**PREVENCIÓN Y TRATAMIENTO EN EL ÁMBITO PENITENCIARIO: LAS MUJERES RECLUSAS DROGODEPENDIENTES EN ESPAÑA[[1]](#endnote-1)**

**PREVENTION AND TREATMENT IN PRISON LAW: FEMALE DRUG-DEPENDENT PRISONERS IN SPAIN**

**PREVENÇÃO E TRATAMENTO NAS PRISÕES: RECLUSAS TOXICODEPENDENTES EM ESPANHA**

Resumen

El tratamiento penitenciario de drogodependencias para mujeres ha sido tradicionalmente genérico (el aplicado para la mayoría masculina penitenciaria) y con pocos estudios diferenciales empíricos a nivel español. Esta investigación plantea a partir de los marcos normativos y la situación expresada por los organismos especializados, estudiar algunos de los factores de riesgo y de protección principales de las reclusas drogodependientes en relación a los programas de tratamiento y los procesos de recuperación a fin de realizar propuestas de acción específicas. La investigación es multimétodo, insertada dentro del Proyecto I+D+I denominado *“Mujeres reclusas drogodependientes y su reinserción social. Estudio socioeducativo y propuestas de acción”* [EDU2009-13408], con una muestra nacional en segundo y tercer grado (Administración General del Estado y Comunidad de Cataluña), correspondiente aproximadamente al 15% de las mujeres reclusas en el panorama nacional. Se han obtenido 538 cuestionarios válidos, 61 entrevistas semi-estructuradas, a los cuales aplicaron, por un lado, métodos de análisis informáticos y programas específicos para los datos cuantitativos (SPSS, V. 15 y 20) y métodos de análisis de contenido para los datos cualitativos. El análisis se ha realizado antes y durante el internamiento, a partir de cuatro perfiles de mujeres reclusas (AA: adictas activas (8´20 %), EX: ex adictas (EX: 67´21%), NA: no adictas (NA: 14,75%) y PMM (9,84%): adictas en programas de mantenimiento de metadona).

 Entre los resultados principales encontramos como factores de riesgo destacados en relación al tratamiento que las mujeres ex adictas no participan, por lo general, en programas de prevención de recaídas. Esta realidad supone un importante problema puesto que casi un 70% de las mujeres son ex consumidoras. Existe un número de mujeres que no participan en los programas por desinformación, desconfianza y compatibilidad con otras actividades o existe una percepción de discriminación de género en el acceso y permanencia de las mujeres en los programas en relación a los hombres. En los factores principales de protección encontramos que la mayoría de las mujeres tienen las presiones familiares como una motivación para acceder a programas y que en algunos de los casos la situación de maternidad o ciertos factores personales, fueron definitivos para el acceso. Finalmente, se propone el modelo PROSO –MD (Programa Socioeducativo para mujeres drogodependientes) para que sea implementado en el ámbito penitenciario según perfiles de consumo a partir de la adecuación a las características y realidades de las mujeres, concretando a partir de una propuesta específica para mujeres ex adictas.

Palabras clave: Prisión, drogodependencias, género, prevención, tratamiento.

Abstract

The penitentiary drug dependence treatment for women has been traditionally generic (applied for most masculine penitentiary) and with few differentiating empiric studies in an spanish level.

Based on a regulatory framework, this research focuses on the study of the main elements of risk and protection implied in the relation between the drug dependant female prisoners and the treatment programs, as well as the recovery processes, in order to propose specific actions.

The research has a multimethod approach, inserted within the Project I+D+I named *“Mujeres reclusas drogodependientes y su reinserción social. Estudio socioeducativo y propuestas de acción”* [EDU2009-13408], with a national sample of second and third degree (Central Government and Community of Catalonia), corresponding to an estimate of 15% of the female prisoners nationally. 538 valid questionnaires, 61 semi-structured interviews has been obtained, in which informatic analytical methods, specific programs for quantitative data (SPSS, V. 15 y 20), and analytical content methods for qualitative data has been applied. The analysis has been developed before and after the internment, including four profiles of female prisioners (AA: Active addicted (8'20%), EX: ex addicted (EX: 67'21%), NA: non addicted (NA: 14.75%) and PMM (9.84%) addicted within methadone maintenance programs ).

