bonta, J., & Andrews, D. A. (2007). Risk-Need-Responsivity model for offender assessment and rehabilitation. In P. S. Canada (Ed.). Canada: Public Safety Canada.

Booth, A., Papaioannou, D., & Sutton, A. (2012). *Systematic approaches to a successful literature review*. Los Angeles, CA.: SAGE Publications Limited.

Bottos, S. (2007). Women and violence: Theory, risk and treatment implications. In C. S. C. Research Branch (Ed.). Ontario: Correctional Service Canada.

Boyd, C. (2011). The impacts of sexual assault on women *ACSSA Resource Sheet*. Melbourne, Vic.: Australian Institute of Family Studies.

Brewer-Smyth, K. (2004). Women behind bars: could neurobiological correlates of past physical and sexual abuse contribute to criminal behavior? *Health Care for Women International, 25*(9), 835-852. doi: 10.1080/07399330490517118

Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18*(5), 401-412.

Bromfield, L., Lamont, A., Parker, R., & Horsfall, B. (2010). Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse and mental health problems *NCPC Issues* (pp. 23). Melbourne: Australian Institute of Family Studies.

Brown, M., & Ross, S. (2010a). Assisting and supporting women released from prison: Is mentoring the answer? *Current Issues in Criminal Justice, 22*(2).

Brown, M., & Ross, S. (2010b). Mentoring, social capital and desistance: A study of women released from prison. *The Australian and New Zealand Journal of Criminology, 43*(1), 31-50.

Browne, A., & Bassuk, S. (1997). Intimate violence in the lives of homeless and poor housed women: Prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry, 6*, 261-278.

Butler, T., & Allnutt, S. (2003). Mental illness among New South Wales prisoners. In C. H. Service (Ed.). Sydney, NSW: Corrections Health Service.

Cameron, M. (2001). Women prisoners and correctional programs. In Australian Institute of Criminology (Ed.), (Vol. 194). Canberra: Australian Institute of Criminology, .

Cannon, E. A., Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2010). Adult Health and Relationship Outcomes Among Women With Abuse Experiences During Childhood. *Violence and Victims, 25*(3), 291-305.

Carlen, P. (1983). *Women's imprisonment: a study in social control* London: Routledge.

Carnaby, H. (1998). Road to Nowhere: A report of women's housing and support needs when leaving prison. Victoria: Flat Out.

Carnovale, M. (2009). Why women kill. *New South Wales Police News, 89*.

Cerveri, P., Colvin, K., Dias, M., George, A., Hanna, J., Jubb, G., . . . Weigall, C. (2005). Request for a systematic review of discrimination against women in victorian prisons. Victoria: Corrections Working Group of the Federation of Community Legal Centres and the Victorian Council of Social Service.

. Characteristics of parents involved in the Queensland child protection system. (2008). In D. o. C. Safety (Ed.). Brisbane: Queensland Government.

Chesney-Lind. (1989). Girls' crime and woman's place: Toward a feminist model of female delinquency. *Crime & Delinquency, 35*(1), 5-29.

Chesney-Lind. (1997). *Female Offender: Girls, Women, and Crime*. Thousand Oaks, CA.,: Sage Publications.

Chiang, K. (2009). Effects of child sexual abuse on parenting and child behaviours om a sample of homeless women. *Dissertation Abstracts International, 69*((12-B)), 7804.

Christopher, K., Lutz-Zois, C. J., & Reihardt, A. R. (2007). Female sexual-offenders: Personality pathology as a mediator of the relationshio between childhood sexual abuse history and sexual abuse. *Child Abuse & Neglect, 31*(8), 871-883.

Clark, H., & Fileborn, B. (2011). Responding to sexual assault within institutional settings *ACSSA Wrap* (Vol. 10). Melbourne, Vic.: Australian Institute of Family Studies.

Classen, C., Nevo, R., Koopman, C., Nevill-Manning, K., Gore-Felton, C., Rose, D. S., & Spiegel, D. (2002). Recent Stressful Life Events, Sexual Revictimisation, and Their Relationship With Traumatic Stress Symptoms Among Women Sexually Abused in Childhood. *Journal of Interpersonal Violence, 17*(12), 1274-1290.

Cobbina, J. E. (2009). *From prison to home: Women's pathways in and out of crime* (dissertation), University of Missouri, St. Louis.

Coid, J., Petruckecitch, A., Feder, G., Chundg, W.-S., Richardson, J., & Moorey, S. (2001). Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-sectional survey. *The Lancet, Vol 358*, 450-453.

Cooper, H. (2010). *Research synthesis and meta-analysis*. Thousand Oaks, CA.: Sage.

Corben, S. (2011). NSW inmate census 2011: Summary of characteristics *Statistical Publication* (Vol. 38). Sydney: Corrective Services, NSW.

Corrective Services NSW. (2010). NSW Inmate Census: Summary of Charactersitics (Vol. Statistical Report No 34). Sydney: Corrective Services NSW.

Corrective Services NSW. (n.d.). Women Offenders Retrieved 23 March 2011, from http://www.correctiveservices.nsw.gov.au/offender-management/offender-services-and-programs/women-offenders

Corston, J. (2007). A review of women with particular vulnerabilities in the criminal justice system. London: Home Office.

Cosden, M., & Cortez-Ison, E. (1999). Sexual abuse, parental bonding, social support, and program retention for women in substance abuse treatment. *Journal of Substance Abuse Treatment, 16*(2), 149-155.

Covington, & Bloom. (2004). *Creating gender-responsive services in correctional settings: context and considerations*. Paper presented at the American Society of Criminology Conference, Texas.

Covington, S. (2008). Women and Addiction: A trauma-informed approach. *Journal of Psychoactive Drugs, SARC Supplement 5*.

Covington, S. (2008a). The relational theory of women's psychological development: Implications for the justice system. In R. Zaplin (Ed.), *Female offenders: critical perspectives and effective interventions* (Second ed., pp. 135-164). Ontario: Jones and Bartlett Publishers.

Covington, S. S., & Bloom, B. E. (2004). *Creating gender-responsive services in correctional settings: context and consideration*. Paper presented at the American Society of Criminology Conference, Tennessee.

Covington, S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, Supplement 5*, 387-398.

Cross, W. (2001). A Person History of Childhood Sexual Abuse: Parenting Patterns and Problems. *Clinical Child Psychology and Psychiatry, Vol 6*(4), 563-574.

Cutajar, M., Mullen, P., Ogloff, J., Thomas, S., Wells, D., & Spataro, J. (2010). Schizophrenia and other psychotic disorders in a cohort of sexually abused children. *Archives of General Psychiatry, 67*(11), 1114-1119.

Cutajar, M. C., Ogloff, J. R. P., & Mullen, P. E. (2011). Child Sexual Abuse and Subsequent Offending and Victimisation: A 45 Year Follow-Up Study. Canberra, ACT: Criminology Research Council

Daly, K. (1998). Gender, crime and criminology. In M. Tonry (Ed.), *The handbook of crime and punishment*. New York: Oxford University Press.

Davidson, J. T., & Chesney-Lind, M. (2009). Discounting women: Context matters in risk and need assessment. *Critical Criminology, 17*, 221-245.

Davis, J. L., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: a review and synthesis of the empirical literature. *Aggression and Violent Behaviour, 5*(3).

. *Debates of the Legislative Assembly for the Australian Capital Territory*. (2008). Canberra: Australian Government Retrieved from http://www.hansard.act.gov.au/hansard/2008/pdfs/P080827.pdf.

. *Department of Correctional Services, South Australia: Annual Report 2009-2010*. (2010). South Australia: Government of South Australia.

Department of Corrective Services. (2009). *Women's way forward: Strategic plan for women 2009-2012*. Western Australia: Government of Western Australia.

Department of Justice. (2007). *Better pathways in practice: The women's correctional services framework*. Victoria: Department of Justice.

DiLillo, D., & Damashek, A. (2003). Parenting Characteristics of Women Reporting a History of Childhood Sexual Abuse. *Child Maltreatment, 8*(4), 319-333.

DiLillo, D., Giuffre, D., Tremblay, G. C., & Peterson, L. (2001). A Closer Look at the Nature of Intimate Partner Violence Reported by Women With a History of Child Sexual Abuse. *Journal of Interpersonal Violence, 16*(2), 116-132.

Dirks, D. (2004). Sexual revictimisation and retraumatisation of women in prison. *Women's Studies Quarterly, 32*(3/4), 102-115.

Domino, M., Morrissey, J. P., Nadlicki-Patterson, T., & Chung, S. (2005). Service costs for women with co-occurring disorders and trauma. *Journal of Substance Abuse Treatment, 28*(2), 135-143. doi: 10.1016/j.jsat.2004.08.011

Dowden, C., & Andrews, D. A. (1999). What works for female offenders: A meta-analytic review. *Crime & Delinquency, 45*(4), 438-452.

Easteal, P. (1994). Don't talk, don't trust, don't feel. *Alternative Law Journal, 19*(2), 185-189.

Easteal, P. (2001). Women in Australian prisons: The cycle of abuse and dysfunctional environments. *The Prison Journal, 81*(1), 87-1123.

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational Transmission of Partner Violence: A 20 year prospective study. *Journal of Consulting and Clinical Psychology, 71*(4), 741-753.

Eliason, M. (2006). Are therapeutic communities therapeutic for women? *Substance abuse treatment, prevention and policy, 1*(3).

Elklit, A., & Brink, O. (2004). Acute stress disorder as a predictor of post-traumatic stress disorder in physical assault victims. *Journal of Interpersonal Violence, 19*(6).

Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Evaluation of the Better Pathways Strategy. (2009). Evaluation of the Better Pathways Strategy, Corrections Victoria. In C. Victoria (Ed.). Melbourne: PriceWaterhouseCoopers.

Fagan, A. A. (2001). The gender cycle of violence: comparing the effects of child abuse and neglect on criminal offending for males and females. *Violence and Victims, 16*(4), 457-474.

Fair, H. (2009). International review of women's prisons. *Prison Service Journal, 184*, 3-8.

Fallot, R. D., & Harris, M. (2002). The Trauma Recovery and Empowerment Model (TREM): conceptual and practical isues in a group intervention for women. *Community mental health journal, 38*(6).

Farkas, K. J., & Hrouda, D. R. (2007). Co-occurring disorders among female jail detainees: Implications for service delivery. *Journal of Social Work Practice in the Addictions, 7*(1-2), 51-67. doi: 10.1300/J160v07n01_04

Fergus, L., & Keel, M. (2005). Conference Review: Is prison obsolete? *ACSSA Aware 9 Australian Institute of Family Studies*.

Finkelstein, N., & Markoff, L. (2004). Women Embracing Life and Living (WELL) Project: Using the Relational Model to Develop Integrated Systems of Care for Women with Alcohol/Drug Use and Mental Health Disorders with Histories of Violence. *Alcoholism Treatment Quarterly, , 22*(3/4), 63-80.

Flanagan, K. (2003). Intervention with sexually abusive young people in Australia and New Zealand. *Journal of Sexual Aggression, 9*(2), 135-149.

Forsythe, L., & Adams, K. (2009). Mental health, abuse, drug use and crime: Does gender matter? *Trends & Issues in crime and criminal justice* (Vol. 384). Canberra, ACT: Australian Institute of Criminology.

Fortier, M. A., DiLillo, D., Messman-Moore, T. L., Peugh, J., DeNardi, K. A., & Gaffey, K. J. (2009). Severity of child sexual abuse and revicitimzation: the mediating role of coping and trauma symptoms. *Psychology of Women Quarterly, 33*(3), 308-320.

Fossey, M., & Black, G. (2010). Under the radar: Women with borderline personality disorder in prison. London: Centre for Mental Health.

Fox, A., Khan, L., Briggs, D., Rees-Jones, N., Thompson, Z., & Owens, J. (2005). Throughcare and aftercare: approaches and promising practice in service delivery for clients released from prison or leaving residential rehabilitation. England: Home Office.

Gelsthorpe, L. (2010). Women, crime and control. *Criminology and criminal justice, 10*(4), 375-386.

Goff, A., Rose, E., Rose, S., & Purves, D. (2007). Does PTSD occur in sentenced prison populations? A systematic literature review. *Criminal Behaviour and Mental Health, 17*(3), 152-162.

Grauerholz, L. (2000). An ecological approach to understanding sexual revictimization: Linking personal, interpersonal, and sociocultural factors and processes. *Child Maltreatment, 5*(1), 5-17.

Green, G. (2011). Developing trauma training for an indigenous community: Hopefully not seagulls. *Australian Social Work, 64*(2), 215-227.

Grossman, J., & Mackenzie, F. J. (2005). The randomized controlled trial: gold standard, or merely standard? *Perspectives in Biology and Medicine, 48*(4), 516-534.

Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). Trauma-Informed Organizational Toolkit. Rockville, Maryland: : Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation.

Hannah-Moffat, K. (2004). Gendering risk at what cost: Negotiations of gender and risk in Canadian women's prisons. *Feminism & Psychology, 14*(2), 243-249.

Hannah-Moffat, K. (2009). Gridlock or mutability: Reconsidering "gender" and risk assessment *Criminology and Public Policy, 8*(1), 209-219.

Hannah-Moffat, K. (2010). Sacrosanct or Flawed: Risk, accountability and gender-responsive penal politics. *Current Issues in Criminal Justice, 22*(2), 193-215.

Hannah-Moffat, K., & Shaw, M. (2001). *Taking risks: Incorporating gender and culture into the classification and assessment of federally sentenced women in Canada*. Canada: Status of Women Canada.

Hardyman, P., & Van Voorhis, P. (2004). Developing gender-specific classification systems for women offenders. Washington D.C.: U.S. Department of Justice, National Insitute of Corrections.

Harer, M. D., & Langan, N. P. (2001). Gender differences in predictors of prison violence: Assessing the predictive validity of a risk classification system. *Crime & Delinquency, 47*(4), 513-536.

Harris, M., & Fallot, R. D. (2001). Using trauma theory to design service systems. In M. Harris & R. D. Fallot (Eds.), *New Directions for Mental Health Services* (Vol. 89): Jossey Bass.

Harvey, A., & Bryant, R. (1999). The relationship between acute stress disorder and post-traumatic stress disorder: A 2-year prospective evaluation. *Journal of Consulting and Clinical Psychology, 67*(6), 985-988.

Harvey, A., & Bryant, R. (2002). Acute stress disorder: A synthesis and critique. *Psychological Bulletin, 128*(6), 886-902.

Harvey, M. (2007). Towards an ecological understanding of resilience in trauma survivors: Implications for theory, research and practice. *Journal of Aggression, Maltreatment and Trauma, 14*(1).

Haskell, L., & Randall, M. (2009). Disrupted attachments: A social context complex trauma framework and the live of Aboriginal peoples in Canada. *Journal of Aboriginal Health, 5*(3), 48-99.

Haskell, L., & Randall, M. (2009). Disrupted Attachments: A Social Context Complex Trauma Framweork and the Lives of Aboriginal Peoples in Canada. *Journal of Aboriginal Health, November*, 48-99.

Henderson, C., & Bateman, J. (2010). Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse Lilyfield, NSW: Mental Health Coordinating Council.

Herman, J. (1992a). *Trauma and Recovery: From domestic abuse to political terror* New York: Basic Books.

Herman, J. (1992b). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377-391.

Herman, J. (2000). The case of trauma and recovery: Conversation with Judith Herman M.D. Retrieved 21 March 2011, from http://globetrotter.berkeley.edu/people/Herman/herman-con3.html

Higgins, D., & McCabe, M. (2000). Multi-type maltreatment and the long-term adjustment of adults. *Child Abuse Review, 9*, 6-18.

Holmes, J. (2010). Femail offending: Has there been an increase? *Issue Paper* (Vol. 46). Sydney, NSW: NSW Bureau of Crime Statistics and Research.

Holsinger, A. M., Lowenkamp, C. T., & Latessa, E. J. (2003). Ethnicity, gender and the Level of Service Inventory-Revised. *Journal of Criminal Justice, 31*, 309-320.

Holtfreter, K., & Cupp, R. (2007). Gender and risk assessment: The empirical status of the LSI-R for women. *Journal of contemporary criminal justice, 23*(4), 363-382.

Hopper, E., Bassuk, E., & Olivet, J. (2007). Shelter from the storm: creating trauma-informed homeless services. *Washington DC: Department of Health and Human Services (US)*.

Horvarth, M. (2010). *Child sexual abuse*. New York: Cambridge University Press.

Howells, K., Heseltine, K., Sarre, R., Davey, L., & Day, A. (2004). *Correctional offender rehabilitation programs: The national picture in Australia*. SA: University of South Australia.

Humphreys, C. (2007). Domestic violence and child protection: Challenging directions for practice. *Australian Domestic and Family Violence Clearinghouse, Issue Paper 13*.

Huntington, N., Moses, D., & Veysey, B. (2005). Developing and implementing a comprehensive approach to servcing women with co-occurring disorders and histories of trauma. *Journal of Community Psychology, 33*(4), 395-410.

Improving outcomes for women offenders: Women offenders policy and action plan 2008-2012. (2008). Queensland: Queensland Government.

Indig, D., McEntyre, E., Page J., & Ross, B. (2010a). 2009 NSW Inmate Health Survey: Aboriginal Health Report. Sydney: Justice Health.

Indig, D., Topp, L., Ross, B., Mamoon, H., Border B., Kumar, S., & McNamara, M. (2010b). 2009 NSW Inmate Health Survey: Key findings report. Sydney: Justice Health

Jenks, A. (2010). *Childhood sexual abuse in incarcerated females: Complex trauma symptomotology and the personality assessment inventory.* (Doctor of Psychology), Pacific University, Hillsboro.

Jennings, A. (2004). Models for developing trauma-informed behavioral health systems and trauma-specific services. US: United States Department of Health and Human Services.

Johnson, D. M., Sheahan, T. C., & Chard, K. M. (2003). Personality Disorders, Coping Strategies, and Posttraumatic Stress Disorder in Women with Histories of Childhood Sexual Abuse. *Journal of Child Sexual Abuse, 12*(2), 19-39. doi: 10.1300/J070v12n02_02

Jordan, B. K., Federman, E. B., Burns, B. J., Schlenger, W. E., Fairbank, J. A., & Caddell, J. M. (2002). Lifetime use of mental health and substance abuse treatment services by incarcerated women felons. *Psychiatric Services, 53*(3), 317-325. doi: 10.1176/appi.ps.53.3.317

Keel, M. (2005). Sexual Assault and Mental Health in Australia. *ACSSA Aware, 6*, 10-22.

Kim, K., Trickett, P., & Putnam, F. (2010). Childhood experiences of sexual abuse and later parenting practices among non-offending mothers of sexually abused and comparison girls. *Child Abuse & Neglect, 34*, 610-622.

King, S., Bamford, D., & Sarre, R. (2005). Factors that influence remand in custody: Final report to the Criminology Research Council: Social Policy Research Group, University of South Australia.

