Promoting Health for Women in Custody in N.S.W.

N.S.W. Corrections Health

Phase I Needs Assessment

A project funded through the National Women's Health Program

Sue Sagewood
Project Officer
January 1997
Acknowledgements

This needs assessment is the result of the efforts of many people who participated in the consultation process. I would like to thank them for their valued time and contribution to the project.

My thanks to:

The project steering committee: Anne Sefton, Gino Vumbaca, Marilyn Wright, Sarah Stewart and members of the Western Sydney Health Promotion Unit. Thank you for your guidance, support and valuable feedback on the draft of this report.

The women inmates at Mulawa, Norma Parker and Emu Plains Correctional Centres who participated in the focus groups so openly and enthusiastically.

The Women's Health Advisory Committee (CHS), the auspicing body of this project. Thank you for your support since the project's inception.

The key informants and service providers who so painstakingly took me through their roles in the correctional system and the Corrections Health Service, and who shared with me with such valuable information.

The prison officers, especially Stewart Campbell, Governor of Mulawa, for providing me with support, much information and a sound background of the correctional system.

The Health Promotion experts in the community whose valuable help and direction kept me on track.

Sue Sagewood
Women's Health Promotion Project Officer
January 1997
Contents

Executive Summary 2

Introduction
Background 4
Literature Review 5
Objectives 6
Demographics 7
Structure of Correctional Centres 7

Methodology 11
Data Analysis 14

Results
Health Services & Health Promotion 15
Interviews with Service Providers 20
Focus Groups 22

Summary 29

Bibliography 32
Appendix 1 36
Executive Summary

Completed as the first phase of the health promotion project Promoting Health for Women In Custody, the Needs Assessment forms the basis for the development of a health education program for women in prison in NSW. It stands also as an important document offering valuable insights into the health needs of incarcerated women.

The Needs Assessment is viewed as the most crucial element of program planning. The success of health education and promotion programs depends wholly on the data collected about the group who will become the focus for the education program. The process of this Needs Assessment involved consultation with service providers, key informants and community organisations concerned with the supervision, care and aid of female inmates. A review of existing literature on a wide range of related topics was also conducted. Importantly the process integrated consultation with fifty eight inmates at metropolitan female Correctional Centres through focus group methodology.

The results of the Needs Assessment reflect clearly that the health needs of women in prison are many and varied, underscoring the need for education about healthy lifestyles. The results also highlight the many other issues which impact upon health and which cannot be addressed through education alone. Health, as viewed by the inmates themselves is not confined to the mere absence of illness, but includes social and environmental factors particular to a custodial existence.

Attitudes of staff, clothing, exercise, diet and the physical and social environment were commonly cited as factors affecting the health of inmates. Medical and counselling services were often seen as failing to meet needs and the use of psychotropic medications was a concern of service providers and the women themselves. By far, the most common need expressed by inmates was to have "someone to talk to" in times of stress and crisis.

A prevailing theme in the responses of all contributors to the Needs Assessment was that the holistic health needs of imprisoned women are not being addressed.

The Needs Assessment identifies a lack of coordinated and specific health education and health promotion for women in custody. It demonstrates clearly that a health education program designed to promote healthy lifestyles is necessary, and that such a program would be positively received by both staff and inmates.

On this basis, the recommendation is made for the development of a health education program to inform and support participants, with the aim of creating opportunities for them to make healthy choices. A pilot program has been developed which will provide a model for evaluation and for future implementation in correctional settings.
The identification of the significant issues relating to health extend beyond the scope of a health education program. This underlines the importance of an integrated, intersectoral approach to health promotion policy, involving those organisations concerned with the wellbeing of women in custody, Corrections Health Service, Department of Corrective Services and the Area Health Services.
Introduction

Background

The needs assessment was conducted over 3 months, from July to end of September 1996. It is the first phase of Promoting Health for Women in Custody, a project to develop a lifestyle education program specifically responsive to the health needs of women in correctional centres in New South Wales.

The project was funded through the National Women’s Health Program, as a non-recurrent grant of $43,000, being the result of a submission from the Women’s Health Advisory Committee, an advisory committee to the Corrections Health Service Board.

The rationale for the project arises from the recognised lack of organised and pro-active health education programs for women in custody and is in line with the Corrections Health Service Board’s Strategic Plan (1993 to 1998) to promote the health of inmates.

Health Promotion, as a means of achieving ‘Health for All’, is a process of enabling people to increase control over and improve their health. Health is now seen as a resource for everyday life rather than an end in itself (Ashton & Seymour, 1988 p.25) and includes social, political and economic aspects, rather than the mere absence of illness. In this encompassing view, health therefore becomes instrumental to other achievements in one’s life.

It is well documented that health is significantly affected by the amount of power or powerlessness one feels (Wallerstein, 1992) and it is for this reason, that the process of empowerment is a major strategy in health promotion. The most popular method used for self empowerment is education. This offers the opportunity for people with power to “provide the conditions and the language and beliefs that make it possible to be taken by those who are in need of it” (Rappaport, cited in Robertson & Minkler, 1994 p.301).

Women in gaol are often from community groups most marginalised in respect of health care and health information. These women include those from Aboriginal and non English speaking backgrounds, unemployed women, single parents, drug users, survivors of domestic and sexual abuse and those having a host of other social, economic and educational disadvantages (Fogel, Shaw, Cordero et al., Penal Affairs Consortium, Thompson). Lack of power is thus, a key issue for incarcerated women.

Therefore the purpose for the development of a health education program is to provide information, support and assistance for women in gaol to build upon their strengths, resources and problem solving abilities to enable them to opt for healthy choices. Such a program may prove to be of lasting value both to themselves and subsequently to their families on their return to the community.
Literature Review

There is relatively little data or research on women in prison in Australia and even less when it comes to women's health in prison. What is well documented, however, is that women entering prison often come from a background of poverty in which they are the sole parent and family support and are often welfare recipients. Histories of sexual, physical and substance abuse are common (Fogel 1991, Shaw 1981, Cordero et al 1992, Penal Affairs Consortium 1996, Thompson 1994, Denton 1994) as is prostitution/sex work.


If these women enter prison with poor health, however, there is no reason to believe that the gaol experience will improve it. In a study of women's health in prison, Fogel concluded, "The prison experience did not improve the health of women", despite them having access to health care services (1991, p.55). In fact, many of the health problems facing women in prison are caused by incarceration itself. Stress related disorders and depression, including headache, fatigue and backache are common (Fogel 1991, 1993, Shaw 1981, Kendall 1994, Sims1992). Weight gain and obesity can become the norm (Shaw 1981, Hampton 1993, Fogel 1991).

The literature also provides some evidence to suggest that psychotropic drugs are over used in women's gaols (Easteal 1992, Sim 1990, Hampton 1993).