Among the main results found, it is relevant to mention the elements of risk related to the absence of participation of ex addicted women in relapse prevention programs. In fact, this is a relevant issue since 70% of the women are ex addicted. There is a large number of women not receiving any treatment in prision and not participating in any program due to lack of information, mistrust and overlap with other activities. Aditionally, theres is a perception of gender discrimination towards the access and permanece of women in the programs, compared with men.  Also, within the main elements of protection, it has been found that most women access a program motivated by family pressure, and in some cases situations such as motherhood and certain personal health issues were determinant factors for a women to access a program.

Finally, a model PROSO –MD (Socio-educational Program for Drug Dependant Women) according to use pattern is proposed to be implemented in a penitentiary field, adapted to the characteristics and realities of the women implied and developing specific a proposal for ex addicted women.

Keywords: prison, drug addiction, gender, prevention, treatment.

Resumo

Tratamento medicamentoso prisão para as mulheres é tradicionalmente genérico (aplicado para o macho prisão maioria) e alguns estudos empíricos diferenciais de nível de espanhol. Esta pesquisa surge a partir dos marcos regulatórios ea situação expressa pelas agências especializadas, para estudar alguns dos fatores de risco e proteção de grandes reclusos toxicodependentes em relação aos programas de processos de tratamento e recuperação, a fim de apresentar propostas ação específica. A pesquisa é multimethod, inserido no Projecto I + D intitulado " *Mujeres reclusas drogodependientes y su reinserción social. Estudio socioeducativo y propuestas de acción* "[EDU2009-13408], com uma amostra nacional em segundo e terceiro grau (Governo Geral e Comunidade da Catalunha), correspondendo a aproximadamente 15% das mulheres presas no cenário nacional. Obtivemos 538 questionários válidos, 61 entrevistas semi-estruturadas para a qual aplicada, em primeiro lugar, os métodos de análise de computador e programas específicos para os dados quantitativos (SPSS, V. 15, 20) e os métodos de análise de conteúdo dados qualitativos. A análise foi realizada antes e durante a internação de quatro perfis de mulheres presas (AA: Ativo viciado (8'20%), EX: ex viciado (EX: 67'21%), NA: não viciado (NA: 14,75%) e PMM (9,84%) viciados em programas de manutenção com metadona).

  Os principais resultados são fatores de risco como liderança em relação ao tratamento de mulheres ex viciados não são, em geral, em programas de prevenção de recaída. Este é realmente um grande problema, já que quase 70% das mulheres são ex-consumidores. Há um número de mulheres que participam dos programas devido à desinformação, desconfiança e compatibilidade com outras atividades ou se houver uma percepção de discriminação de gênero no acesso e retenção de mulheres nos programas em relação aos homens. Nas principais fatores de proteção descobriu que a maioria das mulheres tem a pressão da família como uma motivação para programas de acesso e, em alguns casos, o parto ou de certos fatores pessoais foram decisivos para o acesso. Finalmente, o modelo Proso -MD (Programa para mulheres Sócio-dependentes) é proposto para ser implementado em prisões como perfis de consumo de adaptar-se às características e realidades de mulheres, de especificação de uma proposta específica mulheres viciadas ex.

Palavras-chave: prisão, dependência de drogas, gênero, prevenção, tratamento.

**Introducción**

The regulation referring to drug addiction in the field of prisons within the range of the General State Administration (GSA) in the case of prisoners being active consumers, proposes specialized attention towards people with drug consumption problems contained in Article 116 of Penitentiary Rules (PR) (IIPP, 2012):

In the #1 point of the article, the universality of the access to the drug care programs for all prisoners with substance dependence regardless of their criminal or prison situation is evidenced. The point #2 refers to the strategic and operational planning that takes place in the GSA and in each prison. It implies adherence of the intervention programs to the general policy of the Ministry of Health and general drug plans and their rule planning. From there, there is an enhancement of cooperation with the specialized agencies and the Third Sector. This possibility creates a channel of co-management of the prison administration with institutions and social networks favoring broader coverage, as with organizations like Man Project, Athena Foundation or the Red Cross (Del Pozo, Añaños & García, 2013).

The legislation also poses in point 3, that "for the realization of permanent programs for drug addiction, the management center may dispose of specific departments located in different geographic areas to avoid, where possible, the social uprooting of prisoners who follow a program in them.