Korn, D. L. (2009). EMDR and the Treatment of Complex PTSD: A Review. *Journal of EMDR Practice and Research, 3*(4), 264-278. doi: 10.1891/1933-3196.3.4.264

KPMG. (2009). The Cost of Violence Against Women and their Children. Canberra: The National Council to Reduce Violence against Women and their Children.

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The lancet, 360*(9339), 1083-1088.

Kruttschnitt, C., & Gartner, R. (2003). Women's Imprisonment. *Crime and Justice, 30*, 1-81.

Kubiak, S. P., & Arfken, C. L. (2007). Beyond gender responsivity. *Women & Criminal Justice, 17*(2), 75-94.

Lamont, A. (2010). Effects of child abuse and neglect for adult survivors (NCPC Resource Sheet) *NCPC Resource Sheet*. Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies.

Langan, N. P., & Pelissier, B. M. M. (2001). Gender differences among prisoners in drug treatment. *Journal of Substance Abuse, 13*(3), 291-301.

Lart, R., Pantazis, C., Pemberton, S., Turner, W., & Almeida, C. (2008). Interventions aimed at reducing re-offending in female offenders: a rapid evidence assessment (REA) *Ministry of Justice Research Series*. London: Ministry of Justice.

Lawrie, R. (2003). "Speak out speak strong" - Researching the needs of Aboriginal women in custody - Digest". *Australian Indigenous Law Reporter 85, 8*(2), 1-5.

Lemieux, S. R., & Byers, S. (2008). The sexual well-being of women who have experienced child sexual abuse. *Psychology of Women Quarterly, 32*(2), 126-144.

Lievore, D. (2003). Non-reporting and hidden recording of sexual assault: An international literature review. Canberra: Commonwealth Officer for the Status of Women.

Lindsay, W. R., Ward, T., Morgan, T., & Wilson, I. (2007). Self-regulation of sex offending, future pathways and the Good Lives Model: Applications and problems. *Journal of Sexual Aggression, 13*(1), 37-50.

Liotti, G. (2004). Trauma, Dissociation, and Disorganized Attachment: Three Strands of a Single Braid. *Psychotherapy: Theory, research, practice, training, 41*, 472-486.

Lowenkamp, C. T., Holsinger, A. M., & Latessa, E. J. (2001). Risk/need assessment, offender classification, and the role fo childhood abuse. *Criminal Justice and Behaviour, 25*(5), 543-563.

Loxley, W., & Adams, K. (2009). Women, drug use and crime: Findings from the drug use monitoring in Australia program *Research and Public Policy Series* (Vol. 99). Canberra, ACT: Australian Institute of Criminology.

Luxenberg, T., Spinazzola, J., Hidalgo, J., & Van der Kolk, B. (2001b). Complex trauma and disorders of extreme stress (DESNOS) diagnosis, Part 2: Treatment. *Directions in Psychiatry, 21*(Lesson 25), 395-414.

Luxenberg, T., Spinazzola, J., & Van der Kolk, B. (2001a). Complex trauma and disorders of extreme stress (DESNOS) diagnosis, Part 1: Assessment. *Directions in Psychiatry, 21*(Lesson 25), 373-392.

Macey, R. J., Giattina, M. C., Parish, S. L., & Crosby, C. (2010). Domestic Violence and Sexual Assault Services: Historical Concerns and Contemporary Challenges. *Journal of Interpersonal Violence, 25*(1), 3-32.

Manchak, S. M. (2009). Does gender moderate the predictive utility of the level of service inventory-revised (lsi-r) for serious violent offenders? *Criminal Justice and Behavior, 36*(5), 425-442.

Martin, J., Kautt, P., & Gelsthorpe, L. (2009). What works for women? A comparison of community-based general offending program completion. *The British Journal of Criminology, 49*(4), 879-899.

Maruna, S. (2001). *Making Good: How ex-convicts reform and rebuild their lives*. Washington D.C.: American Psychological Association.

Mazerolle, P., Legosz, M., Jeffries, S., & Rosie Teague, R. (2007). Breaking the Cycle: A Study of Victimisation and Violence in the Lives of Non-Custodial Offenders. Brisbane: Crime and Misconduct Commission.

McCartan, L. M. (2010). Individual and Relationship Factors That Differentiate Female Offenders With and Without a Sexual Abuse History. *Journal of Interpersonal Violence, 25*(8), 1449-1469.

McCloskey, L., & Bailey, J. (2000). The intergenerational transmission risk for child sexual abuse. *Journal of Interpersonal Violence, 15*, 1019-1035.

McCorkel, J. A. (2003). Embodied surveillance and the gendering of punishment. *Journal of Contemporary Ethnography, 32*(1), 41-76.

McDaniels-Wilson, C., & Belknap, J. (2008). The Extensive Sexual Violation and Sexual Abuse Histories of Incarcerated Women. *Violence Against Women, 14* (10), 1090-1127.

Mental Health Coordinating Council. (n.d). Trauma Informed Care in Mental Health Services Consultation on the development of a National Strategy for Trauma - Informed Care (NS-TIC). Retrieved from http://www.mhcc.org.au/documents/NS-TI- Lit-Rev-190510-F.pdf

Messman-Moore, T., & Long, P. (2002). Alcohol and substance use disorders as predictors of child to adult sexual revictimization in a sample of community women. *Violence and Victims, 17*(319-340).

Miller, J. (2008). *Getting played: African American girls, urban inequality, and gendered violence*. New York: New York University Press.

Miller, S. (2005). *Victims as offenders: The paradox of women's violence in relationships*. New Brunswick: Rutgers University Press.

Mitchell, M. (2005). Classification or discrimination? Assessing risk and need in women's correctional centres: Sisters Inside.

Moloney, K. P., van den Bergh, B. J., & Moller, L. F. (2009). Women in prison: the central issues of gender characteristics and trauma history. *Public Health, 123*, 426-430.

Moloney, K. P., Van den Bergh, B.J. & Moller, L.F. (2009). Women in prison: The central issues of gender characteristics and trauma history. *Public Health 123*, 426-430.

Moorea, E., Romaniuka, H., Olssona, C., Jayasinghea, Y., Carlina, J., & Patton, G. C. (2010). The prevalence of childhood sexual abuse and adolescent unwanted sexual contact among boys and girls living in Victoria, Australia. *Child Abuse & Neglect, 34*(5), 379-385.

Morrison, Z. (2009). Homelessness and sexual assault. ACCSA Wrap 7. In A. C. f. t. S. o. S. Assault (Ed.), (Vol. Wrap 7). Melbourne: Australian Institute of Family Studies.

Morrissey, J. P., Ellis, A. R., Gatz, M., Amaro, H., Reed, B. G., Savage, A., . . . Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *Journal of Substance Abuse Treatment, 28*(2), 121-133. doi: 10.1016/j.jsat.2004.08.012

Moses, D., Reed, B. G., Mazelis, R., & D'Ambrosio, B. (2003). Creating trauma services for women with co-occurring disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study. Retrieved from http://www.wcdvs.com/publications/

Mullen, P., & Fleming, J. (1998). Long-term Effects of Child Sexual Abuse. *National Child Protection Clearinghouse; Australian Institute of Family Studies, 9*.

Mullings, J. L., Hartley, D. J., & Marquart, J. W. (2004). Exploring the Relationship Between Alcohol Use, Childhood Maltreatment, and Treatment Needs Among Female Prisoners. *Substance Use & Misuse, 39*(2), 277-305. doi: doi:10.1081/JA-120028491

Ogilvie, E. (2001). Post release: The current predicament and the potential strategies In C. R. Council (Ed.). Canberra: Australian Institute of Criminology.

Ogloff, J., Davis, M., Rivers, G., & Ross, S. (2006). The identification of mental disorders in the criminal justice system. Canberra: Criminology Research Council.

Pawson, R. (2002). Evidence-based Policy: The Promise of `Realist Synthesis'. *Evaluation, 8*(3), 340-358. doi: 10.1177/135638902401462448

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2004). Realist synthesis: an introduction *ESRC Research Methods Programme.* . Manchester: University of Manchester.

Pereira, C. (2001). Strip searching as sexual assault. *Hecate, 27*(2), 187-196.

Penfold, C., Turnbull, P. J., & Webster, R. (2005). Tackling prison drug markets: an exploratory qualitative study. In K. C. Institute for Criminal Policy Research (Ed.), *Online Report 39/05*. London: Home Office.

Plugge, E., Douglas, N., & Fitzpatrick, R. (2006). The health of women in prison: Study findings. Retrieved from http://www.publichealth.ox.ac.uk/research/prison/2007-02-13.6702780065/view

Pollack, S. (2004). Anti-oppressive social work practice with women in prison: Discursive reconstruction and alternative practices. *British Journal of Social Work*, 693-707.

Pollack, S., & Brezina, K. (2006). Negotiating contradictions: Sexual abuse counseling with imprisoned women. *Women & Therapy, 29*(3), 117-133.

Pollock, J. M. (1998). *Counseling Women in Prison* (Vol. 3). Thousand Oaks: SAGE Publications.

Putnam, F. (2003). Ten-Year Research Update Review: Child Sexual Abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 269-278. doi: 10.1097/00004583-200303000-00006

Raj, A., Rose, J., Decker, M., Rosengard, C., Herbert, M., Stein, M., & Clarke, J. (2008). Prevalence and patterns of sexual assault across the life span among incarcertated women. *Violence Against Women, 14*(5), 528-541.

Reisig, M. D., Holtfreter, K., & Morash, M. (2006). Assessing female recidivism risk across female pathways to crime. *Justice Quarterly, 23*(3), 384-405.

