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Interventions for women prisoners and their children in the post-release period

SALLY FRYE & SHARON DAWE

School of Psychology, Griffith University, Brisbane, Queensland, Australia

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Abstract

Women offenders and their children represent a severely disadvantaged and marginalised population. For many children, the very risk factors that contributed to their own mother's incarceration are present in their current lives, creating an intergenerational vulnerability for poor outcomes. Providing an intensive individualised parenting intervention in the post-release period may help improve family functioning. The aim of the present study was to ascertain the feasibility and short-term effectiveness of delivering an intensive multifaceted parenting program, Parents Under Pressure (PUP), to women offenders after release or in low-security confinement where they were living with their children. Twelve women commenced the program and eight completed treatment. Treatment completion was associated with significant positive change, in particular an improvement in maternal mental health and the quality of the parent–child relationship, with reductions found in child abuse potential and problem child behaviours. The present results highlight the potential benefits of delivering intensive multifaceted parenting interventions, such as PUP, to women who have been involved in the criminal justice system.

Keywords: *Children, female offender, mothers, parenting, prison*

The life histories of women offenders are characterised by extreme social and economic disadvantage. They are disproportionately poor, undereducated and unskilled (Bloom, 1999; Bloom & Covington, 1998). It is likely that they have been victims of sexual or physical abuse, and survival of abuse, poverty and substance misuse are their common pathways to crime (Chesney-Lind, 1997). One of the most significant and often overlooked characteristics of women offenders is their status as mothers. Almost all (85%) are mothers and many have sole care of their children on release (Easteal, 2001). Maternal incarceration interferes significantly with the social and emotional development of children (Greene, Haney, & Hurtado, 2000). When mothers are imprisoned their children often display increased levels of behavioural problems including aggression (Baunach, 1985), frequent fighting and hostility (Johnson, 1995), acting out and withdrawal (Fritsch & Burkhead, 1982). School performance is also affected, particularly in the area of academic and classroom behaviour (Henriques, 1982; Sacks, Seidler, & Harris, 1976). In addition to the loss and instability that maternal incarceration creates, many children of women offenders are more vulnerable to negative outcomes due to exposure to difficult life experiences within the family (Messina & Grella, 2006). The risk factors found in women offenders are those well established within the parenting literature as being associated with poor child outcome (Dawe et al., 2006). Maternal substance abuse, poor psychological functioning, socioeconomic disadvantage and histories of violence and trauma have been found to play a key role in the transmission of child maladaptation. An intergenerational cycle of criminality has been proposed in which the trajectory of the child follows that of the mother, despite the best intentions and efforts on the part of the woman offender (Dodge & Pogrebin, 2001; Greene et al., 2000, Johnson, 1995).

Although parenting issues have been recognised as a specific need of women offenders (Harm, Thompson, & Chambers, 1998; Morash, Bynum, & Koons, 1998), prison-based parenting programs have primarily focused on the needs of women parenting from a distance rather than preparation for family reunification. The literature reports on the delivery of parent education classes designed to teach principles of child development and/or effective parenting strategies (Harm, Thompson, & Chambers, 1997; Howze Browne, 1989; Moore & Clement, 1998). A

Correspondence: Dr S. Frye, School of Psychology, Griffith University, Brisbane, Qld 4111, Australia. E-mail: s.frye@griffith.edu.au

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number of prison-based programs have also been developed to strengthen the parent–child relationship during the incarceration period using an array of strategies such as the provision of structured and enriched environments for parent–child visitation (Weilerstein, 1995), opportunities for children to participate in extended visits (Block & Potthast, 1998; Snyder, Carlo, & Mullins-Coats, 2001) or overnight stays (Luke, 2002), as well as the inclusion of in-prison nurseries (Carlson, 1998, 2001).