According to the General Secretariat of Penitentiary Institutions (GSPI), the development of intervention programs in matters of drug dependence is based on three types of teams in each center (IIPP, 2010: 188-189): the GAD *committee*, the *sanitary team*, GAD and *technical team*. The GAD Commission, primarily with functions of management and coordination, is responsible for the approval, coordination of implementation and evaluation of all prevention, care and social reintegration programs within the penitentiary. Chaired by the management of the penitentiary, it is usually composed by the medical/personal subdirection, head of medical services, treatment subdirection and coordination of technical-GADs equipment as well as the coordination of the rest of the programs with other prisoners/drug dependent individuals.

The GAD technical team can be composed of: doctor, psychologist, educator and social worker. The sanitary team participates in activities related to disease prevention, health promotion, diagnosis and treatment of diseases. The prison’s sanitary team performs the design, implementation and evaluation of health programs, the specific program of needle exchange and the program that involves prescribing and dispensing of methadone, also performing interventions in overdose cases, detoxification of abused substances and treatment with antagonists.

The programs developed in Addictions in prison consist mainly of: 1) reduction of risk and harm, 2) addiction cessation 3) sanitary intervention, and 4) psychosocial intervention, clearly demonstrating in the report that the aims are "to reduce the harmful effects of drug consumption at a sanitary, psychological and social level" and "The psychosocial intervention aimed at improving the psychological and social competence, being a key element in the process of resocialization " (Ibidem: 189). In no case it is made explicit that it is necessary to have a learning transformation that can enhance new habits and pro-social behavior, meaning that the basis of change occurs through the disciplines and the psycho-medical interventions. However certain types of programs count in many cases with classifications of socio-educational projection. In this sense, drug programs, are (IIPP, 2010): "sanitary programs, prevention interventions, health education and health mediators, the needle exchange program and the methadone treatment program" (p .189). We can get a general overview plus the mainstreaming of drug prevention in the various programs listed in the following table (Table # 1). Some of the latest instructions regarding penitentiary drug treatment have been the 4/2011 on smoking, 10/2014 on performance in overdose or the 9/2014 on the organization and operation of the therapeutic and educational units (IIPP, 2014).

Performing an identifying and quantitative approach for the attention on drugs in the general reports, it was found that sex segregation was not warned in their participation results, being the following the most significant public and private entities (IIPP, 2010):

*Public Administration*: On an autonomic level, the AGE has signed 5 general agreements that take actions in matters of drug addiction with Andalucía, Extremadura, Galicia, Madrid and Murcia, which take actions on drug addiction. There are 3 specific agreements in the matter of the drug dependency. There are subscriptions with the Ministry of Health of Castilla La Mancha (1999), with the Ministry of Health and Social Welfare of the City of Ceuta (2003), and the Ministry for Equality and Social Welfare of Andalucía (2005).

*Non-Profit Entities*: There are 66 non-profit entities with intra or extra-penitentiary intervention attending and/or hosting the prison population. Of these, if we consider the territorial coverage where they are involved, the *Project Man* would be head as the main protagonist with 39 centers being attended, then the Red Cross with 25 centers and Athena Foundation. CID Group with 9 centers, particularly the centers that are distributed in the autonomous regions of Castilla La Mancha and Madrid.

Keep in mind that the economic crisis has partially reduced the participation of entities in the social community, clearly impacting during recent years in the penitentiary field (Del Pozo and Gil, 2012).

From the existent reality in the penitentiary intervention on drug dependency, the research carried out seeks to study some of the main risk factors and protection of the female prisoners in relation to drug-addicts treatment programs and recovery processes to propose specific action programs.

To this end, we have studied according to the classifications made by DSM IV, four profiles of female prisoners in relation to drug consumption, so that prevention and treatment programs may be relevant. Consider the differential gender focus and the socio-educational perspective. The different groups of women who have been taken into account in the study are:

 *• Active* Addicts (AA): Problematic consumers of illegal drugs, alcohol if it is the principal drug and of daily consumption, as well as the drugs without a prescription. Tobacco does not fall in the definition along with the prescription drugs and alcohol of use, although these can be analyzed in each case.

 *• Addicted to PMM* (MM): participating in methadone maintenance programs.

 *• Ex addicted* (EX): abstinent drug substances defined as previously.

 *• No addicted* (NA): Total consumption abstinent experimental or unsustained time.

1. **Prevention and treatment in the spanish prisons**

Within all health interventions that develop in the penitentiary field, there are typologies of treatment programs and cessation of drug addiction in Penitentiary Institutions, which could be grouped in general terms in (IIPP, 2012).