. Report of an Announced Inspection of Boronia Pre-release Centre for Women. (2009). In O. o. t. I. o. C. Services (Ed.). Perth: Office of the Inspector of Custodial Services.

Rettinger, L. J., & Andrews, D. (2010). General risk and need, gender specificity, and the recidivism of female offenders. *Criminal Justice and Behavior, 37*(1), 29-46.

Richie, B. E. (2001). Challenges incarcerated women face as they return to their communities: Findings from life history interviews. *Crime & Delinquency, 47*(3), 368-389.

Richters, J., Butler, T., Yap, L., Kirkwood, K., Grant, L., Schneider, A. M. A., & Donovan, B. (2008). Sexual health and behaviour of New South Wales prisoners,. In School of Public Health and Community Medicine (Ed.). Sydney: University of New South Wales.

Rideout, K. (2009). *Childhood Emotional Abuse in Incarcerated Females: Use of the Personality Assessment*

Inventory (PAI) in Identifying Complex Trauma Symptomology

Kimberly (Master of Science in Psychology), Pacific University, Hilsboro.

Rossow, I., & Lauritzen, G. (2002). Shattered childhood: a key issue in suicidal behavior among drug addicts? *Addictions, 96*(2), 227-240.

Salisbury, E. (2007). *Gendered Pathways: An Empirical Investigation of Women Offenders' Unique Paths to Crime.* (PhD), University of Cincinnati, Cincinnati.

Salisbury, E., & Van Voorhis. (2009). Gendered pathways: A quantitative investigation of women probationers' paths to incarceration. *Criminal Justice and Behavior, 36* (6), 541-566.

Salomone, J. (2004). *Towards best practice in women's corrections: the Western Australian low security prison for women*. Government of Western Australia.

Sarteschi, C. M., & Vaughn, M. G. (2010). Double jeopardy: A review of women offenders' mental healthand substance abuse characteristics. *Victims & Offenders, 5*(2), 161-182.

Scott, S. (2004). Opening a can of worms? Counseling for survivors in UK women's prisons. *Feminism & Psychology, 14*(2), 256-261.

Seiter, R. P., & Kadela, K. R. (2003). Prisoner Re-entry: What works, what does not, and what is promising. *Crime & Delinquency, 49*(3), 360-388.

Select Committee on the Increase in Prisoner Population. (2000). *Interim Report*. Sydney: NSW Government.

Sexton, P. S. (1985). Contraband control and the use of x-rays in the prison environment. *Pacific Law Journal, 16*(2), 409-430.

Shearer, R. A. (2003). Identifying the special needs of female offenders. *Federal Probation, 67*(1), 46-51.

Sheehan, R. (2011). Policy developments in Australia. In R. Sheehan, G. McIvor & C. Trotter (Eds.), *Working with women offenders in the community* Abingdon: Taylor & Francis.

Sheehan, R., McIvor, G., & Trotter, C. (2013). *What works with women offenders*: Willan.

SistersInside. (2004). *Submission of Sisters Inside at the Anti-Discrimination Commissioer for the Inquiry into the Discrimination on the basis of sex, race and disability experienced by women prisoners in Queensland*. Queensland: Sisters Inside.

Smith, P., Cullen, F., & Latessa, E. J. (2009). Can 14,737 women be wrong? A meta-anlysis of LSI-R and recidivism for female offenders. *Criminology and Public Policy, 8*(1), 183-208.

Smyth, K. F., & Schorr, L. B. (2009). A Lot to Lose: A Call to Rethink What Constitutes “Evidence” in Finding Social Interventions That Work, *Malcolm Wiener Center for Social Policy*

Working Paper Series: John F. Kennedy School of Governmen, Harvard University.

Söchting, I., Corrado, R., PhD, , Cohen, I., Ley, R., & Brasfield, R. (2007). Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization? *British Columbia Medical Journal, 49*(6), 320-326.

Sorbello, L., Eccleston, L., Ward, T., & Jones, R. (2002). Treatment needs of female offenders: a review. *Australian Psychologist, 37*(3), 198-205.

Swan, S. C., Gambone, L. J., Caldwell, J. E., Sullivan, T. P., & Snow, D. L. (2008). A review of research on women's use of violence with male intimate partners. *Violence and Victims, 23*(3), 301-314.

Tarczon, C. (2012). Mothers with a history of childhood sexual abuse: Key issues for child protection practice and policy *ACSSA Research Summary*. Melbourne, Vic: Australian Institute of Family Studies

Taylor, K., & Blanchette, K. (2009). The women are not wrong: It is the approach that is debatable. *Criminology and Public Policy, 8*(1), 221-229.

Teague, R., & Mazerolle, P. (2007). Childhood physical abuse and adult offending: are they linked, and is ther scope for early intervention *Crime and Misconduct Commission*. Brisbane.

Trask, E., Walsh, K., & DiLillo, D. (2011). Treatment effects for common outcomes of child sexual abuse: A current meta-analysis. *Agression and Violent Behaviour, 16*(1), 6-19.

Turner, S. (2010). Case management with women offenders: Literature review. Melbourne: Monash University Criminal Justice Research Consortium.

Van der Hart, O., Nijenhuis, E., & Steele, K. (2005). Dissociation: An insufficiently recognised major feature of complex post traumatic stress disorder. *Journal of Traumatic Stress, 18*(5), 413-423.

van der Kolk, B. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* (pp. 182-213): New York, NY, US: Guilford Press.

Van der Kolk, B., Pelcovitz, D., Roth, S., Mandel, F., MacFarlane, A., & Herman, J. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry, 153*(Supp.), 85-93.

Van der Kolk, B., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of complex adapatation to trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Van Roode, T., Dickson, N., Herbison, P., & Paul, C. (2009). Child sexual abuse and persistence of risky sexual behaviors and negative sexual outcomes over adulthood: Findings from a birth cohort. *Child abuse & neglect, 33*(3), 161-172.

Van Doorn, G., & Geyer, A. (2011). NSW Community census 2010: Summary of characteristics *Statisical Publication* (Vol. 37). Sydney: Corrective Services, NSW.

Van Voorhis, P., Salisbury, E., Bauman, A., & Wright, E. (n.d.). Gender responsive risk/nees assessment: Final Report. Cincinnati: National Institue of Corrections.

Van Voorhis, P., Salisbury, E., Wright, E., & Bauman, A. (2008). Achieving accurate pictures of risk and identifying gender responsive needs: two new assessments for women offenders. Cincinnati: National Institute of Corrections.

Van Voorhis, P., Wright, E. M., Salisbury, E., & Bauman, A. (2010). Women's Risk Factors and Their Contributions to Existing Risk/Needs Assessment. *Criminal Justice and Behavior, 37*(3), 261-288. doi: 10.1177/0093854809357442

Walsh, K., DiLillo, D., & Scalora, M. J. (2011). The Cumulative Impact of Sexual Revictimization on Emotion Regulation Difficulties. *Violence Against Women, 17*(8), 1103-1118. doi: 10.1177/1077801211414165

Walsh, K., Fortier, M., & DiLillo, D. (2010). Adult Coping with Childhood Sexual Abuse: A Theoretical and Empirical Review. *Aggression and Violent Behavior, 15*(1), 1-13.

Warner, S. (2001). Women and child sexual abuse: Childhood prisons and current custodial practices. *Issues in Forensic Psychology*(2).

Ward, T., & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, crime and law, 10*(3), 243-257.

Ward, T., Collie, R. M., & Bourke, P. (2009). Models of offender rehabilitation: The Good Lives Model and the Risk-Needs-Responsivity Model. In A. R. Beech, L. Craig & K. D. Browne (Eds.), *Assessment and treatment of sex offenders: a handbook*. USA: John Wiley & Sons.

Ward, T., & Stewart, C. (2010). Criminogenic needs and human needs: a theoretical model. *Psychology, crime & law, 9*(2), 125-143.

Whiteacre, K. W. (2006). Testing the Level of Service Inventory-Revised (LSI-R) for racial/ethnic bias. *Criminal Justice Policy Review, 17*(3), 330-342.

WHO. (2005). WHO multi-country study on women's health and domestic violence agaisnt women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization.

WHO. (2009). Women's health in prison: Correcting gender inequity in prison health. In United Nations Office on Drugs and Crime (Ed.): World Health Organisation.

Women in prison summary. (2010). *Justice Action Australia*. Retrieved from http://www.justiceaction.org.au/index.php?option=com_content&task=view&id=149&Itemid=32

. Women's Mentoring Program. (2010). *Justice System Services*, from http://www.vacro.org.au/Justice_System_Services/Womens_Services/Womens_Mentoring.htm

Worrall, A. (1990). *Offending women: Female lawbreakers and the criminal justice system*. London: Routledge.

Wybron, D., & Dicker, K. (2009). *ACT women and prisons. Invisible bars: The story told behind bars.* Canberra: Women's Centre for Health Matters Inc

Yates, T. M., & Masten, A. S. (2004). Fostering the future: Reslience theory and the practice of positive psychology. In P. A. Linley & S. Joseph (Eds.), *Positive Psychology in Practice* (pp. 521-539). New Jersey: John Wile & Sons, Inc.

Zlotnick, C. (1997). Posttraumatic Stress Disorder (PTSD), PTSD Comorbidity, and Childhood Abuse among Incarcerated Women. *The Journal of Nervous and Mental Disease, 185*(12), 761-763.

Appendix A: Project objectives

As per clause 2.2 of consultancy agreement

Rationale:

To examine whether, in light of the available research, Corrective Services NSW should alter current policy and practice in addressing women's sexual trauma histories.

Focus:

Adult women prisoners in NSW community and custodial correctional settings.