Recommendations for improving women's health in prison range from supplying better food, better trained staff, better clothing and a more open, pleasant environment, to providing educational programs for inmates and staff (Easteal 1992, Fogel 1991, Hampton 1993, NSW Women In Prison Task Force, Corrections Health Service 1985, Bartolo 1992, Thompson 1994). "Preventive and therapeutic interventions that address individual health problems" should also be developed as well as improving the gaol environment to "decrease its stressful nature and thus its adverse impact on health" (Fogel 1993, p.376). Considering the prevalence of poly-drug use amongst female inmates, there are clear recommendations for the establishment of detoxification units and for specialist drug-intervention strategies within the women's correctional system (Kevin 1995, Denton 1994).

Whilst some progress has been made within the NSW correctional centres for women, many of the recommendations made by the NSW Women in Prison Taskforce are still as relevant today as they were in 1985.

What is clear from the literature is that the specific requirements of women from culturally diverse backgrounds must be taken into consideration. For if women in prison are generally disadvantaged, then women from non English speaking
backgrounds are "a minority within the minority" (Easteal, 1992, p.v) and appear to suffer more than English speaking women. The same may be said for women from Aboriginal and Torres Strait Island backgrounds who are generally over-represented in the correctional system. Women with an intellectual disability who are even more of a minority within the system lack recognition even in the literature.

It is evident from the literature that all the above issues must be considered if the health of women in gaol is to be improved (Thompson, 1994). This holistic approach, looking at "the whole spectrum of a woman's needs", (Moffat, 1994, p197) is not such an unrealistic or unreasonable goal. In Dublin, California, an innovative program, the Prison Integrated Health Program has been successfully running since 1990. Central to the program is "the belief that health is a function of physical, mental, emotional and spiritual wellbeing" and that it is only by addressing all these aspects of people's lives that behaviour can be changed, disease be prevented and health be promoted (Thompson, 1994 pp.55-59). The P1HP, designed for staff and inmates, works on the philosophy of health promotion to create a healthy community for all who work and live there. Since the program's inception, the prison has reported a significant improvement in the health of inmate participants and has also contributed to the "redefinition" of departmental structure (Thompson, 1994 p.58).

A health promotion approach must be taken to facilitate the radical social change within the prison system which must occur if the health needs of women are to be better met. For this reason, policy and environmental issues and the implementation of education programs for staff of corrective services and health services, as well as for the inmates, must be addressed (Fogel 1991, 1993, Hampton 1993, Moffat 1994, NSW Women In Prison Task Force 1985).

Objectives of the Project

The objectives of the needs assessment were:

1) to determine the health related services available to women in custody

2) to determine the existing health related education programs at Mulawa, Norma Parker, Emu Plains and Long Bay Correctional Centres*

3) to explore the health concerns of incarcerated women

4) to make recommendations for the health education program.

*(Long Bay Correctional Centre for men was used as a comparison in the collection of information regarding health education programs)
Demographics

There are about 320 female inmates in NSW making up 5% of the total prison population (Women's Services Unit, 1996).

Female inmates are aged 18 years and over, with more than 50% of women aged between 23 and 34 years (Eyland, 1995). Only 6% are aged 50 years or over (Trimboli, 1995). The vast majority (87.5%) of women receive a sentence of less than one year.

A disproportionate number - about 18% of female inmates are of Aboriginal or Torres Strait Island descent (Women's Services Unit 1996). This percentage is about 18 times higher than the percentage of Aboriginal and Torres Strait Islander women in NSW (1%) (Edwards, 1995, p.3). 7% are women from non English speaking backgrounds (Eyland, 1995), with 21% having been born outside of Australia (Edwards, 1995, p.3).

In a study of 130 women in 1993, Kevin found that 72% of inmates perceived there to be a relationship between their drug use and their imprisonment with 32% of women using heroin on a daily basis prior to their imprisonment. 25% of the sample stated that they had received income from sex work (prostitution) with the majority stating "that they did this work to finance drug use" (Kevin,1995 p.vii). Benzodiazepines were used daily by 16% and alcohol by 15% of the sample with most women reporting "very heavy levels of use" (Kevin, 1995 p.vii).

The majority of women in gaol have children (66%) with 35% of mothers reporting that they are solely responsible for their children (Kevin, 1995).

Structure of the Correctional Centres

The main correctional centres for female inmates in NSW are located in, and on the outskirts of Sydney metropolitan area. Women are received at country centres before being transferred to Mulawa. A small residential unit (19 women) has recently opened at Grafton. All correctional centres for women are subject to the Department of Corrective Services specific Women's Program.

The Mulawa Correctional Centre is the main reception facility for women. At Mulawa, female inmates are initially assessed and classified and, according to this assessment, the placement of the inmate is decided. They can be accommodated at:

- Mulawa, a medium security gaol,
- Emu Plains Correctional Centre, a minimum security prison farm,
- Noma Parker Centre, a work release centre at Parramatta,
- the Transitional Centre, a pre-release centre at Parramatta, or
- Grafton Women's Unit accommodating all classifications of inmates.
The correctional centres are working gaols where the women work cleaning, cooking or maintaining the grounds. Many women are employed in the Corrections Services Industries situated at Mulawa and the plastics recycling industry, the market garden or the dairy at Emu Plains. The women are paid an allowance for their work which is credited directly to their personal gaol account. This money may then be used by the inmate at 'buy-up' time.

**Buy-ups**
Each week inmates can purchase items from the canteen list eg. tobacco, food, snacks. Each fortnight, inmates can purchase cosmetics, including deodorant and shampoo. The activities buy-up, once per fortnight, allows the purchase of property, eg. clothes, hairdryers.
The money is then debited to the inmates personal account.

Each inmate has a program pathway developed for and with them. This program may allow the inmate to move through the system, from maximum security to minimum, according to their classification, or through to the works release centres, ideally establishing contact with the community prior to their release.

**Case Management**

Integral to the inmate's program is case management. Introduced by the Department of Corrective Services in 1994 as part of its "interactive offender management strategies", case management was designed to manage "each inmate as an individual and assessing each on a case by case basis" (1994/95 Annual Report, DOCS). It involves custodial staff having a case load of 10 to 15 inmates, making case notes and recommendations relevant to that individual inmate.

**Mulawa**

Mulawa, established in 1970 as a women's medium security gaol, has an inmate capacity of 207. The inmates are accommodated within three distinct areas:

**Stage 1 - (Mulawa)** with a capacity of 84 inmates includes the reception/induction area, the Corrections Health Service clinic, the protection/segregation area (Conlon) and the therapeutic unit.

**Stage 2 - (Wyndana)** has a capacity of 86 inmates divided between four units housing sentenced and remand inmates.

**Stage 3 - (Dawn De Loas Centre)** has a capacity of 72 inmates housed in five units which include a drug free wing, a wing for trusted inmates and wings for long term inmates.
At Mulawa, the day starts at 6.30 a.m. when inmates have an hour to shower and eat prior to starting work at 7.30 a.m. At 2.30 p.m. work finishes and inmates have free time until 5 p.m. or up to 7 p.m. in some wings, after which they are locked into their wings. Medication dispensing occurs between 7 and 8.30 a.m. and 3 to 4.30 p.m.. Methadone dosing occurs between 7 and 9.30 a.m.