Empirical investigations into the effectiveness of these programs suggest that gains can be made with prison-based interventions. Parent education classes have been found to result in significant improvements in maternal self-esteem (Harm, Thompson, & Chambers, 1997; Howze Browne, 1989), knowledge of child development, behaviour management strategies and communication skills (Moore & Clements, 1998; Showers, 1993). Participation in specialised mother–child visitation programs have been associated with a higher frequency of mother–child contact, greater closeness in the relationship, and higher levels of parental satisfaction (Snyder-Joy & Carlo, 1998). Prison nursery programs have been found to create stronger bonds between participating women and their children and higher levels of custodial contact after release (Carlson, 2001). The importance of addressing the mother's own issues within the broader context of a parenting program has also been acknowledged (Boudin, 1998). The presence of a history of personal victimisation and substance abuse has been shown to negatively impact on outcomes achieved in parenting programs (Harm et al., 1998).

These studies, although few in number, are encouraging and provide some evidence that interventions targeting women offenders for the purpose of strengthening parenting skills and enhancing the mother–child relationship can produce positive results. The delivery of parenting interventions, however, within prison provides few opportunities for women to actively practise new skills and behaviours with their children, a critical component that has been consistently associated with better parent and child outcomes than programs that utilise a less active model of skill acquisition (Kaminski, Valle, Filene, & Boyle, 2008). Furthermore, although such interventions may be helpful, the transition from prison and the re-establishment of family life is recognised as a time of great stress for women (Davies & Cook, 1999), and it is uncertain how parenting gains achieved within prison translate into the post-release period.

For the majority of women, the issues to resolve within the post-release period are immense. The overriding goal for most mothers is to re-establish relationships with their children. Yet the strain of separation, coupled with financial, occupational, residential and social pressure, intensifies the difficulty of this task. Upon release, women report experiencing feelings of displacement, rejection and confusion about their role within the family (Beckerman, 1989). Typically, they return to their home community and experience the same difficult conditions without any support or services to help address underlying problems (Morash et al., 1998; Prendergast, Wellish, & Falkin, 1995, Taylor, 1996). Many women convey concerns about their ability to resume the parenting role, and express a sense of inadequacy and fear (Baunach, 1985). Placement of children in foster care creates additional challenges after release because mothers are required to prove levels of parental fitness in order to regain custodial rights of children. Within this context, the provision of services to prepare and support women offenders in the post-release period appears a compelling idea. Family re-unification programs that provide individualised intensive interventions after release might help women offenders cope more effectively with the myriad of issues they confront on re-entry and thus improve outcomes for their children.

One program that has shown promise in populations that share many of the characteristics of women in the criminal justice system is the Parents Under Pressure (PUP) program. This intensive parenting program has been specifically designed for use with multi-problem families with young children under 8 years of age. The components found in all parenting interventions, for example child management skills and enhancing the parent–child relationship, are complemented by a series of modules that focus on helping the parent(s) identify and regulate their own emotional state, manage their substance use and extend social networks. The program is delivered on a weekly basis within a home-based treatment delivery model across 3–4 months. The effectiveness of the PUP program has been evaluated in a series of single case studies (Dawe, Harnett, Rendalls, & Staiger, 2003; Harnett & Dawe, 2008) and a randomised controlled trial (Dawe & Harnett, 2007). In the latter study, participation in the PUP program was associated with reductions in child abuse potential, parental psychopathology and child behaviour problems for parents on methadone maintenance. No such reductions were found in families who received standard care, while some slight reductions were found for those parents who received a brief intervention.

The present pilot study builds on this work by determining whether the PUP program is effective in another high-risk population, namely women involved with the criminal justice system. This is the first systematic study that has provided women offenders with a comprehensive intervention that

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addresses parenting issues, child behaviour problems, as well as lifestyle factors for those previously in custody or when residing in low-security accommodation with their children. The aim of this study was to determine whether women within the correctional system were prepared to engage with an intensive, individualised parenting program, and second, whether participation in such a program was associated with improved levels of maternal functioning and child behaviour.