Purpose

To provide advice to Corrective Services NSW on the available research and practice evidence about how the effects of sexual victimisation interface with offending and reoffending pathways and what broad directions can be taken to address sexual victimisation in the correctional context.

Preliminary Research questions

- How do the impacts of child sexual abuse affect women's participation in and the outcomes of offender programs?
- How do such impacts affect their wellbeing in correctional contexts?
- Given the prevalence of sexual victimisation among this population, how can correctional systems best address its impacts on clients?

Objectives:

To develop an evidence-informed framework to guide interventions and support (including health and other allied services) for women in correctional settings with sexual victimisation histories. It will specifically consider:

- The relevance of victimisation in women's offending pathways and behaviours;
- Support currently available to women in other correctional systems that addresses sexual victimisation;
- Best stages/s in an offender pathway to participate in support program for their victimisation;
- Risks/issues involved in addressing sexual trauma therapeutically in a corrections context;
- Issues in relation to Aboriginal women in corrections;
- Issues in relation to women with complex needs and particular combination of needs.

Research Methodology

- A synthesis of the literature will be undertaken in the domains of criminology, social work, public policy and health that are relevant to the topic area and purpose.
- Realist literature reviews provide explanatory analyses of how and why interventions in complex issues worked in particular contexts and settings.

The review will involve three phases.

1. Scoping analysis to determine: the most relevant and available literature;

2. A critical analysis of key areas of debate, concern and risk involved in addressing the impacts of sexual victimisation in the correctional context.
3. Realist analysis (based on first and second stages) of current approaches, practices and interventions that best address women's sexual victimisation trauma in a correctional context (both broadly and in terms of specific corrections outcomes such as a reduction in re-offending).

The final product will synthesise key findings into an evidence informed framework.

Appendix B: Scoping review - Women in custody and sexual assault survival

Overview

Literature searches on three broad areas have been undertaken to July 30, 2010. These areas are:

- Sexual victimisation among female offenders
- Aboriginal women prisoners; and
- Impacts and outcomes of child sexual abuse.

Several databases were used to search for research published between 2000 to the present. These are named in the table below.

Table 1

Australian data bases	International databases
Australian Criminology Database (CINCH) Attorney-General's Information Service (AGIS) Family & Society Plus	National Criminal Justice Reference Service Abstracts Database (NCJRS) PsycINFO Psychology and Behavioural Sciences Collection ProQuest Social Science Journals SocIndex

A range of search terms, search categories and combinations has been used to locate relevant research.

Table 2

SU: Female prisoners, female offenders, Aboriginal women prisoners, trauma, women in crime
KW or in abstract: recidivism, complex trauma, complex needs, treatment needs, women's imprisonment

Initial targeted searching on the impact of sexual victimisation trauma on women in custody yielded very few resources. Single subject terms such as "Aboriginal women prisoners" and "female prisoners" were relied on instead at this early stage. These yielded large numbers and were subsequently manually filtered in relation to sexual victimisation experiences.

Purpose of this review

The purpose of this initial review was to:

- Get a sense of what the evidence base suggested about the connection between women's experiences of sexual victimisation;
- Identify particularly relevant and/or promising areas that should be the focus of the next stages (the critical review and the realist analysis of effective interventions);
- Identify gaps or challenges in the evidence base and ways of addressing these.

Summary

At this stage, our research has shown that the Australian evidence base relevant to the key research questions is somewhat thin on the ground in comparison to the international and particularly US research. What is especially useful are: the national level and ? state based monitoring resources like DUCO and DUMA; sentencing trends reports; and other regular snapshots of correctional populations. There is also a fairly strong field of qualitative research looking at women's trajectories into and out of custody, and the factors associated with those?.

The US evidence base is particularly strong on statistical analysis and meta-analyses of factors associated with effective treatment programs, and has a more robust evidence base on gender-specific programming. There is a very small body of literature that considers trauma-informed frameworks for the correctional environment.

Overall, the literature we have reviewed is in agreement that:

- Women in corrections have extensive victimisation histories
- They enter into the correctional system with greater disadvantage than men in terms of material or socio-economic disadvantage, and with higher levels of psychological distress. Drug misuse appears as a maladaptive coping mechanism.
- Effective treatment and rehabilitation interventions need to acknowledge the different pathways into offending and the high level of need the women bring with them upon entry into corrections.

There is less certainty about the following:

- Frameworks and models for this (we describe those that emerged repeatedly in the searches)
- The appropriateness, costs and benefits of custodial settings as therapeutic setting in relation to sexual abuse trauma.

What is absent or almost so relates to:

- The concept of trauma as it is explored in the extant sexual assault literature. Concepts relating to disempowerment, survival resilience, and recovery may be useful.
- Evidence base on working with complex trauma, complex needs and sexual victimisation

Table 3 provides a snapshot of the key areas that are emerging as the most promising and/or relevant for the next stages.

Key themes in the current evidence base

There is a high prevalence of sexual victimisation among the female corrections population

A majority of women in corrections have experienced prior sexual and physical assault victimization, particularly sexual abuse in childhood (Johnson & Young 2002; Mazerolle et al., 2008; Teague & Mazerolle 2007; Warner 2001). The research consistently finds that the prevalence reported significantly higher rates of sexual victimisation across the lifecourse than women in general community samples.[38]

[38] Although we note that there are no national prevalence rates on child sexual abuse or indeed on lifetime or repeat victimisation.

Community samples

A review of seven Australian studies of child sexual abuse found a prevalence rate of just over 1 in 4 women (27.5%) reporting an experience of child sexual abuse (Andrews et al., 2002). Another piece of research data from a 10-year cohort study of a nationally representative sample of students aged 14-15 years in Victoria, Australia from 1992 to 2003 was used to estimate child sexual abuse before 16(assessed retrospectively at age 24), a prevalence rate of 17% (Moorea et al. 2010). In terms of adult sexual assault, approximately 1 in 6 adult women (almost 1.3 million women) have experienced sexual assault (since 15) (ABS 2006).

Women in corrections

In a study involving a random sample of 199 female prisoners in NSW, 59% of women said that they had been forced or frightened into doing something sexually that they did not want to do in their lifetime, and 57% of women said that they did not tell anyone or seek help following the incident/s (Richters et al. 2008). In this sample of women, revictimisation was common: a third of women said they had experienced sexual coercion between 3 and 9 times, and a further 13% said it had occurred more than 10 times.

US data shows similar rates. In McDaniels-Wilson and Belknap's (2008) research, 44% of women reported illegal attempted penetration and 60% reported illegal completed penetration (defined as using force, position of authority or alcohol/drugs to perpetrate offence). The mean number of times this had occurred to participants was between 3.3 and 4.5.

Women in community corrections also demonstrate high rates of sexual victimisation. Research by the Crime and Misconduct Commission found that between a quarter and third of women reported coerced, unwanted or forced sexual activity, including sexual intercourse (Mazerolle et al., 2008). Again, the degree of sexual re-victimisation in the sample was very high for both males and females. Overall, among the victims of CSA in this sample, 81 per cent experienced some form of sexual victimisation as an adult.

Other work suggests even higher rates: Sisters Inside (2004) estimated that prior to incarceration, 98% of women prisoners had experienced physical abuse and 89% had experienced sexual abuse (Kilroy, 2001). Research conducted by Women's House found that 70-80% of women in adult prison in Queensland were survivors of incest(Kilroy 2004).

Related factors

The research evidence is also clear that it is not just the experience of sexual abuse – which we could assume involves multiple instances of victimization – but also that there are a range of compounding factors in which these experiences are located. These include:

- Low levels of education
- High rates of survival sex
- Previous incarceration
- Majority have children
- Chronic revictimisation experiences
- Family trauma and turmoil
- Exposure to many forms of childhood trauma, especially extreme emotional and physical neglect

- Poor outcomes in adolescence
- Housing instability pre- and post-release
- High rates of unemployment
- High rates of drug use

(Mazerolle, et al., 2007; McDaniels & Belknap, 2008)

Factors associated with revictimisation

- Individual's personal history
  - Effects of previous/initial abuse
  - Characteristics of abuse; traumatic sexualisation; alcohol and drug abuse, dissociative disorders, learned expectancy, social isolation, low self esteem, internalisation/stigmatisation
- Early family experiences (e.g. family breakdown)
  - Interpersonal relationships
  - Increased contacts with potential perpetrators
  - Engaging in high risk sexual behaviours; poor risk perception; negative peer socialisations
  - Likelihood that perpetrators will act aggressively
  - Stigmatisation, powerlessness & low self esteem increase the "mark" of vulnerability; social isolation
- Social location
  - Social disadvantage; lack of resources; social isolation; feelings of being unsupported
- Social structure
  - Cultural beliefs
  - Victim-blaming or stereotyping women as "good" or "bad" girls; internalisation of blame
  - Lack of social and institutional support for sexual assault victims

(Adapted from Grauerholz, 2000)

Women's pathways into offending and the nature of their offending is qualitatively different from men's

How they offend

Women's offending behaviour and the nature of their offending is qualitatively different from men's. The available research tends to suggest "women commit fewer and less serious crimes" (Women's Health Victoria 2008; 3). Typically, drug offences, fraud and property theft are identified as "women's offences" although we do note:

- an emerging shift as identified by the research (women's offending becoming more violent) although caution needs to be exercised as it's not clear how dual arrest policies in relation to domestic violence are impacting this; and
- caution in using US findings around this as drug use is criminalised to a greater degree.