In Wyndana and Dawn De Loas Centre, food is prepared and cooked by the inmates within the wings. In the area of Mulawa, food is brought pre-cooked from Silverwater Gaol in hot boxes. All lunches (sandwiches) are prepared in the Mulawa kitchen.

**Emu Plains**

Emu Plains was established as a minimum security women's gaol in February 1995. Its inmate capacity is 120 and the inmates are located within two separate areas:

**The Compound** has a capacity of 78, where all inmates are assessed for six weeks before being allowed to leave the compound area unaccompanied. The compound has single cells, with a toilet and basin only, located in long blocks. Shower blocks are located separately. Food, (breakfast and dinner), is cooked in the main kitchen and served in a large dining hall. Lunches (sandwiches) are also prepared in the main kitchen.

**Jacaranda Cottages**, newly opened in February 1996, consist of eight cottages each housing 5 inmates with provision for the accommodation of up to 16 resident children. Here, inmates cook for themselves with their allocated rations.

**Norma Parker**

Norma Parker was established as a minimum security correctional centre for women in 1980 and is now an annexe of the Emu Plains Centre. It has a capacity of 25 inmates working towards or established on work release programs, who leave the centre on a daily basis going to work or college. These women are less restricted than women in other centres and may have access to day and weekend leave programs. Here, inmates cater for themselves with their allocated rations.
Transitional Centre*

This centre was established as a half-way/transitional residence in October 1996 for up to 22 women. Operating as a minimum security centre, these two renovated houses can also accommodate children of inmates. Here the women are on work or education programs progressing towards release from custody.

Grafton*

Newly opened in January 1997, the Women's Unit is part of the regional reception correctional centre for male inmates. The unit can accommodate up to 19 women of all classifications (new receptions, remand, sentenced and periodic detainees) and there may be provision in the future for a small number of children to live with their mothers.

*Note. The Transitional Centre and Grafton were not used in the Needs Assessment as they had not opened at the time of the research.
Methodology of Needs Assessment

Background to Needs Assessment

The Needs Assessment is viewed as the most crucial element of community analysis and program planning. Successful program planning in health education and promotion depends on the data gathered about the individual, group or community that will be the focus of the program, in this case, the women inmates. Consideration must also be given to the context and environment of the inmates to allow the program planner to have a broader understanding of the health problem to be addressed and the resources which are available to do it. Need has been defined as "the condition in which something necessary, desirable or very useful is missing or wanted" (Longman Dictionary 1987). This definition highlights the fact that the concept of need is in fact value-based and socially constructed. Therefore, depending on our particular personal values, different issues become constructed as needs.

For this reason, a Needs Assessment must incorporate: the felt needs and expressed needs of the inmates the normative needs as determined by the 'experts', the service providers comparative need by comparing services available in one gaol to those in another.

To identify the health needs of women inmates in NSW Correctional Centres, this needs assessment was conducted through:

- Survey of existing health services / health promotion
- Interviews with key informants / service providers
- Focus groups with the inmates

Survey of existing health services / health promotion

This process involved:

- Interviews with Corrections Health Service providers, with particular emphasis on issues relating to the physical, spiritual and mental health of female inmates.
- Interviews with the HIV/Health Promotion Unit and other Departmental service providers.
- Research conducted in the three women's gaols to determine health promotion activities and health education programs available. Data and material was also collected from Long Bay gaol to determine what health promotion was available in the male correctional system.
Interviews with key informants / service providers

Over 30 interviews were conducted with key informants who were selected on the basis of their knowledge of the prison system and expertise as service providers to female inmates. They included: nurses and medical staff, drug and alcohol workers, welfare workers, psychologists, education officers, prison officers, CHS and DOCS executive officers, policy advisers in DOCS head office, as well as community based prisoner support groups.

The purpose of the interviews was to gain insight into the basis and method of service provision and to gain an overview of the workers perceptions of the needs of women in custody. This process involved asking probing questions during face to face interviews lasting about 30 minutes to one hour.

Focus groups with inmates

It was decided that a focus group format would be the best method to gather information from this group of women for several reasons. First, focus groups could be arranged easily and information gathered quickly and efficiently to fit in with the tight schedule of the project. Second, focus group methods avoid the formal nature of questionnaires and surveys in which low literacy skills of many of the participating women might not be taken into account.

Focus groups make few demands on literacy and language is less of a barrier so that all women including those from Aboriginal and ethnic backgrounds are able to be included.

Focus groups conducted in a non threatening and permissive environment, are especially useful for female inmates, who by their very incarceration and the nature of their backgrounds have limited power and influence. They are particularly useful for helping participants to identify issues for themselves whilst other women are expressing their feelings on a topic. By comparing and contrasting, the women can become more explicit about their own views, and through probing questions from the facilitator, they may become aware of issues previously not thought about. In contrast to a survey, the interaction in the focus group creates a cuing mechanism which has the potential to extract more information than other methods.

Ten (10) Focus Groups were conducted

5 Focus Groups at Mulawa, including
1 in the drug free wing of Dawn de Loas
1 in the protection wing of Conlon,
1 with remand inmates and
2 with long term inmates.
1 Focus Group at Norma Parker
4 Focus Groups at Emu Plains, including
   1 in the Compound,
   1 in the Jacaranda Cottages,
   1 for older women (over 50 years)
   1 for Aboriginal women.

The rationale for holding separate groups for older and Aboriginal women was to acknowledge the diversity within the gaol population and in recognition of the fact that their needs may be different.

It should be noted that attempts were made to convene groups for younger women and for women from non English speaking backgrounds, but these women declined on the grounds that they were busy or not interested. The limited resources available for the project made it difficult to expend the time and energy necessary to encourage these women to participate. Those women from these groups who expressed an interest in the project attended other focus group sessions.

A memo introducing the project officer and suggesting focus group meetings, was sent to all wings at Mulawa and Norma Parker and to each of the Jacaranda Cottages. In the Compound at Emu Plains, memos were posted in prominent positions. The women were mainly recruited by word of mouth through the project officer talking with individual inmates about the nature of the project. In most cases, a group was pre-arranged with two or three women who brought friends along.
The older women's group at Emu Plains was arranged by invitation to all women over the age of 50 years.

The focus groups were usually held after work in the afternoons (2.30 - 3.30 pm) in the wings where the women lived. One group at Norma Parker was held in the evening (5.30 - 7pm) to enable women to attend after work. The older women's group was held at 10 am at Emu Plains.