* *Prevention and education for health*: Aimed at preventing initiation of consumption and reducing risky conduct.
* *Maintenance with Methadone:* A program that, for example, is developed to prevent harmful effects on a sanitary, psychological and social level of heroin consumption, contributing to the abandonment of the intravenous route for consumption and preventing the transmission of diseases acquired in this way.
* *Cessation in therapeutic modules*: Program that is developed in specific units to get periods of abstinence and a reordering of personal and social dynamics.
* *Social reintegration program:* Beholds a complex process of socialization and normalization, including the acquisition of skills and resources to respond to the personal needs of drug addicts, trying to support their integration into family life, cultural, work, and social environment, as well as deriving to community devices to continue treatment upon their release to freedom, and by doing so, prevent their marginalization.

From a socio-educational perspective we could expose that it is being developed a new model of intervention in SGIP, but it should deepen in the educational approaches through specialization of this preventive approach (Socidrogalcohol, 2012). In the context of freedom deprivation sentences this approach mainly focuses on proposals to prevent relapse and recidivism (Lipton, Falkin and Wexler, 2000; Añaños, 2010), allowing greater and better integration and overcoming inefficiency or neglect of programs. Prevention should additionally focus from the ecological and holistic conceptions. These dimensions incorporate an improvement and complementation of the medical-sanitary intervention model that addressed the phenomena of drug addiction from a disease perspective, generating projects and actions based on social inclusion, community development and health promotion approaches (Del Pozo, 2013). The concept of *holistic prevention* is understood from this point of view as required, and has, therefore, the socio-cultural dimension, social conditions, the gender, the emotional component, etc. This means that not solely or primarily it is determined and approached the consumption from individual factors but also from the context and complex realities that surround the human being (Ayala and Fornaguera, 1996).

The socio-educational interventions in drug addiction have been conceptualized from different types of prevention programs (Pantoja & Añaños, 2010: 120). If we adapt these programs to the profiles of the female prisoners, we could place the following classifications:

* *Universal prevention programs*:These are actions aimed at the general public or a large group of unidentified individuals on the basis of no individual risk factor or if there are, they are not critical. These programs are those that would have to be developed with non-addicted women.
* *Selective prevention programs or adapted to segments of the population*:According to objective data (provided from the epistemology or other research) the possess proven risk factors. These programs would be developed with female who are not consumers who might have by external factors (family history of consumption or couple consumption), prisoners at the center (with a relationship to other consumer partners, etc.).
* *Indicated prevention programs*: Population with problematic drug use as well as no less serious criminal or violent behaviors, family problems or social exclusion. These programs should be developed with women with prolonged consumption. For example, they could be within this typology but not only women that had as main substances cannabis, alcohol or psychoactive drugs, etc.
* *Specific prevention programs*:Aimed at those individuals who permanently live in the world of drug abuse, those that have made drugs a part of their lives and who refuse –because they can’t or they don’t want- to leave their situation. It would serve women who have or would have maintained a problematic use of heroin and/or cocaine primarily, or poli-consumption and also the ones that were found to be with methadone maintenance programs.

At the indicated and determined preventive programs, which are the ones where drug abusers are involved, usually two phases or approaches in treatment programs are configured: addiction detoxification and drug abuse cessation (NIDA, 2012). The first phase concerns the action of the drug-addict’s medical and psychological intervention when withdrawal symptoms appear as a result of not consuming drugs. Detoxification can be at home, ambulatory and at the hospital. At this stage there is no direct and basic intervention of the personal educational agent.

During the cessation there should be participation of the professional presence of agents on a psychotherapeutic and socio-educational level so that personal learnings from personal knowledge are developed, as well as search for values ​​or lifestyles, accountability, strengthening of self-esteem and social skills. On the level of resources or areas of treatment of addiction cessation we can find: outpatient centers, therapeutic communities or day centers.

Other educational measures may be directed towards reflection, information and training that enhances the identification of the issues and circumstances that, from the family area, can have a positive influence on prevention of drug consumption (FAD, 2013): Information on different types of substances considered as drugs, as well as the risks associated with their consumption, knowledge of basic guidelines on how to address situations of problematic drug use in the family or development of capacity to improve family life through the negotiation of rules and limits; participation in the social environment of the same, and positive use of leisure time, adoption of attitudes and acquisition of abilities related to a proper emotional environment and family communication skills. During the consumption cessation and development of preventive actions it is appropriate to propose the family as an agent of special importance where family dynamics (including all members) are enhanced to enable opportunities to activate the training and education process of the children, develop a "safe" coexistence, promotion of protective factors and family mediation. In short, the work focused on the family (family competence) (Orte, Ballester y March, 2013).