Method

Participants

Twelve women offenders were recruited from correctional settings. Nine were contacted while still incarcerated and the PUP program commenced prior to their release and continued into the post-release period. Three women were engaged in the program while placed on community custody orders and the entire PUP program was delivered in the community setting. Inclusion criteria required that the women were living or intended to live after release with a child over the age of 18 months within the Brisbane metropolitan area. Ethics approval for the study was obtained from Department of Corrective Services (Queensland, Australia) and the Griffith University Human Ethics Committee.

The mean age of participating women was 30.2 years ($SD = 5.5$, range 22–40 years). The mean length of custodial sentences being completed by the women was 14.3 months ($SD = 14$, range 2–48 months). For women serving community-based orders the mean sentence length was 24 months ($SD = 10.4$, range 18–36 months). All women reported a history of sexual and physical abuse, domestic violence, histories of drug or alcohol dependence with poor educational attainment and reliance on government benefits at the time of the current offence.

The mean age of the target child was 5.6 years ($SD = 3.9$, range 2–12 years). At initial assessment, 10 of the 12 women were residing with the target child and two women were residing with additional children besides the target child (families 2,7 included an additional four and two children, respectively). Two women intended to resume parenting duties at a future date after release (families 11 and 12). Eight women had additional children living in alternative care (families 2, 3, 4, 5, 6, 9, 11 and 12). The total number of children residing in alternative care was 21.

Treatment intervention: Parents Under Pressure program

The PUP program was delivered in accordance with the guidelines documented in the Therapist's Manual and Parent Workbook. All sessions were conducted at the woman's place of residence either in custody or within the community. At the initial session a comprehensive assessment of each family's needs was conducted and this information was used to form the basis of an individualised case formulation developed collaboratively with each family. Specific targets for change were articulated during this assessment phase and these became the focus of the PUP treatment.

The PUP program consists of 10 structured modules that are delivered in response to the individualised needs of each family. For example Module 3, "Challenging the notion of an ideal parent", focuses on parenting competencies and what the parent is currently doing well. Module 4, "How to parent under pressure", focuses on teaching the parent ways to manage negative emotional states and, importantly, ways to tolerate difficult emotions without use of dysfunctional strategies such as drugs or alcohol. Module 5, "Connecting with your child and encouraging good behaviour", teaches positive ways of managing child behaviour through the use of praise and reward. Parents are also encouraged to strengthen their relationship with their child through child focused play. Module 6, "Mindful child management", teaches non-punitive child management strategies such as time out or use of logical consequences. Parents are also taught how to gain greater control over their own emotional reactivity so that discipline and behavior management occurs in a calm frame of mind. Module 7, "Coping with lapse and relapse", teaches ways to minimise the possibility of future relapse into drug or alcohol use. Module 8, "Extending social networks", helps parents to identify additional areas of support and encourages parents to make contact. Module 9, "Life skills", provides practical information on diet, budgeting and health care. Module 10, "Relationships", aims to improve effective communication between partners and to identify past unhelpful relationship patterns.

At the commencement of each PUP session, time is spent checking out the family's current situation to determine whether any pressing issues have arisen that require immediate intervention. Such issues are welcomed within the PUP program because they provide opportunities to build and strengthen problem-solving skills and lead to the development of real-world action plans that are put into practice in the coming week. Often issues raised have a direct bearing on the duration and content of sessions conducted, as well as instigating additional case management input.

Duration of sessions varied in response to the woman's needs and family issues. The extent of time that therapists engaged in case management issues

was also dependent on the circumstance of each family. All treatment was conducted at the client's place of residence.

Measures

A semi-structured interview obtained basic demographic information and relevant history from the mother. Self-report questionnaires measuring functioning across the following ecological domains were completed during the initial assessment, at the completion of treatment and again at follow-up 3 months later: (a) maternal psychological functioning, (b) child emotional, social and behavioural functioning, and (c) parent–child relationship.