Discussion in each one and a half hour session was focussed around 4 broad questions:

- Relating to mind, body and spirit, what do you need to improve your health and wellbeing?
- What access to health services do you have?
- If you were the Governor, how would you organise the prison services, like the clinic, counselling and education, to better meet your health needs?
- On what sorts of health related issues would you like more information?

Probing questions and reflective questioning were used during the session to keep the women focused on health related issues and to draw out more information where necessary. Being the only worker present in each focus group, the project officer was facilitator and scribe which allowed for free exchange of information. Butchers paper was used to record the women's responses making
them visible to the participants. This open recording shared the details and ownership of the discussion, allowed for correction of misconceptions and enabled preservation of confidentiality.

Data Analysis

Information derived from interviews with service providers and focus groups with inmates was analysed on a question by question basis, sorting it into a range of responses. Key themes were then identified and written up under appropriate headings. Variations and discrepancies which might reflect significant differences between the respondents were noted.

The content of focus groups recorded on butchers paper was summarised as soon as possible following the focus group. The interviewer's notes were the only method of recording information received from interviews with service providers.
Results

Existing health services / health promotion

Within the correctional system in NSW there are two separate departments with the co-operative responsibility for inmates: the Department of Corrective Services (DOCS) and the Corrections Health Service (CHS).

The Corrections Health Service, a division of the NSW Health Department, is responsible for the provision of a range of health care to inmates and is staffed by doctors, psychiatrists and dentists. Nursing staff cover the areas of general, crisis-intervention, women's health and methadone nursing.

DOCS is responsible for the provision of psychologists, drug and alcohol workers, welfare workers, activities, education and a chaplaincy, as well as providing custodial and security officers.

Clinical and counselling services provided by CHS and DOCS respectively comprise the majority of client interactions in female correctional centres. The three goals operate somewhat differently to each other and will be discussed separately.

Mulawa

Corrections Health Service

The clinic provides medical and nursing care for all inmates at Mulawa and operates 24 hours per day. It is staffed by a team of general and enrolled nurses, one women's health / public health nurse, one methadone program nurse and three mental health nurses.

Visiting female medical officers provide sessional consultations for one full day and four half days per week. This includes an Aboriginal Medical Service session.
Psychiatrists visit for one full day and two half days per week.
A dentist visits one day per week and the optometrist once a month.
The clinic has a six bed annexe for women who are unwell or in need of close observation.
Custodial officers are rostered at the clinic 24 hours per day.

The need for women to be seen by clinic staff primarily arises from identification of medical and allied issues at reception or as a result of ongoing monitoring by CHS and DOCS staff. Access to the clinic may also be initiated by the inmates, who present at sick parade in the morning and request attention; they are assessed by a registered nurse, temporary management initiated as necessary and then booked into the appropriate clinic. Depending on the number of
patients to be seen and the nature or urgency of the illness, the wait to be seen by a medical officer can vary from a few days to a week or two.

Women who are on Methadone and other medications present at the clinic 'pill window' to receive their medications from the dispensary. Other medications are dispensed as necessary during clinic sessions or are delivered to the women in their wings at night between 6.30pm and 8pm.

Health education tends to be carried out on a one to one needs basis when the women attend the clinic to see the medical officers and nurses. This particularly applies during consultation with the Women's Health Nurse, who is responsible for HIV and STD screening and the day to day monitoring of the pregnant population.

There are no formal health promotion or health education programs offered by Corrections Health Service.

**Department of Corrective Services - Inmate Development Service (IDS)**

**Counselling**
There are 4 full time psychologists who provide counselling services for the entire population of inmates during standard working hours. Referrals to the psychologist can be made by inmates themselves or by CHS and other prison services. Counselling is on a one to one basis and there are no groups running.

**Drug and Alcohol**
There are 2 full time general plus one part time Aboriginal D&A counsellors to service the whole gaol population. Counselling tends to be on a one to one basis, although groups run on a regular basis, namely Relapse Prevention and Anger Management. Community groups such as Alcoholics Anonymous and Narcotics Anonymous also visit the gaol to run groups on occasion.

**Fitness / Exercise**
There is a qualified Fitness Instructor / Custodial Officer who co-ordinates the activities program. There is a sparsely equipped gym at Mulawa. An aerobics teacher conducts classes twice a week. Volleyball, tennis and softball games are organised but only a small number of women regularly participate or use the gym facilities. The activities officer regularly takes a group for morning walking sessions around the perimeter of Mulawa and he provides some education on food and nutrition, usually on a one to one basis.

**Education (Health)**
The Education Service provide visiting teachers who run health education courses according to demand by inmates. Currently there are a 12 week nutrition course and a weekly meditation class.
The HIV/AIDS Peer Support Program is regularly offered at Mulawa provided through the HIV/Health Promotion Unit. This program seeks to educate inmates on HIV/AIDS, Hepatitis and Other Blood Born Diseases and STDs, so that they, in turn, may educate and support other inmates.

Welfare
There are 2 full time welfare workers with a brief to provide advice and support to the inmates on welfare and family issues and to help to bridge the gap between the "inside" and the "outside". This service, along with pre-release information, is provided on a one to one basis.

Emu Plains

Corrections Health Service
The clinic is staffed by three general nurses and one enrolled nurse and operates between 7.30 a.m. to 3.30 p.m. 7 days per week. The nurses work an on-call system for any emergencies outside of these hours. Visiting female medical officers attend one full day and two half days per week. This includes the Aboriginal Medical Service session. An obstetrician visits once per fortnight as does the women's health / methadone doctor and the dentist. An optometrist visits once per month. A psychiatrist visits once per week.

The need for women to attend the clinic primarily arises from identification of medical and allied issues as a result of information provided on transfer from other correctional centres or by ongoing monitoring by CHS and DOCS staff. Access to the clinic may also be initiated by the inmates, who present at sick parade in the morning and request an appointment. They are assessed by a registered nurse, temporary management initiated as necessary and then booked into the appropriate clinic. Depending on the number of patients to be seen and the urgency of the illness, the waiting time can vary from a few days to a week or two.

Health education tends to be carried out on a one to one needs basis when the women attend the clinic to see the medical officers and nurses

Women who are prescribed Methadone and other medications present at the clinic 'pill window' to receive their medications. Methadone is dispensed in the morning, other medications in the afternoon.

There are no formal health promotion or health education programs offered by CHS
Department of Corrective Services - Inmate Development Service

Counselling
There is one full time and one part time psychologist who offer counselling on a one to one basis. There are no therapeutic groups in progress.

Drug and Alcohol
There are one full time and 2 part time D&A workers. Counselling tends to be one to one with group work being offered in Harm Reduction, Relapse Prevention, Anger Management and Stress Management and Relaxation. Women may access community groups such as Alcoholics Anonymous and Narcotics Anonymous when their security classification allows them to be released for such purposes.

Fitness / Exercise
A custodial officer coordinates the activities program. This role also involves coordinating buy ups, shopping trips and bingo sessions, allowing little time to be spent on the organisation of exercise programs or sporting activities.