* 1. **The prevention and treatment on drug-addictions from the gender differential perspective**

 Social roles assigned to women, not only are not equivalent to those of men, but contribute to situate women, on a greater extent and with other disadvantaged groups that do not have equal opportunities, in a real situation of personal and social vulnerability. This is already, by itself, an imbalance, a situation of risk determined by a social context that could be the basis of the occurrence of "maladaptive" behaviors including substance consumption. On the other hand, in the same way that gender determines what is socially desirable with the "duties" and expected "obligations", it also states, by gender, a penalty arising from the violation of these roles.

 The assessment of drug use is not the same if it is done by men than by women. Women are often more affected by the social penalization (stigma) that accompanies their problem. Besides the importance of roles, childhood and its protection, and consequently the risk that it is or could be for children to have the consumption by women/mothers, it is an established value in the social construct.

 Women present specific female *risk factors or protection factors* referred to (Urbano y Arostegui, 2004:34):

* + - *The biological sex and the different organic or biological consequences* that the consumption brings about.
		- *Maternity.* The real or future possibility to be mothers.
		- *Gender differences* in terms of expectations of conduct, assigned roles and the role traditionally occupied by women, and hence the penalty resulting from the occurrence of certain behaviors or attitudes that transgress this role.

In the case of those who are mothers, which is a majority of women prisoners (about 80%) (García Vita & Melendro Estefanía, 2013), separation and rupture of the mother-child bond can be one of the determining factors in abandonment of the rehabilitation programs. Instead, encouraging the maintenance of this bond and the accompanying of the children during the program has shown to be a positive determinant. As reality not tended enough, we consider it essential and a priority to not uproot the coexistence of the minor children, in cases where the addiction/detoxification does not harm the interests of the child in the long term. There are many cases where public or private programs not take care of women in therapeutic communities, outpatient programs, day centers, residential resources, etc. in which the children may be with their mothers. This situation worsens, in some cases, family breakdown and distress scenarios for the offspring; likewise, vulnerability is reinforced as a risk factor for women when they are unable to live with their children.

Also, the phenomenon of drug trafficking and consumption of substances from the feminization of poverty that affects their socio-labor and socio-educational process must be taken into account (Del Pozo, Jiménez & Turbi, 2013). In this regard, it is important to analyze how the male partners influence in the women's contact with drugs, as well as how the initiative and abusive consumption of these lead many women to further marginalization and social exclusion (Del Pozo & Peláez, 2013).

From this premise, we would have to consider essential to develop preventive and interventional approaches to justify the imbalance between men and women in the assumption of family responsibilities, the care of children and elders in the family, etc. directly affect the consumption of psychotropic drugs by women (Orte, 2008). It is also necessary to deconstruct the demoralizing criminalization exercised towards women-consumers, and the association of a greater psychological vulnerability, anxiety disorders, stress or depression, solely because they are women (Castaños & Palop, 2007).

The socio-educational dimension involves the integration of drug-dependent women in the development and community participation, preventing the stigmatization of them, as well as working on improving specific and networking intervention. These objectives could be general goals to work on in the socio-educational action in prisons, that education has as one of its biggest challenges (Caride & Gradaille, 2013).

From this standpoint, *Education* *(prevention)* focuses as a foundation all the interventions developed in drug treatment programs. From this preventive approach it would be necessary to incorporate Education in all cases of intervention with women prisoners (Active Addicts, addicts in methadone maintenance programs, former addicts and non-active). Drug programs from the gender perspective have a development from policies and actions that could consider the needs and issues related to women such as pregnancy and/or maternity, abuse problems exercised towards the girls and their impact in consumption, the situation of female prostitution or HIV (Mavrou, 2011). Preventive treatment programs should be designed in penitentiary establishments that have included in their preventive foundations the decreasing of the risk factors, enhancing of the protection factors and decrease of the negative consequences of consumption.