Maternal psychological functioning

Levels of maternal psychological functioning were assessed using the Brief Symptom Inventory (BSI) (Derogatis, 1992), the Parenting Stress Index–Short Form (PSI) (Abidin, 1990) and the Child Abuse Potential Inventory (CAPI) (Milner, 1986). The BSI provides a profile of an individual's psychological symptom status, yielding nine primary symptom dimensions as well as a general measure of psychological functioning, the Global Severity Index (GSI), which was used in the current study. Internal consistency of the BSI has been established, with Cronbach's alpha coefficients ranging from .71 to .85. In this study a GSI score $\geq$63 was used to identify participants with psychological symptoms warranting clinical concern (Derogatis, 1992).

Levels of distress associated with the parenting role were assessed on the PSI (Abidin, 1990). The PSI consists of three subscales that measure different aspects of perceived stress in the parenting role. In the current study the Total Score was used to determine the level of distress experienced by the mother within the parenting role. This measure has been found to have good test–retest reliability ($r = .84$) with high internal consistency ($\alpha = .91$). In this study the cut-off point for a high score was 91 (90th percentile). High scores on the PSI have been associated with abusive parenting (Lacharite, Ethier, & Couture, 1999; Mash, Johnston, & Kovitz, 1983).

The CAPI (Milner, 1986) was used to identify those mothers who may be at risk for physical child abuse potential. For the present study an overall measure of abuse (Abuse scale) was reported. When using the Abuse scale as an outcome measure, the cut-off score recommended to minimise false positives is 215. This value was used in the current study. A valid elevated Abuse scale indicates that the respondent has characteristics similar to known, active child abusers. The internal reliability of the Abuse scale is reported to be in the range of .92–.96 across a number of studies (Milner, 1986). The CAPI contains three validity scales: a Lie scale, a Random Response scale, and an Inconsistency scale. In general, the validity of the CAPI Abuse scale should be questioned when any of the three validity scales are elevated. It is possible, however, to use an elevated Abuse scale score when the Lie scale is elevated due to 'Faking Good' (Milner, 1986).

Child functioning

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) was used to measure the target child's emotional, social and behavioural functioning. The SDQ consists of five subscales: emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behaviour. The first four subscales are used to derive a Total Problem Score and it is this score that is reported in the current study. Construct validity has been demonstrated across a number of studies and shown to be significantly correlated with the Child Behaviour Checklist (Achenbach, 1991). The internal reliability of the SDQ has been reported to be .82 (Goodman, 2001; Hawes & Dadds, 2004). Based on Australian norms presented on the SDQ website (www.sdqinfo.com/ba3.html) and a recent Australian study (Hawes & Dadds, 2004), a clinical cut-off score of 16 on the Total Problems Score was used in this study to identify children with social emotional behaviour issues of clinical concern. The SDQ was used to measure the functioning of all target children aged $\geq$3 years ($n = 11$). The Child Behaviour Checklist/2-3 (CBCL/2-3) (Achenbach, 1992) was completed for children too young to complete the SDQ ($n = 1$). The later results are not included in the current study.

Parent–child Functioning

The Parent–Child Dysfunctional Interaction (P-CDI) subscale of the PSI (Abidin, 1990) was used to assess the quality of the parent–child relationship. The P-CDI measures the degree to which the parent is dissatisfied with the child and the perception that the child does not meet parental expectations. The cut-off for a high score is 27. High scores are taken to reflect serious vulnerability in the parent–child relationship. Scores $\geq$30 are considered suggestive of the potential for child abuse. The internal validity of the P-CDI subscale has been reported as .85 (Abidin, 1995).

Procedure

Women offenders who met criteria for inclusion into the study were invited to participate by correctional

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staff. PUP therapists met initially with each mother to provide further information about the study and obtain informed consent to participate in the research study prior to the first assessment session. The PUP program was conducted in the community for those previously in secure custody ($n = 4$) and those on community orders ($n = 3$). For those women in low security ($n = 5$), the PUP program commenced during their sentence and continued in the post-release period. Follow-up assessments occurred at the completion of treatment and again 3 months later. Treatment was delivered by two registered psychologists with experience in treating complex families and trained in the PUP program.