There is a reasonably equipped gym at Emu Plains and because of the centre’s minimum security ranking and open layout, there is ample space and opportunity for inmates to walk within the grounds of the gaol.

Education (Health)
There is no health related education program available at Emu Plains except for the HIV/AIDS Peer Support Program.

Welfare
There is one welfare worker who provides counselling, advice and support to the inmates on a one to one basis, and who provides a pre-release program.

Norma Parker

Corrections Health Service
There are no permanent nursing staff rostered at Norma Parker. Nurses from the nearby Parramatta Correctional Centre for men provide a 2 hour clinic every morning to address immediate health concerns and to issue pills and methadone to the inmates prior to them leaving for work. In cases of emergency or sickness, the nurses are called to assess inmates who may then be taken to Westmead Hospital Casualty or the local Medical Centre. The CHS Medical Officer on call may also be contacted for advice.
A female Medical Officer attends Norma Parker once a fortnight.
Women from Norma Parker can be transported to Mulawa to see the medical officer, psychiatrist or dentist when required.

Due to the shortage of custodial staff, it is sometimes difficult to arrange escorts for inmates to attend medical visits. Women who have significant short term
illnesses or who require regular medical attention can be transferred to Mulawa for accommodation and better access to medical facilities although this does entail moving from minimum security back to medium security ranking.

There are no formal health promotion or health education programs offered by CHS

**Department of Corrective Services - Inmate Development Service**

**Counselling**
Welfare workers and Drug and Alcohol counsellors are rostered to visit Norma Parker on a weekly basis.
A psychologist visits twice a week to offer one to one counselling.

**Fitness / Exercise**
There is a gym at Norma Parker and facilities exist for certain inmates to walk outside the centre precinct.

**Long Bay**

CHS central administration and a Schedule 2 hospital are located at Long Bay Correctional Centre. CHS administration appoints clinical nurse consultants, based at Long Bay, in mental health, drug and alcohol and public health to support and advise the nursing staff at other NSW gaols. The consultants' heavy clinical and administrative work load allows limited opportunity for them to assist staff at other clinics to develop any health education programs relevant to the inmates.

Long Bay Correctional Centre provides some health education to its inmates, although because of limited resources, this usually occurs in response to acute needs. For example, following a recent concern about TB in correctional centres, a TB awareness campaign was initiated.

The HIV/Health Promotion Unit provides information sessions on Hepatitis C and offers the Peer Support Program. There is a Lifestyles Unit at Long Bay providing specialist care and education to male HIV positive and Hepatitis C positive inmates.

Other than the programs mentioned, there are no formal health education programs offered at Long Bay.
Interviews with Key Informants/Service Providers

Communication
Generally, there was a uniform response from key informants regarding the challenges of maintaining communication between the two services, DOCS and CHS, particularly in regard to the management of individual inmates.

Case management (DOCS) was generally viewed by most key informants to be "a waste of time", although supported at the executive level. Whilst the philosophy behind case management was generally approved of and seen as a way to help inmates psychosocially, it was felt that the case management approach needed further development and training. There was a common belief that inmates would "only tell you what they think you want to hear" and the general perception was that little energy was given to case management by many case officers. It was often said that interdisciplinary and interagency consultation in case management should be enhanced, particularly with Corrections Health, to improve the concept and effectiveness of the strategy.

Health services
Overall, it was felt that health services provided to inmates were adequate, although there was general agreement that staffing levels could be enhanced. This was seen to be necessary both to benefit the inmates and to relieve the pressure imposed on staff by high work loads. Staff working within the clinic felt that much of their work was in crisis intervention and management, (suicidality, drug withdrawal, self harm). Because of the priority given to these cases, less time was available for inmates with less urgent or routine medical requests.

Many of the service providers believed that the waiting time may be too long but case loads and available time and resources could not permit some services to be extended any further. In particular, outside appointments to specialist community services may incur the usual long waiting period and on the day of an appointment, there might be insufficient custodial staff to escort the inmate resulting in the appointment being missed.

Along with the perception that health services provided were adequate, many key informants felt that no matter what they did, the inmates would "never be satisfied". The remark, "the more you give the more they want", was a regular comment during interviews.

There was a general view held by service providers, that many women came into gaol with pre-existing conditions which required medical assistance and that they used their sentence as a time in which to access free treatment. This treatment might certainly include dental work. The follow up of abnormal tests, particularly pap tests and blood tests, which may often have been neglected since the last time the inmate was in gaol were also cited as examples.

It was generally said by workers within the gaols that the inmates were "manipulative" to get what they wanted. This attitude was particularly common
regard to the inmates' use of drugs and methadone. Whilst it was generally said by many DOCS staff that "methadone and psychotropic drugs were used too frequently" and that it was "too easy for inmates to get on the methadone program", there was a concern about a lack of communication between services that might allow some women to be able to access unwarranted medication. This was seen only to perpetuate the drug culture operating amongst these women both within and outside the gaol.

**Mental and emotional health services**

For some direct service staff of DOCS, there was a feeling that they were expected to place "too much emphasis on behaviour modification and cognitive development" and not enough on dealing with trauma or the issues behind women coming into prison. It was regularly stated that there was a great need for crisis support programs and education programs to be developed for the women around drug use and abuse and its relation to relapse and reoffending.

Many prison officers and non custodial DOCS staff shared the belief that women inmates were a lot more difficult to work with than men. "They're a lot more demanding" and "they complain constantly about minor issues", were common responses. However, women were viewed to have more emotional and physical needs than male inmates with many service providers claiming that the system was "not set up for women".

There was general agreement that more counsellors should be available within the gaol, to the extent that responses like "there should be one prison officer and one counsellor in each wing" were not uncommon. It was recognised by most staff, that women tend to have more problems in gaol than men. These were frequently listed as "emotional problems due to separation from family and children", "low self esteem", and "depression and anxiety". It was recognised by many service providers that many of the mental health and emotional problems experienced by the women could be the result of environmental factors, such as sexual assault and domestic violence, but that little was available within the system to help or counsel these women.

**Education services**

It was generally suggested that there was a widespread "lack of motivation" amongst the inmate population, in part fuelled by the environmental limitations, which accounted for their apparent apathy towards exercise and education programs. It was a general view that the inmates did need education around issues such as lifestyle, drug use, contraception, self awareness and self esteem and that this should be part of the conditions of their sentence.

The majority of DOCS service providers who engaged in any type of education or counselling favoured one to one sessions over groups, which they believed to be "too difficult". Problems were perceived to lie in the women's lack of motivation to do groups and an unwillingness by the inmates to participate in groups because of the possibility of disclosure and issues surrounding confidentiality. There also existed a belief by some service providers that "groups just don't work". There
were some workers who strongly urged that more group work should be done within the gaol, but complained that lack of time or organised approaches mitigated against this.