* 1. **The actual situation of drug-dependent women in prison**

 The programs developed in spanish penitentiary centers have been mainly applied to the male population and without regard to the characteristics of feminization of poverty (Yagüe, 2007, 2010; Añaños, 2013). In many studies of drug addiction that are posed by the theoretical community or the empirical programs, it is necessary to note that no gender specifics are contemplated, for example Orte (2008) and Llopis (2008) point out the need to incorporate the gender perspective in intervention processes with drug-dependent women, where it is necessary to point out specific topics (interpersonal and partner relationships, abuse, double social penalty, sexuality and relationship to the body, maternity and presence of children in treatment, difficulties in the labor market, self-esteem, etc.).

 Guided by the study promoted by the Institute of Women on female ex-prisoners, 81% of them have suffered mental abuse, 73% have been victims of physical abuse and 46% have been victims of sexual violence (Women’s Institute, 2005).

 If in addition to having gone through such situations, we add the lack of access to decent work, decent housing, economic security, etc., ending with their imprisonment, we find a woman with low or no self-esteem, lack of development of skills that will facilitate her to take a place in society, causing in consequence a situation of helplessness. This situation is accentuated in the case of gypsy women, which not only have higher rates of having suffered situations of gender violence, but show little awareness of the violence of which they are victims, joined with the resistance of their environment, hinder the development of programs in this direction.

 Those gender-specific needs, penitentiary, social, educational, etc. on drug addiction of women and mothers who are prisoners that are manifested by the Administrations and entities on the issue should be contemplated in design of programs and in their implementation.

 We can say, after the reviewed literature and international recommendations regarding the subject, that in Spain there are comprehensive socio-educational treatment programs tailored to gender and the profile of drug-dependent women (Panayotopoulos, 2008; Fernández, 2008; Añaños, 2010) much less, for those who are paying a sentence in a semi-liberty regime (modules of women and mothers, Social Integration Centers (SIC), extra-penitentiary units, dependent units and external units, etc.). On the contrary, generic treatment and reintegration programs are applied to them, these programs do not take into account the peculiarities as a major personal, family and social impairment, low self-esteem, loss of autonomy, etc. This can lead to the abandonment of the programs in which they participate and relapse in the consumption of drugs, and ultimately, it can lead to a significant failure in their social reintegration.

 However, in regard to drug programs in the penitentiary area, two advances have been mainly developed: One, a specific manual on drug dependency for professionals, but also for the entire population at a general level (with some concretions of application to women). Intervention on drugs in penitentiary centers, having as a priority to ensure a complete care in prisons for the internal population with drug problems (PNSD, 2006).

 Another one from an advance in gender inequalities, is the *Health intervention program from a gender* perspective with women deprived of liberty- *Practical guide for group intervention with women prisoners* (Women’s Institute, 2007), etc. Although it has improved the technical strategies, it continues to mainly maintain a therapeutic approach, and they are not applied with coordination by all the collaborating entities and actions that are executed with drug-dependent female prisoners in second and third penitentiary grade, period during which it is essential to prepare for freedom and full reinstatement (March, 2010).

1. **Method**

This study focuses on women of the penitentiary environment in two regimes of life (open and regular) and who are classified in 2nd or 3rd degree of compliance with their penalty. The population from which the sample was extracted was conformed by 3,484 women. A stratified process took place, reaching a sample of approximately 17% of the population. The selection of the sample to survey and interview was conducted at random order within those who voluntarily and with previous informed consent agreed to participate in the 42 selected centers across the country. The research is multi-method, inserted into the project I + D + I called *"Drug-dependent women prisoners and their social reintegration. Socio-educational study and proposals for action"* [EDU2009-13408], with a national sample in second and third grade (General Government Administration and Community of Cataluña), corresponding to about 15% of women prisoners in the national scene. 538 valid questionnaires have been obtained, 61 are semi-structured interviews to which were applied, firstly, methods of computer analysis and specific programs for quantitative data (SPSS, V. 15 and 20) and methods of content analysis for the qualitative data. The analysis was performed before and during the internment, starting from four profiles of women prisoners (AA: Active addicts (8'20%), EX: ex addicted (EX: 67'21%), NA: not addicted (NA : 14.75%) and PMM (9.84%) addicts in methadone maintenance programs).

1. **Results and Discussion**

As we stated in the theoretical framework and the state of the question of study, the research focused recovery processes of addiction (detoxification/rehabilitation) in relation to treatment programs and those factors that we identified as risky as well as protection related to reintegration. Let us therefore approach the most significant results.

* 1. **Risk factors**
		1. ***Absence of specific programs, motivation for treatment and relapse prevention***.