Data analysis

Treatment intensity was measured by monitoring the total number of face-to-face contact sessions per woman as well as the total number of non-contact hours spent by the therapist on case management tasks. Changes in psychological functioning across the treatment and follow-up period were assessed using repeated measures analyses of variance (ANOVA) with the within-subjects factor of time (pre-treatment, post-treatment, 3-month follow-up) on each of the outcome measures: BSI-GSI, CAPI Abuse scale, PSI Total Distress, PSI: P-CDI and the SDQ Total Difficulties Score. A conservative intention-to-treat analysis was performed. Missing values at follow-up were replaced with the end-point or "last value" available for the participant (Kendall, Flannery-Schroeder, & Ford, 1999). Post hoc analyses were performed using Bonferroni corrections.

The extent to which each woman made clinically significant change was also assessed. Individual scores on each self-report measure were compared to normative data at pre-treatment and post-treatment assessment, and at follow-up to determine the level to which treatment was associated with a return to the normal or non-clinical range (Kendall et al., 1999). For this study the scores on each of the key measures of maternal functioning are reported, with scores obtained on the PSI and the BSI being converted to percentiles to allow easier comparison with normative data.

Results

Treatment attendance and intensity

Eight of the 12 women remained in treatment until program completion. The women who dropped out of the PUP program did so relatively early in the treatment phase. Three dropped out after completing only one community-based session (Families 3,9,11). Family 12 was considered a dropout because there was no agreement that treatment goals had been met. Following the completion of her ninth treatment session, this woman unexpectedly left her accommodation and her whereabouts became unknown (Table I).

Of the eight women who completed the PUP program, the mean number of treatment sessions was 20 ($SD = 8$, range 11–38 sessions) and the mean duration of sessions was 86 mins ($SD = 17.6$, range 61–112 min). The intensity and duration of the treatment program for each woman was variable. The mean number of total face-to-face treatment hours for the eight completing women was 28.6 hr ($SD = 12.4$, range 11.2–51.5 hr). The corresponding mean number of total indirect hours engaged in case management was 11.6 hr ($SD = 9.5$, range 2.3–32.3 hr). The mean number of total treatment hours for the eight completing women was 40.2 hr ($SD = 21.4$, range 14.2–83.4 hr).

Change in maternal functioning across time

There was a significant main effect of time on the maternal functioning measures (i.e., the CAPI Abuse scale, PSI Total Score and the BSI-GSI). There were also significant improvements in the parent–child functioning measure (i.e., PSI: P-CDI) and the child behaviour measure (SDQ Total Difficulties). Post hoc tests indicated a significant reduction in scores from pre-treatment to post-treatment, and from before treatment to follow-up on the PSI Total Distress, PSI: P-CDI subscale and the SDQ Total Difficulties score. There was also a significant reduction from pre-treatment to follow-up on the BSI-GSI (Table II).

Clinical Significance

Individual scores on each of the key outcome measures of maternal functioning are provided in

Table I. Treatment duration and intensity

Family	1	2	3	4	5	6	7	8	9	10	11	12
No. sessions	19	19	1	18	38	14	19	11	3	21	4	9
Face to face (hr)	33	36	2	21	52	17	29	11	4	33	4	8
Case management (hr)	15	7	2	9	32	2	13	3	1	10	1	4
Total treatment hours	48	43	4	30	84	19	42	14	5	43	5	12

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Table III for each client who completed the treatment ($n = 8$). At pre-test assessment four of the eight women scored in the clinical range (>215) on the CAPI. Although one of these had an elevated score on the Faking Good Index, this score is interpreted as indicating the presence of abuse potential because the Abuse scale exceeded the clinical cut-off. The score obtained from Mother 1 is consistent with someone who was choosing to provide responses that were considered socially desirable. At post-test assessment and follow-up the scores of all women on the CAPI Abuse scale were no longer within the clinical range.