Although the criminogenic factors for men and women may be the same (anti-social behaviour, substance abuse) they influence offending patterns differently (Martin et al 2009). Male offenders are more likely to

commit violent offences, whereas women's offending tends towards property and drug offences. Women are also more likely to be initiated into substance abuse by their partners (Covington & Bloom 2004). This can then lead to theft and deception offending if access to drugs or money for drugs becomes limited. This is also true for women who abuse substances due to trauma related incidents, such as domestic violence or sexual victimisation. Much of the literature points to women's offending as based on social disadvantage (Scott 2004; Covington & Bloom 2004; Women's Health Victoria 2008). Women are more likely to be the primary caregiver to dependent children. Where socially disadvantaged women cannot access social and/or economic support for their families, they may turn to illegal means to secure resources for themselves and their dependent children.

The nature of their violent offending

Although women's offending tends towards crimes against property rather than against people, there are still numbers of women in prison for violent offences. The trend toward violent offences committed by women is thought to be on the rise (Cameron 2001). Both internal and external factors are believed to contribute to violent offences. External factors such as social disadvantage can lead to the commission of violent crimes by women. Factors associated with gender, such as women's status in modern society, can also play a role. Violence may stem from poverty, lack of education and unemployment as well as a history of exposure to family violence and child sexual abuse (Bottos 2007). Internal factors can include the gendered socialisation imperatives around women and anger. Women are taught to "inhibit expressions of anger, thereby compelling them to internalize negative affective states" (Bottos 2007; 15). Mental illness or the requisite mental destabilisation that occurs after prolonged substance abuse is another internal factor that may lead to violence by women. Feminist research also points to the defensive nature of women's violence. Women may react violently after prolonged exposure to intimate partner violence and/or sexual abuse, particularly if children are at risk. Further, women's violence is more likely to be "driven by self-defence and fear" (Swan et al 2008). Most violent offences by women are one-off events and very few women are repeat violent offenders (Bottos 2007).

Sexual abuse trauma has significant long term impacts on survivors

Overall, the literature suggests that the experience sexual abuse impacts on women in the following ways:

- Post-traumatic stress disorder
- Cognitive distortions
- Impaired sense of self and interpersonal difficulties
- Avoidant and maladaptive coping behaviours (such substance misuse and problematic sexual interactions)
- Suicidal ideation
- Self-harming behaviours

Child sexual abuse victims report a lifetime history of more exposure to various traumas and higher levels of mental health symptoms (Barnyard et al. 2001).

Child sexual abuse victimization leads to a range of issues around health and wellbeing well into adulthood. How victim/survivors learn to cope can have an affect on the rest of their lives. For instance 'avoidant coping' or more simply learning to cope with the abuse by avoiding dealing with it has been associated with trauma symptoms (Fortier et al 2009). Avoidant coping may be signalled by drug and

alcohol abuse and can lead to further victimization in adulthood. Women with a history of child sexual abuse victimization are found to be more likely to engage in casual and unprotected sex while reporting less satisfactory sexual rewards and greater sexual costs (Lemieux & Byers 2008).

The proportion of those with a drug addiction and past child sexual victimization report greater numbers of suicide attempts and suicide ideation (Rossow & Lauritzen 2002). Child sexual abuse victims are also at greater risk of mental health problems (Banyard et al 2001; Mullen et al 2004). As well as being at risk of experiencing dysfunctional interpersonal relationships (Davis & Petretic-Jackson 2000).

Research has shown that men and women deal with child sexual abuse differently (Van Roode et al. and that any treatment options would need to attend to gender (Fallot & Harris 2002).

The impacts of trauma have a relationship to women's pathways into offending

Regarding the role of CSA in offending pathways, a causal relationship has not been made explicit. However many studies indicate that prior sexual victimization may be a risk factor in criminal offending as well as re-victimization in the future (Christopher et al. 2007; Brewer-Smyth et al 2004; Battle et al 2003; Fagan 2001; Teague & Mazerolle 2007). Past victimization may intersect with mental health issues often exacerbated by drug and alcohol abuse (Battle et al 2003; Sarteschi & Vaughn 2010).

There is very little Australian research that explicitly considers sexual abuse *trauma* and its relationship to women's offending pathways, or its impact on participation in offender programs. However it is acknowledged that in comparison to male offenders:

- Women have higher rates of psychological distress;
- Demonstrate different patterns of drug use.

And their wellbeing once in the correctional context

Easteal (2001) states that the correctional contexts may be re-victimising for female offenders with a history of child sexual abuse. For many women sexually abused as children, attachment theory states that they may have difficulties in creating attachments and connections to others (Covington & Bloom 2004; Cosden & Cortez-Ison 1999). This stems from the lack of support and attachment between the child and the abusive adult. This is in line with psychological studies that claim women's normative psychological development can be explained via relational theory. This means that women require connections and a sense of belonging for their psychological wellbeing.

For women with attachment disorders, it may be difficult to accept social support (Cosden & Cortez-Ison 1999). The implication for correctional contexts means that women may feel isolated and unable to engage in rehabilitative programs or offender programs with any effectiveness. This may lead to acting out and further isolation. Social isolation is a risk factor for reoffending.

Environmental factors can have a huge impact on behaviour (Covington & Bloom 2004). Therefore women with substance abuse problems that stem from past sexual victimization may encounter the prison complex as similar to her attacker. Easteal considers this a continuation of the structure of abuse. Prison imperatives such as 'don't talk', 'don't trust' and 'don't feel' reinforce the reasons behind the substance abuse in the first instance (Easteal 2001). The guilt and the shame of child sexual abuse that led to maladaptive behaviours are reinforced once again. Access to drugs within the prison complex can exacerbate these issues through continued substance abuse.

Maladaptive stress and coping mechanisms can create negative effects in correctional contexts. Women dealing with post-traumatic stress disorder may encounter security measures such as strip searches as re-victimizing and act in ways that draw more security measures. This is counterbalanced with programs that aim to inculcate positive coping mechanisms in inmates.

Lack of connection with family and particularly children may reinforce attachment disorders often found in victim/survivors of child sexual abuse. Security imperatives of correctional facilities may mean that women are reluctant to have children visit if they are to be security checked. This again leads to social isolation and problems with coping.

Women in corrections require different rehabilitation programs

The literature is suggests gender specific risk and needs assessment for women prisoners (see particularly the work of Covington). Howells et al (2004) in a review of offender rehabilitation programs offered in Australia stated "the lack of development of programs for Indigenous offenders and female offenders is noticeable" (Howells et al 2004; 2). There is a growing understanding that female offender needs differ from male offender needs and their motivations to offend and re-offend require different program responses. Child-care issues are specific to women as primary care-givers. Of particular importance is women's history of victimisation and the attention around program delivery that deals with the related traumas and impact of child sex abuse.

Several writers such as Ward et al. and Easteal observe an evolution in correctional research, practice, and policy concerns from punitiveness and deterrence to rehabilitation to the prison as a therapeutic setting. Programs that deal with women's psychosocial problems (that lead to offending) are thought to be more effective "when co-occurring problems are treated concurrently rather than sequentially" (Howells et al 2004; 64).

What does this literature suggest about how to a) design effective programs that address offending and b) address trauma

Rehabilitation programs within prison systems exist due to the notion that offenders' behaviour can be modified to ensure non re-offending upon release. However, the main function of prisons is punitive. A tension therefore exists between the need to offer support programs and the need to punish for offences committed. This tension is particularly salient when discussing women offenders as such large numbers of women prisoners enter the system with a history of child sexual abuse, physical abuse and other types of victimisation. Pollack and Brezina (2006) suggest that these tensions and contradictions need to be attended to when designing therapeutic services for incarcerated women. "The philosophy and mandate of corrections…are generally opposed to those of sexual abuse counselling" (Pollack & Brezina 2006; 122). The power relationship that is required for a punitive setting cannot be utilized in a therapeutic setting. Correctional institutions are concerned with security and risk management, whereas a therapeutic alliance (relationship between therapist and client) is concerned with healing and wellbeing. Pollack and Brezina (2006) have identified four areas that require attention in order that uneven power relations do not jeopardise the therapeutic alliance.

- Normalising the impact of trauma
- Collaboration
- Sharing
- Advocacy

An important aspect of therapy is to avoid pathologising the coping mechanisms of victim/survivors of child sexual abuse. Although the coping mechanisms may have led to offending, a risk management model (which seeks to identify a causal relationship) should not co-opt the therapeutic process. Collaboration between the therapist and the client needs to be transparent so that trust can be built. This is especially important in a prison setting if the therapist is required to report sessions to management. Pollack and Brezina recommend co-writing sessions between therapists and clients for increased trust and decreased "potential for the re-enactment of abusive dynamics" (Pollack & Brezina 2007; 127). Peer support is an important dynamic in healing and close relationships with other prisoners should be encouraged in particular settings. Finally, advocacy both by the therapist and self-advocacy by the prisoners can help give prisoners back some form of control over their lives.

Two approaches are emerging in the literature: gender responsive frameworks and the enhancement model.

Gender responsive frameworks

Addressing the needs of incarcerated women relies upon developing gender-responsive policies and programs. This means there needs to be a recognition that women commit offences for very different reasons than men, regardless of whether their criminogenic factors are the same. Covington and Bloom (2004) have devised six guiding principles for gender-responsive programs for incarcerated women:

- Acknowledge that gender makes a difference
- Created an environment based on safety, respect and dignity
- Develop policies and practices which are relational and promote healthy connections to children, family, significant other and the community
- Address substance abuse, trauma and mental health issues through comprehensive, integrated and culturally relevant service and appropriate supervision
- Provide women with opportunities to improve their socioeconomic conditions
- Establish a system of community supervision and re-entry with comprehensive, collaborative services

Basically these guiding principles are responding to the needs of women and any trauma inducing sexual victimisation. The principles attend to the substance abuse and mental health issues that may be tied to both past victimisation and to offending. There is also a recognition of the need to attend to cultural differences. Covington and Bloom (2004) also consider the fact that many incarcerated women are the primary caregivers to dependent children and that these relationships require nurturing. Further, women require vocational training so that upon release they are able to financially provide for themselves and their children. Finally, accessing support when released from prison recognises that social isolation is a risk factor for re-offending.