 To begin, it should be noted that 57% of women; therefore more than half of them, think that treatment programs favor men more than women. This problem with a female face evidences the historical gender discrimination suffered by women prisoners as prison minority (Almeda, 2003; Igareda, 2006; Del Pozo, 2012). Advancing in the existent relationships between the various consumption profiles and prison treatment it is made clear that 67.21% of the female population are former addicts, 9.84% are in methadone maintenance program and 8.20% are active addicts. The rest are not addicted (Figure #1). From the research, perhaps the most problematic risk factor lies in that 62.3% of women have never received treatment (Figure #2). This finding is striking, since the relapse prevention programs should be the main focus of programs for women, since most fall into the profile of ex-consumers.

 Knowing that a large part of the population are ex-consumers, and the other part are on methadone programs or are active consumers, we must reflect on this high risk situation. Equally, from interviews it could be extracted that 40 women were ex-addicts (EX: 67.21%). However, according to the data, 77 women did not follow the treatment they were receiving before completion of their sentence. It is possible to deduce that they did not follow it because they did not want to, because they were not offered the treatment, or because there was no offer this program in the penitentiary center. This situation is worrying, and it is one of the major risk factors for relapse that the study has detected.

 This reality is deeply problematized when analyzing some of the inconveniences that women express for the realization of programs derived under the prison system (difficulties for being on other activities: 0.7%; distrust of rules or of the programs: 0.9 % lack of programs or offers for transfer or conduction 0.4%). This how an ex-addict expresses the inefficiency and mistrust towards the programs "*It is of no use to me*" (EX\_E209).

 The ex-addicted women propose as main motives that they do not need it because they no longer consume. But it is in the case of active-addicts where we find the bigger action field. The very high percentage of 52.2% think they do not need a program. This fact places the treatment with this population as a challenge. The ones that are in MMP also expose, but with a low percentage, that they were not offered to enter in them (1.6%); and others even being in them, said they do not need it (3.1%) or that they do not consume (1.6%); which demonstrates the need to strengthen programs for relapse prevention. The difficulty in self-confidence, coping with the semi-freedom period, the low level of detoxification, etc. can produce problematic situations and constitute a clear risk that requires a treatment support for women in MMP. Let’s address a fragment of the interviews:

“*Not here, I am really scared here, eh. I pass, I pass, it has crushed my life but I haven’t consumed. I had a relapse but not anymore. It has been offered to me but no.* (That was here in the prison, where she was offered heroin and cocaine)*.* (MM\_E109).

Nevertheless, the main problems that the professional staff establishes to achieve the objectives present in the programs related to the field of drug dependency, from qualitative data (Question #48), and by priority order would be, in the first place, problems of personal kind mainly: Low motivation, mental illness, no assumption of the dependency problem, toxicity by ingestion of substances.

* 1. **Protection factors**

From the study differentiated by consumption profiles, we found as the reasons given as most significant for each population type that led to the start of treatment (Figure # 3).

* + 1. ***The family as a protection factor***

While the active addicts have family pressures as an little important protective factor in their recovery (13%), as a process of recovery detox/cessation in women is developed, they are taking an assumption from higher states of contemplation over the problematic (Prochaska & Diclemente, 1982); where the family (mother, father, brothers/sisters and partners, etc.), is substantial for action in the transformation and maintenance of abstinence. Thus, women in methadone programs give it a value of 32.8%, which are in a deeper phase of attempt and treatment for control of the consumption than the active addicts.

 In this sense, the ex addicted women are those that value the most from a longitudinal perspective of the process of addiction and detox/cessation, stating in a 92.8% that the family is the main factor for the protection in reduction and elimination of the consumption (just as it has been proved on the theoretical framework). This is how one of them expressed in an interview the importance of siblings in her life and her recovery process, when she is asked about maintaining abstinence:

 *“to help my mother, so I can’t fail her, because if they do doping to me, no, I can’t fail my brother, I can’t fail him.”* (EX\_E316).

* + 1. ***Individual protection factors: Pregnancy, health and others***

 Individual factors related to the processes of contemplation and action of the problem of consumption are also important. A significant number of women (98) who followed their treatment in prison, did so because they needed it:

*“More than the program we have to be conscious and put a lot of effort on it, a lot of will, but there they give you some talks that support you.”* (EX\_E310). That's how strongly an ex-addicted woman expresses the need to take charge of her own life to take assume with full consciousness the will for the necessary change:

*“You have to get up by yourself. I can’t tell anyone to pick me up I don’t do it […] it has to be me"* (EX\_E204).