Percentile scores are provided in Table III for the two measures of maternal stress (PSI Total score) and overall psychological wellbeing (BSI-GSI). At pre-test assessment all women were experiencing high levels of distress, with four women scoring within the clinical range on the PSI Total score and one woman scoring within the clinical range on the BSI-GSI. Notably these scores improved dramatically in the post-treatment and follow-up period for all of those women who completed treatment.

Discussion

To date there have been few attempts to systematically evaluate intensive programs that help women involved in the criminal justice system transition successfully into the community. This pilot study evaluated the feasibility and effectiveness of an intensive parenting intervention for women offenders. Findings indicate that women offenders are interested in participating in parenting programs and keen to improve outcomes for their children. Twelve women were recruited to participate in the PUP program. Of the eight women who completed the program, seven were retained for 3-month follow-up assessment. Program participation was associated with significant lifestyle improvements, in particular maternal emotional wellbeing, levels of stress experienced in the parenting role as well as significant improvements in child behaviour outcomes. Furthermore, for most women the gains appeared to be maintained in the short term. Although there is some basis for cautious optimism, several key findings from the current pilot need to be heeded. These

Table II. Means and standard deviations for outcome measures for PUP program

	Pre-Treatment Mean (SD)	Post-Treatment Mean (SD)	Follow Up Mean (SD)	*F*	*p*	Post hoc
Maternal functioning						
CAPI Abuse	197.81 (113.65)	142.00 (87.29)	136.09 (91.36)	4.68	.02	
PSI Total	89.90 (24.87)	66.72 (18.29)	66.72 (17.26)	13.44	.00	Post < Pre FU < Pre
BSI Global	.58 (.27)	.46 (.32)	.44 (.34)	6.05	.01	FU < Pre
Parent-child functioning						
PSI P-CD	23.0 (6.9)	18.45 (5.08)	18.09 (5.18)	9.57	.001	Post < Pre FU < Pre
Child behaviour						
SDQ Total[a]	15.33 (9.64)	8.67 (5.66)	8.44 (5.15)	9.14	.01	Post < Pre FU < Pre

Notes: BSI Global = Brief Symptom Inventory Global Severity Index; CAPI = Child Abuse Potential Inventory Abuse Score; PSI total = Parenting Stress Index Total Stress; SDQ Total = Strengths and Difficulties Questionnaire Total Difficulties Score; PSI P-CDI = Parenting Stress Index Parent-Child Dysfunction sub scale; Pre = Pre-treatment; Post = Post-treatment; FU = Follow Up. [a]sample size = 9.

Table III. Changes in levels of maternal functioning

	CAPI (Abuse)								PSI Total score (percentile)								BSI-GSI (percentile)							
	1	2	4	5	6	7	8	10	1	2	4	5	6	7	8	10	1	2	4	5	6	7	8	10
Before treatment	24†	**269**	187†	126	35	**242**	**237†**	**375**	83	**99**	85	84	83	**99**	**92**	**99**	62	**91**	75	48	38	82	79	**X**
After treatment	53†	181	106	56	68	123	201	93	68	84	77	66	76	73	74	85	26	75	26	7	75	62	62	**X**
3-month follow-up	44	164	127	47	39	101	**W**	**X**	67	81	70	72	71	73	**W**	**X**	18	75	38	10	18	60	**W**	**X**

Notes: BSI-GSI = Brief Symptom Inventory (Global Severity Index); CAPI (Abuse) = Child Abuse Potential Inventory (Abuse Scale); PSI Total score = Parenting Stress Index Total Score; W = withdrawn from study; X = did not complete questionnaire.
†Elevated Faking Good Index.
Bold, scores on or above the clinical cut-off.

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issues have implications for future research into this area as well as any efforts by organisations to execute a large-scale implementation of PUP or any other intensive, case management approach for women in the post-release period.