Overall, most service providers believed that more health education and health promotion should be provided. The HIV/Health Promotion Unit and CHS staff were keen to become involved in health education programs at the women's gaols and were aware of the many health issues facing female inmates. However, the common response was that time and staff constraints allow no space in which to develop and promote such programs.

Unless specified within the text, there was little difference between the responses from staff of both organisations DOCS and CHS.

See appendix 1 for a list of interviewees.

Focus Groups

A total of 58 women (20% of the population) participated in the ten focus groups. Common themes emerged from the groups and these are discussed below under relevant headings.

These responses of the women are based on their own perceptions. They were written down as spoken and not checked for validity by the project officer.

Physical Health

Clinical services
Every group discussed the difficulty experienced in accessing clinical services, including those provided by medical officers, psychiatrist, dentist and optometrist. The main difficulty seemed to arise from the process of getting one's name on the doctor's list and then waiting, sometimes for weeks at a time, to be seen; "I put my name down three times before I got seen". Responses like, "I had the flu - it took 2 weeks to see the doctor", were common. All the women interviewed expressed a need for better access to medical staff, through more doctors' hours and 24 hour clinics where medical assistance could be obtained. Many women expressed the desire for female staff only, particularly as far as the mental health team was concerned.

There was a suggestion from several women that the process to access medical practitioners be changed to become more user friendly. Two such suggestions were for a "list" or a "box" to be placed at the clinic door where women could write down their own names and who they would like to see, rather than relying on the memories of staff, or attending the pill window at sick parade.
Several women expressed fear about getting sick at night when they were locked in their cells, or unable to access medical attention. There was general concern that the clinics "ran out" of supply of medications; "I took antibiotics for 4 days - then they ran out - so I stopped".

There was a general desire by inmates to be taken seriously in their requests to see medical staff, "because we're crims they don't listen to us". A feeling of "lack of trust" in clinic staff because of perceived breaches of confidentiality and a lack of privacy was prevalent; "when you go to the clinic there's an officer standing right outside the door".

There was a concern about not knowing what medical services existed voiced by several women. Aboriginal women in particular believed that many women did not know about the Aboriginal Medical Service in the gaols. Another woman who had been in gaol for several months was not aware that a Women's Health Nurse worked at Mulawa. Many women asked that information be issued to them on arrival stating the health services available.

There was also a fairly uniform agreement in regard to the perceived inconsistency of advice from medical staff, "one tells you one thing and another something different", and lack of continuity of staff, "You have to see different people all the time. Different doctors give you different treatment".

Two groups prioritised the medical services they required to improve their general health as; "getting moles and skin cancers removed", "getting tattoos removed" and "getting breast lumps checked".

Many women in the groups discussed their drug abuse, both outside and within the correctional setting. There was a general concern for the lack of proper drug withdrawal facilities and programs within the three women's gaols, and an expressed need for more support for women who were withdrawing from drugs - prescribed or otherwise. They also perceived the need for "more support when you want to come off" drugs, and felt that they were often encouraged to stay on medications and methadone when they wanted to stop.

*Physical environment*
Many women at Emu Plains felt their health was compromised due to the cold rooms and lack of heating, "The rooms are freezing...". The older women in particular wanted room heaters: "you should be able to get a heater at buy ups". The women on protection in Conlon at Mulawa felt that their physical environment was less than ideal. These women may spend 23 hours per day locked up within the confines of Conlon which has limited outside space and the internal environment is smoky, somewhat dirty and noisy. There was a feeling of over crowding due to the limited space: "You spend most of your time on your own - lock yourself in your cell" was a common response. Conlon women were most vocal in their demand for more outside activity and better living conditions.
Clothing
Clothes were also seen as a health issue by most women. They expressed a need for more clothes, warmer clothes for winter and cooler clothes for summer; "I suffer in summer because I don't wear shorts - I'm too old". There was a general demand for clothes from home to be made available, particularly underwear. The lack of "decent bras" was a major concern for many inmates: "we don't get issued with bras". "I've been waiting 3 months for a bra".

It was also recognised by many women that the clothes issued to them were old, thin and damaged and often much too small, especially for larger women: "you're given clothes but they're too small - you have to wait for bigger ones - I've been waiting for 2 months for t-shirts".

Clothes were linked with self esteem by many women: "you've got to look ok to feel ok", and being able to wear "decent clothes" was seen as a way in which women could feel better about themselves.

Hygiene
Across the groups there was a fairly consistent response to the need for improved access to essential toiletries, like "shampoo, deodorant and toothpaste". "After reception you can't get anything for a week or two - toothpaste, hair brush, shampoo, - you have to borrow and then you're always behind - you owe someone". Most women said that Mulawa should provide these essential items, especially in the first month after reception when most women do not have the money to buy them. Toothbrush, toothpaste, soap and shampoo are provided for women at Emu Plains.

Some groups voiced the concern of poor accessibility of washing machines and dryers. Several women raised the issue that insufficient towels and sheets were made available and that a lack of washing facilities meant that clean linen was not always available.

Dietary Needs
There was unanimous agreement across the three gaols that the current diet is inadequate for women, being high in carbohydrate and protein. The women expressed the need for more variety in the diet, particularly with vegetables, "less meat", "more vegetarian food" and an increase in dietary vitamins, calcium and iron. They felt the diet was inadequate for women with Hepatitis C and most women said that they supplemented their diet with foods bought through buy-ups.

There was a general dislike for the daily sandwiches, especially from some of the older women: "I have never eaten spaghetti sandwiches in my life". In the areas within the three gaols where the women catered for themselves, the cooking of meals was often shared so that they ate well. However, some women were seen as "too lazy to cook".
Asian women reported that they did "not like Australian food" and therefore many did not eat out of their rations, but survived on buy-ups.

The food taken to Mulawa from Silverwater kitchen was criticised by the inmates as being often "disgusting" and "inedible". "Last night dinner looked like PAL". The inmates in Conlon also believed that their food was tampered with by other inmates in the kitchen, "they spit in it - put stuff in it like ash and butts".

At Emu Plains, the women suggested that food be provided at weekend visits, so visitors and inmates could eat at the visiting area. There were suggestions for "barbeques" and for "food to be provided from the kitchen" at cost to visitors.

The food was blamed for the weight increase experienced by most women in the three gaols. They felt that the diet was good for men, but not for women.

**Exercise**

Whilst the majority of women complained about the lack of organised physical activity, they were also very much aware of the "lack of motivation" of many to participate in any exercise. Several groups cited the need for yoga, self defence classes, meditation and relaxation classes.

Most groups joked about the "Mulawa spread", in discussing weight gain amongst the inmate population, but it was a major concern for many women who were becoming overweight through inactivity and lethargy.

Older women felt that their needs were not catered for at all and suggested "table tennis" as an option for exercise. They also requested that seats be placed around the gaol grounds at Emu Plains, so they could walk around the grounds and rest in between.