Enhancement models

The enhancement model developed by Ward and Stewart (2010) takes human well-being as the basis for behavioural modification. Ward and Stewart (2010) reject the rehabilitative model of harm avoidance and instead believe that the positive enhancement of basic human needs can lead to a reduction in offending and re-offending. Examples of basic needs may be autonomy, relatedness and competency. They state that instead of using the notion of criminogenic needs, which are not needs at all but actually risk factors,

that rehabilitation should be based on actual human needs. Criminogenic needs (such as impulsivity or skill deficits in general) are just obstacles to meeting actual human needs and have led to maladaptive strategies which lead to offending. In other words the criminogenic needs are symptoms of a human need. The enhancement model makes "no real distinction between psychological and social or vocational factors" (Ward & Stewart 2010; 141). The enhancement model aims to identify which human needs are not being met and tailor rehabilitation efforts towards achieving those needs. Ward & Steward argue that rehabilitative efforts should strive toward a positive goal of fulfilled human needs as "all human lives should reflect the best possible outcomes rather than the least worst possibilities" (Ward & Steward 2010; 143).

Table3: Relevant and/or promising areas to focus on in the next stages

Key area	Key themes/issues emerging in literature	Gaps/unknowns	Other comments
Complex needs (dual diagnosis, impact of complex trauma, co-occurring disorders)	Women have higher rates and more intractable issues in relation to mental health compared to men – both before and after prison. Drug misuse compounds this Length of time – some research suggests that mental health services best address needs of stable populations not short-stay prisoners	Trauma is not often mentioned within the literature on mental illness and distress. A lot is known about the poor mental health of women entering, leaving and re-entering corrections. However, this is not overlayed or reinterpreted from a trauma perspective. There is also little discussion of complex trauma itself in relation to women in corrections. Self harm? Medication?	Would recommend outlining issues regarding sexual abuse trauma and the way in which a trauma model differ from more individualised interpretations of psychological distress. A trauma "lens" considers issues of disempowerment, disconnection, and resilience.
Post-release support needs and uptake of services/programs	Post-prison experience is "distinctly gendered" – roles and relationships and structural disadvantage such as lack of employment are part of making transition Role of social capital and social connectedness in desistance Socio-economic factors significantly impact on women's capacity to access services, complete programs and reoffend Basic needs such as stable housing are key to effective post-release support Flexible, tailored and "women-centred" services	There is significant research that suggests that trauma, particularly as a result of repeat sexual victimisation erodes survivors' capacity for connectedness.A psychological perspective may code this as avoidant or dissociative.	As above but with an applied consideration – how are or how can post release supports be trauma informed? The discussion about trauma informed (vs trauma specific i.e. specialised) service responses has tended to focus on socially marginalised not criminalised populations, but there may be useful service provision approaches to draw on.
Factors associated with reoffending	Drug use - Relationship between drug use, dependence, and victimisation affects ongoing recidivism. Some research suggests that repeated admissions to prison is predictor of drug dependency and that treatment does not seem to be effective Housing instability, housing transience associated with return to prison Underlying disadvantage Poor mental health		
Treatment and rehabilitation programs (needs, participation, effectiveness for women)	Drug use - Having a range of issues prior to incarceration (housing, sexual abuse, mental health) is associated with higher treatment needs Lower uptake and completion rates of treatment/diversion programs for	Challenge seems to be about not only being gender responsive/specific in program design but uptake and completion	Question becomes what the barriers to uptake and completion are.

	women, especially those with higher levels of drug dependence and poor health and mental health but participation and completion seems to result in better outcomes. Benefits/costs of therapeutic communities		
Frameworks, approaches and models for intervention regarding reoffending	Risk, Needs, Responsivity, Readiness – how do such assessments align with what is known about women's offending? Gender-responsivity framework Desistance framework esp.	Little research that develops gender specific modes	
Frameworks, approaches and models for intervention regarding sexual abuse trauma	Trauma informed models Sexual abuse counselling NB Issues of setting combined with length of stay need to be carefully considered. There is mixed sentiment about the capacity of prison settings to do trauma-relevant support – on the one hand they provide an opportunity to begin to address particular issues, but there is the danger than this can leave women without their defensive/ survival mechanisms	Effectiveness of trauma informed programs? Models and effectiveness of counselling?	Suggest looking at the complex trauma and complex needs literature more broadly in terms of what types and focus of interventions are suitable /appropriate/effective at different times. There *are* services providing counselling services across Australia – suggest initially key informant consultations to see what the issues are.
Cultural difference, cultural competence and specific needs in supporting Aboriginal women in corrections	Demonstrate higher levels of psychological distress than non-Aboriginal women Kinship needs and relationships		

Selected references

Women and corrections. (2008). Victoria: Women's Health Victoria.

Andrews, G., Gould, B., & Corry, J. (2002). Child sexual abuse revisited. *The Medical Journal of Australia, 176*(10), 458-459. Retrieved from http://www.mja.com.au/public/issues/176_10_200502/and10179_fm.html

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2001). The long-term mental health consequences of child sexual abuse: an exploratory study of the impact of multiple traumas in a sample of women. *Journal of Traumatic Stress, 14*(4).

Battle, C. L., Zlotnick, C., Najavits, L. M., Cutierrez, M., & Winsor, C. (2003). Posttraumatic stress disorder and substance use diorder among incarcerated women. In P. Ouimette & P. Brown, J (Eds.), *Trauma and Substance Abuse: causes, consequences, and treatment of comorbid disorders*. Washington DC: American Psychological Association.

Bottos, S. (2007). *Women and violence: Theory, risk and treatment implications*. Ontario: Correctional Service Canada.

Brewer-Smyth, K., Worbert Burgess, A., & Shults, J. (2004). Physical and sexual abuse, salivary cortisol. and neurologic correlates of violent criminal behavior in female prison inmates. *Biological Psychiatry, 55*(1), 21-31.

Cameron, M. (2001). *Women prisoners and correctional programs*. Canberra: Australian Institute of Criminology.

Christopher, K., Lutz-Zois, C. J., & Reihardt, A. R. (2007). Female sexual-offenders: Personality pathology as a mediator of the relationshio between childhood sexual abuse history and sexual abuse. *Child Abuse & Neglect, 31*(8), 871-883.

Cosden, M., & Cortez-Ison, E. (1999). Sexual abuse, parental bonding, social support, and program retention for women in substance abuse treatment. *Journal of Substance Abuse Treatment, 16*(2), 149-155.

Covington, S. S., & Bloom, B. E. (2004). *Creating gender-responsive services in correctional settings: context and considerations*. Paper presented at the American Society of Criminology Conference.

Davis, J. L., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: a review and synthesis of the empirical literature. *Aggression and Violent Behaviour, 5*(3).

Easteal, P. (2001). Women in Australian prisons: The cycle of abuse and dysfunctional environments. *The Prison Journal, 81*(1), 87-112.

Elya E. Moorea, Helena Romaniuka, Craig A. Olssona, Yasmin Jayasinghea, John B. Carlina, & George C. Patton. (2010). The prevalence of childhood sexual abuse and adolescent unwanted sexual contact among boys and girls living in Victoria, Australia. *Child Abuse & Neglect 34*(5), 379-385.

Fagan, A. A. (2001). The gender cycle of violence: comparing the effects of child abuse and neglect on criminal offending for males and females. *Violence and Victims, 16*(4), 457-474.

Fallot, R. D., & Harris, M. (2002). The Trauma Recovery and Empowerment Model (TREM): conceptual and practical isues in a group intervention for women. *Community mental health journal, 38*(6).

Fortier, M. A., DiLillo, D., Messman-Moore, T. L., Peugh, J., DeNardi, K. A., & Gaffey, K. J. (2009). Severity of child sexual abuse and revicitimzation: the mediating role of coping and trauma symptoms. *Psychology of Women Quarterly, 33*(3), 308-320.

Howells, K., Heseltine, K., Sarre, R., Davey, L., & Day, A. (2004). *Correctional offender rehabilitation programs: The national picture in Australia*. SA: University of South Australia.

Kilroy, D. (2001). *When will you see the real us? Women in prison*. Paper presented at the Women in Corrections: Staff and Clients Conference.

Lemieux, S. R., & Byers, S. (2008). The sexual well-being of women who have experienced child sexual abuse. *Psychology of Women Quarterly, 32*(2), 126-144.

Martin, J., Kautt, P., & Gelsthorpe, L. (2009). What works for women? A comparison of community-based general offending programme completion. *British Journal of Criminology, 49*, 879-899.

Mazerolle, P., Legosz, M., Jeffries, S., & Rosie Teague, R. (2007). *Breaking the Cycle: A Study of Victimisation and Violence in the Lives of Non-Custodial Offenders*. Brisbane: Crime and Misconduct Commission.

McCorkel, J. A. (2003). Embodied surveillance and the gendering of punishment. *Journal of Contemporary Ethnography, 32*(1), 41-76.

McDaniels-Wilson, C., & Belknap, J. (2008). The Extensive Sexual Violation and Sexual Abuse Histories of Incarcerated Women. *Violence Against Women, 14* (10), 1090-1127.