 Regarding pregnancy, while addicted women do not give significance to this cause (1.4%) the ones found in methadone maintenance programs (which usually have passed from contemplative state to the action), are the ones that give greater prominence to this motivation with a 7.8%. Although it is still a very low percentage.

 If we analyze the individual protection factors related to awareness of recovery from a physical illness (HIV, hepatitis, etc.) and mental illness, it is evident that women in methadone programs present by 14.1% the awarded value to this motive. These women, who would be in a state of action on matters of their addiction, have a deeper state of consciousness that active addicts who practically don’t point to this motive (1.4%) as a protective factor. Also, we found that women in MMP, participate in a more mature and conscious stage in the recovery process that the ones who are addicted. In this case, it is the physical health that has a greater presence, overcoming mental illness that is represented by 10.9%. However, the women who are active-addicts do award importance to psychological problems on a 10.9%.

However, the professional staff warns of personal factors such as maternity, pregnancy or personal stability, to help women on making decisions for change in lifestyle, especially if the woman has or will have children. This is how one of the women expressed motivation in the recovery processes of mothers for reasons of maternity:

*“I know that for the mothers who have children it is a great motivation, but of course you have to show that you want to change”* (EX\_E107).

More than half of the staff (65.2%), therefore, believes in the successful results by women in relation to the *achievement of* objectives, indicating that if there were enough programs for the entire population and they were adapted to the characteristics, problematic situations could be reduced.

1. **Main conclusions**

Taking into account the most relevant conclusions regarding the risk factors and protection addressed in the programs, and the adaptation to the characteristics of women on their reintegration processes:

* 1. ***Risk Factors:***
* Gender discrimination: It is perceived by women that programs favor male prisoners more than women prisoners.
* Relapse prevention: Almost 70% of women are ex-consumers, yet a necessary approach is not contemplated in preventing relapse because 62.3% of them do not have a treatment in prison. Ex-addicted women granted as main reasons that *they do not need* it because they *no longer consume* it. But it is in the case of active-addicts where we find the largest field of action. The high percentage of 52.2% think they do not need a program.
* Access efficiency of the programs: There is a group of women who point out their distrust in the programs, misinformation of them or compatibility with other activities (22 women expressed their distrust of rules and/or effectiveness of the treatment programs). However, professional staff notes that there it is other problems that interfere with the achievement of the objectives set by the programs and that they deal with personal problems of the women, such as inconsistency, mental illness and effort or reluctance to change.
	1. ***Protection factors***
* Family: Ex-addicted women are those that value from the various profiles 92.8% that the family is the main motivation in their recovery process.
* The health and individual factors: The former addicts contemplate that individual factors are very important to stop the consumption. Regarding the related to health as the main motivation, MMP are those who value this situation as principal for the maintenance and recovery.
* Positive perception of professional staff in achieving the objectives: 65.2% of the professional staff feel that the results of women are satisfactory. This data points out along with the low participation of mainly the women in the ex-addicted programs, that the the implementation of major programs is necessary, as well as universal access and inclusion of specific gender characteristics.
1. **Proposals**

After the study, the PROSO-MD referring to Socio-educational Program within the MSE (Del Pozo & Añaños, 2013), in the category of "Drug-dependent Women" is proposed.

It is conceived within a pathway of insertion/reinsertion, according to the criminal/penal process for women. Conceived in five phases in the process of liberty deprivation-compliance of penalty, is structured in a progressive process of actions developed through the preventive situation without conviction, prison first penitentiary grade, second grade, third grade and probation.

From the bases and diagnostic studied in the development of the study, we have prioritized a set of needs and potentials on which to act, developing those contents and strategies that we have considered to be more relevant and appropriate to the characteristics found.

In this regard, it should be noted that the process is conceived from seven general areas of action that we have prioritized as most important: *Family, childhood, socio-cultural, socio-educational, socio-labor, health and gender*.

The program structure includes seven sections: Areas of action, general objectives, contents-actions, methods, timing and evaluation. In relation to health, it is mainly based on promoting health and socio-educational action on the drug dependency. For this, it is essential, in the context of the intervention to exist a medical-psychological multidisciplinarity in the treatment of addictions, but in our case, we have only included in the program the major socio-educational dimensions.

By means of an example and considering the case of former addicts as a population at particular risk for lack of programs in preventing relapses, we present the following summary-table #.2.

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