Women at Emu Plains did have access to areas in which to walk, but at Mulawa and Norma Parker, exercise was more of a problem as these centres lacked areas large enough for walking. Many women complained that access to the gym at Mulawa was often hampered by the time it took to get through the security gates and early lock-in times which meant that little time was available after work.

**Mental Health**

Every group perceived there to be an "over use of psychiatric medications". The common feeling from these women was that "psych drugs are used to keep us quiet - we're easier to handle if we're medicated". Whilst there was general agreement from most women that within gaol there was a "pill culture", many women felt that this culture was "initiated from the top" with "over-prescription of drugs". There was a general feeling that drugs were "used in place of
counselling", particularly in times of crises, when women complain about going through periods of "not sleeping or feeling anxious".

There was honesty around the issue of "swapping pills" between inmates within the gaols, with the women maintaining that this occurred primarily when someone was "not coping". This practice was seen as the better alternative to "incarceration in the safe cell".

There appeared to be a definite division between the women who used drugs and those who did not, with the non-using women complaining of the difficulties of living in close proximity to women who were "stoned or pilled" or "just sedated through prescribed medication". The women generally said that there were consistently long waits to see the psychiatrist. Many women objected to having to see a male mental health nurse for screening prior to being given an appointment with the doctor.

The older women expressed different needs to the younger women around issues of emotional support particularly in time of grief and loss associated with death of family members and friends. They believed their mental health issues to be different in that they are older, usually non drug using and they said they experienced stress differently.

Overall, there was an expressed need for more access to the telephone, especially to contact children, family members, lawyers and during emergencies, "like when someone is in hospital". Many women said that "a phone call equals a visit when your family live miles away" and poor access to the 'phone was seen as a major source of anxiety and depression for many women.

Counselling

The women said that linked in with the over use of psychotropic medication is the issue of not having "someone to talk to". The comment, "there's no option - no help other than drugs", was common and almost every woman made reference to the need for "someone to talk to" whenever stress entered their lives. This "someone" did not necessarily have to be a psychologist, (in fact, many women wanted "not psychologists - just a counsellor"), but someone with experience in sexual assault and abuse, drug and alcohol issues, crisis counselling, and who also "should be female".

There was general agreement that in times of stress or crisis there was no one to talk to and that, in fact, staff were more likely to "lock you up before they talk to you" or "put you on drugs".

Access to a "mediator or counsellor" was also needed in relation to living areas, where conflict between inmates could be dealt with effectively.

Again, difficulty in accessing counsellors was a problem for many women, with long waits being the norm; "I've been here for one year - no one has seen me - I talk to no one". The majority of women saw the need for more counselling services at the three gaols, with several women requesting access to "more group work".
Case management was generally not viewed favourably by the women as an outlet for "someone to talk to". They believed there to be a lack of trust by the women, particularly concerning breaching of confidence by prison officers and a perceived lack of experience in the officers. Many women did not want to talk with male officers about personal issues and the age difference between officer and inmate was also identified as a problem. In regard to case management, several inmates wanted to be able to choose their case manager. Some women expressed satisfaction with their case officer and found it to be helpful.

**Education**

The majority of women were positive about the education services provided except to say that it often became difficult to finish a course because of being moved to another gaol or being released. They felt that women in full time education were discriminated against because of the lower allowance paid to them compared to women who worked in the industries. Many women expressed the need for incentives to encourage more women into education, such as "more money" or "time off one's sentence".

In regard to health education, the women felt that if emotional needs were dealt with through education programs addressing "self esteem", "self awareness", "communication", "motivation", "positive thinking" and "self empowerment", then they would start to feel better about themselves. They felt that this would enable them to deal with "drug and alcohol issues". There was general agreement that many women needed to learn skills in "healthy lifestyle", "setting boundaries" and "parenting".

The majority of women expressed a need for a pre-release program addressing such issues as "housing", "employment", "reintegration into the community", "budgeting" and "running a house and family". Many of these women were feeling "institutionalised" and somewhat fearful of returning to the community, needing skills to help them cope on release.

There was an awareness of the lack of motivation in many women to attend courses in gaol and it was suggested that "one off sessions" in the wings might be a positive thing to attract women.

Several women throughout the groups said they needed later starts in the day and later lock-ins in the evening to allow them to be able to participate in programs to improve their health, such as exercise or education.

**Attitudes of staff**

The "poor attitudes" of custodial staff were discussed in every group as a major concern affecting the health and wellbeing of inmates. Clearly, all the women who attended the groups wanted to be treated with "more respect" by staff and officers. The statement, "they treat you like children", was common throughout the groups. Much of the mental stress felt by these women was attributed to the
"custodials winding you up" and being consistently "ignored by officers", or being sent away with the rebuke "tell someone who cares". Other stress producing factors included "not having important messages passed on", having "no privacy with phone calls" which produced a "fear of incrimination" and having application forms "lost": "90% of the forms disappear".

The women often felt discriminated against, in particular the Aboriginal women, and generally said that most of the stress within the gaol was generated from poor staff attitudes towards inmates.

**Self Esteem and Sense of Self**

Self esteem was mentioned frequently within the groups with the majority of women relating to low self esteem and poor self image. Most women were aware that their self esteem and that of others needed to be raised and offered strategies through which this could be achieved:

- to have access to clothes in which they felt comfortable, including "sensible clothes from home" and to be able to get "decent bras".
- to have some respect from staff, including a more positive attitude towards them.
- to engage in work which involved some learning rather than the "mindless tasks" offered by the prison industries.
- to have access to information and education on "communication", "motivational issues" and "women's stuff", including body awareness, health and hygiene.
- to have support and education around drug abuse, sexual assault and domestic violence, as these were the issues facing many women and were seen as contributing factors to low self esteem.
- to have incentives offered by the gaol system to give women the motivation to do things for themselves.
- to have programs like the 'Getaway Program', or time "outside", like special trips "to the movies or the zoo".

Self esteem was also discussed in relation to food. It was felt that it was important that food "look nice" and that a wider variety of foods be available because this is "what makes you feel good". Obesity was also a major issue, with most women agreeing that the weight gain common in gaol was not good for self esteem.

**Spiritual Health**

The women at Emu Plains felt that their spiritual needs were not being cared for as the chaplain had been sick for several months and there was no chapel or regular site to pray or meditate. Many of the Emu Plains participants saw a great need for a chapel and many requested a regular meditation group to be held, similar to the one at Mulawa, to address the spiritual nature of women which often gets lost whilst in gaol.
Summary

The aim of this Needs Assessment was to determine the health education and health services available to women in custody and to explore the health concerns of incarcerated women. The results of the Needs Assessment were to form the basis for the development of a health education program.

It is evident from the Needs Assessment that the health needs of women inmates are many and varied and whilst they acknowledge the need for education around 'healthy lifestyle', there are many other issues which impact on their health which cannot be addressed through education alone. Health, as viewed by the women in gaol is not confined to the mere absence of illness. Indeed, the women are well aware of the social and environmental issues which impact on their health whilst incarcerated.