Mullen, P. E., Burgess, P. M., Wells, D. L., & Moss, S. A. (2004). Impact of child sexual abuse on mental health: Prospective study in males and females. *The British Journal of Psychiatry, 184*, 416-421.

Pollack, S., & Brezina, K. (2006). Negotiating contradictions. *Women & Therapy, 29*(3), 117-133.

Richters, J., Butler, T., Yap, L., Kirkwood, K., Grant, L., Schneider, A. M. A., et al. (2008). *Sexual health and*

behaviour of New South Wales prisoners. Sydney: University of New South Wales.
Rossow, I., & Lauritzen, G. (2002). Shattered childhood: a key issue in suicidal behavior among drug addicts? *Addictions, 96*(2), 227-240.
Sarteschi, C. M., & Vaughn, M. G. (2010). Double jeopardy: A review of women offenders' mental healthand substance abuse characteristics. *Victims & Offenders, 5*(2), 161-182.
Scott, S. (2004). Opening a can of worms? Counseling for survivors in UK women's prisons. *Feminism & Psychology, 14*(2), 256-261.
SistersInside. (2004). *Submission of Sisters Inside at the Anti-Discrimination Commissioer for the Inquiry into the Discrimination on the basis of sex, race and disability experienced by women prisoners in Queensland.* Queensland: Sisters Inside.
Swan, S. C., Gambone, L. J., Caldwell, J. E., Sullivan, T. P., & Snow, D. L. (2008). A review of research on women's use of violence with male intimate partners. *Violence and Victims, 23*(3), 301-314.
Teague, R., & Mazerolle, P. (2007). *Childhood physical abuse and adult offending: are they linked, and is ther scope for early intervention.* Brisbane.
Van Roode, T., Dickson, N., Herbison, P., & Paul, C. (2009). Child sexual abuse and persistence of risky sexual behaviors and negative sexual outcomes over adulthood: Findings from a birth cohort. *Child abuse & neglect, 33*(3), 161-172.
Ward, T., & Stewart, C. (2010). Criminogenic needs and human needs: a theoretical model. *Psychology, crime & law, 9*(2), 125-143.
Warner, S. (2001). Women and child sexual abuse: Childhood prisons and current custodial practices. *Issues in Forensic Psychology*(2

Appendix C Key aspects of transitional support

Information

In a study conducted by Baldry et al (2002) into women's transitional needs, they found that over 65% of those interviewed had received no information regarding accommodation or support services provided to assist in obtaining accommodation prior to their release. More alarming was the fact that many of those did not even know their release dates had been moved forward, meaning they had no opportunity to seek out assistance. Information transfer from corrective services to prisoners remains an area of grave concern (Baldry et al., 2002; Carnaby, 1998).

Information exchange also means listening to women and their needs. A study by Carnaby (1998) on the release needs of female prisoners identified that women would prefer to meet with their support worker prior to release so that they had already made contact. This facilitated a friendly encounter when women contacted the support worker upon release (Carnaby, 1998). This does not always guarantee success and follow through by the releasee however (Brown & Ross, 2010a). In a study by the Home Office in the U.K, it was found that greater engagement with services was predicted by persistent contact by aftercare staff (Fox et al., 2005). These issues all rely on the successful transfer of information and incorporation of women's voices in planning for a successful transition post-release.

Reconnection

A large percentage of female prisoners are primary caregivers to dependent children. A focus on re-establishing connections with children is an important part of assisting women with connecting with their communities in the post-release phase.

There can be many obstacles in reconnecting women and their children. Often releasees lose custody of their children prior to incarceration, so regaining custody may be a matter of proving they are fit to look after dependents. They may need to be enrolled in parenting focused programs or substance abuse programs. Attempting to regain custody of children may be fraught with many issues, including the possibility that children have been abused, issues with the mother's role strain (Berry & Eigenberg, 2003) and maternal distress. Reconnecting with a previous partner, particularly if the relationship was exploitative or abusive can exacerbate the above issues.

Reconnection with family and friends (taking care to consider whether relationships are healthy and respectful and not exploitative and abusive leading to women's re-victimisation), community, and more broadly society, remains an important aspect of trauma recovery. It is connected with the concept of social capital and taking one's place in society. Reconnection is sometimes called re-integration into society. However as stated by Ogilvie (2001), often the women who end up in prison have nearly always held marginal positions in society prior to incarceration and therefore they are actually being supported to integrate into society for the first time, rather than to re-integrate. This means paying particular attention to simple processes that releasees may have never encountered before, such as filling out a rental application, writing a resume and establishing a home base (Berman, n.d.).

An important way to connect women to their communities may be assisted by mentoring. Following is a discussion of a mentoring program run by the Victorian Association for the Care and Resettlement of Offenders (VACRO).

Mentoring and Social Capital

One way of fostering connectedness is by providing the opportunity for releasees to connect with community women and the community. The Victorian Association runs one such program for the Care and Resettlement of Offenders (VACRO). The program offers training to women from the community who are interested in being mentors. The training is relating to issues that might come up for released women, such as the ability to recognize a relapse into drug use or how to gently challenge anti-social behaviours and attitudes ("Women's Mentoring Program," 2010).

In a recent evaluation of the program Brown and Ross (2010) framed the value of the relationship as providing much needed social capital to the mentee. They explain that social capital and connectedness are central to desistance theory and relate to "individuals' social connectedness and social ties, their embeddedness in a set of relations of trust…[and] their participation in civil society" (Brown & Ross, 2010b, p. 38).

Brown and Ross (2010) offer some insights into some of the factors that were more closely associated with successful participation in the program. They found that younger women with serious drug and alcohol issues did not follow through with meeting their mentors once they were released. The ingredients to success were older women with greater stability in their lives. Many older women carried on the mentor/mentee relationship for over a year (Brown & Ross, 2010b). This matches quite closely the criminological paradigm of life course criminality. Briefly, this means that the older a criminal becomes, the more likely they will withdraw from criminal behaviour and seek to gain stability in their lives (Brown & Ross, 2010b). In consideration of the requirement to assist women with greater need while they are in a prison environment, a mentoring program may work with younger women if safety is established prior to their release. Brown and Ross (2010) are quite clear about the need for stability and are wary of the ability of any interventions to have effect if women are returning to chaotic and overwhelming environments (Brown & Ross, 2010b).

Consistency & Reliability (staffing considerations)

Transitional support workers have a responsibility to advocate on behalf of releasees so that the modelling of respectful relationships that occur within prison with trauma informed staff can be seamlessly extended beyond the walls of prison. This is not to assume that there will not be obstacles, difficulties and disappointments. However providing safe, reliable and consistent support provides the motivation for women to put to practice their autonomy and efficacy.

This understanding is echoed by studies into the needs of women releasees. Carnaby (1998) found that the transitional support process had been disappointing for many women. One woman reported that she waited outside the prison upon release for a housing support worker who was to meet her there, only to have no one come. This lack of consistency and reliability creates distrust and anxiety and can lead to the commission of illegal behaviour (Carnaby, 1998, p. 62).

In a US study of released women that used life histories to uncover themes and issues related to reintegrating, Richie (2001) found that trauma and PSTD related to sexual and physical violence was highly prevalent in her sample. The women spoke of feeling unsafe from the threat of violence even while inside correctional facilities. One woman suggested her violent partner held her arm behind her back in full view of a prison guard during a visit, and the guard did nothing to protect her (Richie, 2001). Others had discovered their children were being sexually abused by their partner, who had been violent toward the women prior to the women's incarceration (Richie, 2001). These horrifying situations create tension and anxiety and require specific forms of advocacy and intervention by trauma informed staff who conduct themselves consistently and are reliable in their communications and actions with releasees.

Housing

Transitional support and through-care services relating to appropriate accommodation can be vital to successful post-release transition and reducing recidivism. Housing can be one of the most difficult areas for women releases (Sheehan, McIvor & Trotter 2013). Their concerns relate to accessing housing that is safe, meaning far from neighbourhoods characterized by high crime, drug use and known criminal associates (Carnaby, 1998). Some of the issues faced by women in the study conducted by Carnaby (1998) are illustrative:

- Women are often required to find accommodation before their children are released to them, however it is often the case that public housing is prioritized for those with children
- Having no money on release is an enormous barrier to securing appropriate accommodation
- A common issue related to housing is one of maintaining public housing while in prison. Many women are not informed of the process required to secure public housing while incarcerated (Carnaby, 1998)

It is also often true that housing is required prior to securing work, however it can be difficult to secure housing if you are not employed. These obstacles can be disheartening for releasees and can lead to falling back into drug use which often leads to recidivism (Berman, n.d.).

Bridging the Gap evaluation recommendations

Some particularly insightful recommendations made by the Bridging the Gap program run in Victoria provide a basis from which to consider program design and delivery modes. Their recommendations come from an evaluation of the program in 2003 and include:

- Short-term, medium-term and long-term support should be provided by transitional support services. Long-term should only make up "20% of their workload" (Flanagan, 2003, p. 114)
- Drug use desistance is a crucial element in successful outcomes. Strategies to engage participants in drug programs is imperative to success and multiple strategies should be adopted
- Failure to deal with drug use can lead to re-offending. Participants willing to continue drug programs outside of prison should be given priority for transitional post-release support
- Continuity in drug treatment is indicative of post-release success. Participants who have completed drug programs in prison to be given option of continuing treatment via transitional support services upon release
- Integrated and coordinated services are the best transitional support service model
- Personal agency and taking responsibility for rehabilitation leads to post-release success. Data collection on desistance from drug use and criminal behaviour throughout transitional support process can illuminate the specific factors behind this.(Flanagan, 2003)