Current findings

The profile of women in this study was consistent with findings from other studies (e.g. Davies & Cook, 1998; Kilroy, 2000; Singer, Bussey, Song, & Lunghofer, 1995). The women experienced high rates of psychological distress, a significantly heightened potential for child abuse and, for the majority, the parental role was a significant source of anguish and distress. Such a risk-laden profile lowers the probability of achieving competent, adaptive outcomes as these women move through the corrective system into post-release life. Although all women at the commencement of treatment appeared to genuinely seek improved outcomes for themselves and their children, for some the number of risk and vulnerability factors they encountered after release was overwhelming and this derailed their commitment to the program, resulting in disengagement and withdrawal. For others, the transaction of individual and environmental factors resulted in positive adaptation and the development of competence, which may in turn have the potential to alter future trajectories for these women and their children.

The promising outcomes achieved in the current study required considerable therapist input and time. On average, each woman who completed the program received 28 hr of face-to-face contact, and an additional 12 therapist hours were engaged in case management tasks. This level of treatment intensity was required to assist the women to manage difficult family circumstances and the chaotic lifestyle that was experienced after release. Time was required to connect the women to community resources as well as to provide input to help manage legal, financial, accommodation and family issues that had arisen as a consequence of their incarceration. For those women who had children placed in care during their incarceration ($n = 3$), direct assistance was given to address social services concerns and support was provided during the process of family re-unification. The home-based nature of the PUP program meant that additional therapist time (average 12.5 hr per woman) was spent travelling to and from family homes over the duration of the study. This component of the PUP program is regarded as critical because it offset any issues the women might have experienced with transportation, and facilitated regular therapist contact despite the intrusion of unexpected crises and family disruption. One mother on release from prison was required to complete a period of home detention and would have been unable to participate in a clinic-based program. Overall, the average number of therapist hours involved in each family intervention was 52.5 hr. This figure is considerably higher than the number of therapist hours required for the delivery of more traditional, group-based parenting programs such as one designed by Webster-Stratton (1997), in which parents meet weekly for 10–12 sessions for a 2-hr period. Although traditional group parenting programs have been demonstrated to produce enduring positive change in the functioning of many families, there is accumulating evidence that for multiproblem families, such as women offenders, more intensive types of family interventions are required to address a broader range of issues than only parenting competence.

Evidence is emerging that intensive interventions of this kind are cost-effective. Conduct disorder in childhood often results in huge financial outlays in the long term. The trajectory of many children displaying antisocial behaviours at age 7 and 8 is overwhelmingly bleak, in that 40% will become recidivist delinquents as teenagers and go on to experience substance dependence, unemployment, marital difficulties, antisocial behaviour and crime (Scott, 1998). The delivery of multisystemic interventions (MST) to youth and their families is proving to be a cost-effective way of addressing serious criminal activity among adolescents (Henggeler, 1999). Although the current study did not include a cost-effectiveness component, it is strongly recommended that future evaluations of intensive family-based interventions for high-risk families attempt to obtain measures of cost benefit.

Implications for future research

For the majority of women there appeared to be marked discrepancies between the results of self-report assessments obtained at pre-test assessment and perceived levels of emotional functioning. It is noted that the pre-test scores of several women on the CAPI were invalid due to elevations on the Faking Good Index. This issue may also have extended to other measures that did not contain validity indices. For example at pre-test assessment seven of the eight women who completed treatment scored within the normal range on the BSI-GSI and four women scored within the normal range on the PSI-Total score. These scores appeared at odds to personal disclosures made by the women themselves, who, over the course of the intervention, spoke openly about the level of psychological pain and distress they experienced. It appears plausible that this discrepancy is a function of the custodial setting itself. Prisons are, above all, highly maladaptive

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settings. Easteal (2001) refers to the dictum of "Don't talk", "Don't trust" and "Don't feel", as the dominant rule in families characterised by addiction, abuse and other manifestations of dysfunction. Given the backgrounds of women offenders and the dysfunctional nature of the prison culture, adherence to this code might perform an adaptive function. The difficulties experienced by women offenders in establishing trusting, supportive relationships with treatment providers highlights the need for services to offer long-term interventions that facilitate the development of warm, positive and trusting therapeutic relationships. Women offenders present with a range of complex issues that cannot be readily addressed within a short-term treatment model. From a research perspective, uncertainty regarding the validity of self-disclosure brings into question the usefulness of self-report measures for women residing within the corrective settings. In the design of future studies it would be sensible to build multiple points of participant assessment, with the first taken while in custody and the second taken immediately on leaving custody. Future evaluations should also consider use of clinician-rated measures of psychopathology and parenting behaviours. Such measures enable client issues to be directly assessed and are less dependent on the willingness of clients to disclose aspects of their current psychological functioning.