Staff attitudes, clothing, diet and the living environment were commonly cited as issues affecting the health of inmates. Poor access to essential toiletries and exercise also impacted on their health and wellbeing and were seen as contributing factors to poor sense of self or low self esteem. Many women expressed dissatisfaction with both medical and counselling services and perceived there to be an over-use of psychotropic medications, the latter also being acknowledged by many staff. This perceived "over-use" may be attributed to the lack of "someone to talk to" which was a significant issue in every focus group, or by the women's demands for treatment for anxiety and depression. Related to this were issues raised by the non-drug using women who complained of the difficulties of living with women who were "pilled".

The perceived deficiencies in services provided by both DOCS and CHS resulted in a significant response from both inmates and service providers that the correctional centres are not meeting the holistic mental, physical and emotional needs of the women within the constraints of existing resources.

It is clearly documented in the literature and reflected in responses from both staff and inmates, that there are consistent health issues which need to be addressed before any improvement in the health of inmates can be anticipated. These health issues often predate women entering prison and are a reflection of their social backgrounds and life experiences. Histories of substance abuse, physical and sexual abuse are common. Many women suffer gynaecological problems and sexually transmissible diseases associated with prostitution/sex work and poverty. In addition, women from non English speaking and Aboriginal backgrounds have their own specific health issues as do women with intellectual disability which can often be related to access and equity barriers.

Therefore, any attempt at health promotion within the correctional system must address the wider socio-environmental view of health (O'Connor & Parker, 1995 p.46). Counselling services which can deal with sexual abuse and domestic violence need to be extended, as do drug and alcohol services. Staff, both custodial and non custodial, need to have the training and support which is fundamental to working with women, particularly when they carry the role of case
officer. Communication already existing between DOCS and CHS and community based agencies should be improved to maximise the support network necessary for the provision of a holistic health service to female inmates.

The health issues identified by this needs assessment extend far beyond the scope of this project. However, since they have been identified, it is suggested that the health needs of the women can be best met by using a formal health promotion strategy involving major stakeholders, including DOCS, CHS, Area Health Authorities and consumer representatives. Health promotion strategies need to be integrated, intersectoral and participatory and cannot rely on individual behaviour or authority.

This Needs Assessment clearly identifies the lack of coordinated and specific health education and health promotion activities for women in the NSW correctional system. It also clearly demonstrates that a health education program addressing issues around healthy lifestyle is necessary.

Health issues which have been identified by both service providers and inmates include physical, mental, emotional and spiritual needs and it is on the basis of these needs that a health education program is being developed and implemented with the following principles:

- The program be developed in consultation with inmates so that their experience of health becomes integral to this program. Women in gaol are often vulnerable and disenfranchised members of the community and for reasons of empowerment, emphasis must be placed on identifying the needs and wishes of the women and the development of strategies to meet those needs.

- The information be provided following adult learning principles, enabling the women to increase their knowledge of healthy lifestyle and facilitating options and choices about health.

- The program be developed with the aim of increasing women's cognitive, affective and behaviour skills.

- The program address and offer information on the needs identified by the women. These include exercise and nutrition, body image, sexuality and reproductive health, preventive health, drug and alcohol issues including psychotropic medication, communication skills such as conflict resolution and assertiveness, and stress management and relaxation techniques.

The philosophy of the Ottawa Charter for Health Promotion is to combine diverse and complementary strategies and mechanisms for providing health for all. These include communication, education and legislation along with organisation and structural change.
Following the principles of the Ottawa Charter, it is only through a formal health promotion approach that these changes can occur so that:

- **a healthy public policy** can be built to improve the social and physical environment of the gaols and so enhance the health of inmates.

- **supportive environments** for health can be established through the **strengthening of community action** and the **development of personal skills**. This involves the education of both staff and inmates and through improvement in the communication between service providers and recipients.

- **reorientation of the health service** can be effected. This means that the CHS should not be the only body responsible for promoting the health of inmates. In fact, issued with the agenda, all service providers and inmates possess the power to achieve the improvement of the health of incarcerated women.

Education is but one strategy to develop the personal skills necessary to improve one's health. However, it cannot occur without simultaneous changes in the environment, in policy and in health service provision.
Bibliography


Central Sydney Area Health Service (1994) *Program Management Guidelines for Health Promotion*. NSW Health


Corrections Health Service *Strategic Plan for Corrections Health Service 1993 - 1998*. State Health Publication No.(PD) 94-088


NSW Department of Corrective Services (1996) *HIV/AIDS, Communicable Diseases and Health Promotion*. NSW DOCS HIV & Health Promotion Unit,


Women's Services Unit (1996) *Submission for a Gender-Specific Classification System*. Department of Corrective Services, NSW
Appendix 1

List of key informants and service providers

Aboriginal Women's Health Nurse, Parramatta, WSAHS
Aboriginal Deaths in Custody Workers, Emu Plains and Mulawa
Aboriginal Project Officer, DOCS, Blacktown
Chaplain, Mulawa
Chief Executive Officer, CHS, Long Bay
Chief Health, Drug & Alcohol Officer, DOCS, Roden Cutler House
Children of Prisoners Support Group Workers, Silverwater
Clinical Nurse Consultant, Mental Health, CHS, Long Bay
Clinical Nurse Consultant, Public Health, CHS, Long Bay
Dentist, CHS, Mulawa
Drug and Alcohol Workers, DOCS, Emu Plains and Mulawa
Drug and Alcohol Workers, Kingswood Community Health Centre
Drug and Alcohol Workers, WESDARC, St. Mary's
Education Officers, DOCS, Emu Plains and Mulawa
General Nursing Staff, CHS, Emu Plains and Mulawa
Governor, DOCS, Mulawa
Governor, DOCS, Emu Plains
Health Promotion Officers, Central Area and WAHA
HIV & Health Promotion Staff, DOCS, Roden Cutler House
Manager of Industries, DOCS, Emu Plains
Medical Practitioners, CHS, Emu Plains and Mulawa
Mental Health Nurses, CHS, Mulawa
Methadone Nurse, CHS, Mulawa
Nurse Unit Manager, CHS, Mulawa
Nurse Unit Manager, (Acting), CHS, Emu Plains
Parole Officers, DOCS, Emu Plains and Mulawa
Prison Officers, DOCS, Emu Plains and Mulawa
Programs Managers, DOCS, Emu Plains and Mulawa
Psychiatrists, CHS, Emu Plains and Mulawa
Psychologists, DOCS, Emu Plains and Mulawa
Senior Prison Officers, DOCS, Emu Plains and Mulawa
Welfare Workers, DOCS, Emu Plains and Mulawa
Women's Health Advisor, WSAHS
Women's Health Nurse, CHS, Mulawa
Women’s Services Unit Staff, DOCS, Roden Cutler House