Organisational issues for future development

Although it is well-established that the post-release period is particularly difficult for women offenders (Davies & Cook, 1999, Morash et al., 1998; Prendergast et al., 1995; Taylor, 1996), the delivery of intensive case management parenting programs to assist women offenders and their families requires considerable shift in both organisational structure and policy within correction services. Prisons have been traditionally viewed as a place of punishment, with restrictive correctional policies viewed as an appropriate consequence of lawbreaking behaviour. Although it is not the intent of this paper to suggest that women offenders bear no responsibility for their incarceration, it is proposed that correctional sentencing might provide a window of opportunity to work with these mothers and help improve outcomes for themselves and their families. The implementation, however, of an intensive intervention for women offenders during the post-release period does raise some interesting issues. If a woman is not actually on parole, there is neither a legal requirement that she attend a program nor is there a need for a justice or corrective services department to provide treatment. Which arm of government should then take responsibility for the delivery of treatment? Health, child protective services certainly have much to gain from improving family functioning in such high risk families but is it their mandate to provide case management?

It is also important to bear in mind that the majority of women offenders in the criminal justice system do not receive custodial sentences. Most convicted offenders, both male and female, receive non-custodial sentences such as community-based orders, which enable the offender to remain in the home environment while completing sentencing requirements. In March 2008 there were 1,853 women in corrective custody across Australia, with a further 9,973 women completing community corrections orders within their home community (Australian Bureau of Statistics, 2008). Thus, in order for an intensive family intervention to be accessible to the largest possible number of women offenders, this may be the ideal setting for the PUP program, particularly because working with families in their home environment ensures that treatment is directed at those systems that are both influencing and being influenced by the behavior of the families (Henggeler, Schoenwald, Bourdin, Rowland, & Cunningham, 1998).

Summary and conclusion

The return to family life after a period of incarceration is a critical time. Most women on exit from prison express a sense of optimism and hope for a new beginning. Despite their best intentions, however, the reality of post-release life presents many obstacles that often impede the fulfilment of these aspirations. Although prison is a difficult time for women, the subsequent hardships they endure upon release are no less significant. The realignment of correctional policy initiatives with programming initiatives designed specifically to address the needs of women might provide a starting point for the emergence of more positive outcomes for women offenders and their families.

Results from this study highlight the potential benefits of delivering intensive multifaceted parenting interventions such as the PUP program to women offenders. Many of these women are interested in participating in parenting interventions, and there is evidence that treatment completion is associated with significant changes, particularly in relation to levels of maternal emotional wellbeing, confidence in the parenting role, the quality of the parent–child relationship and concurrent child behaviour as well as general lifestyle improvements. Although ostensibly women in this study chose to take part in the PUP program to improve their parenting skills, for the majority the primary focus of the program was directed towards their own psychological wellbeing.

In a sense, the parenting agenda provided the lure for participation, but once engaged, attention was expanded to include those areas that directly impacted on the parental role. Successful outcomes associated with this program highlight the possibility of addressing the cycle of dysfunction that often characterises the families of women offenders and with that, the opportunity for fostering positive adaptation and competence in the future trajectories of their children. While these programs should be available to all people in a community, they are critical for women within the correctional system. Ultimately, however, decisions regarding the dissemination of programs such as PUP are influenced by issues of cost, with future studies being required to demonstrate not only program effectiveness and client satisfaction, but also cost saving. This must be demonstrated to optimise the probability of ongoing funding for program implementation.

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