

School of Occupational Therapy and Social Work
Faculty of Health Sciences

Stories and Stats: A Mixed Methods Study of Staff and Male
Prisoner Patient Experiences of Prison Based Mental Health
Services

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Declaration

"To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university."

Signed

Kate Hancock

Date: 07/05/2010

Hope is the thing with feathers
That perches in the Soul,
And never sings the tune without the words,
And never stops at all,
And sweetest in the gale is heard;...

Emily Dickson 1830-1886
(Complete Poems, 1924)

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For the people I have named and those who remain unnamed, you have been the lighthouses that make for a safe journey in rough seas;

The desire to enter into the world around you and having no idea how to do it, the fear of observing too coldly, too distractedly, too raggedly, the rage of cowardice, the insight that is always arriving late, as defiant hindsight, a sense of utter uselessness of writing anything and yet the burning desire to write something, are the stopping places along the way. At the end of the voyage, if you are lucky you catch a glimpse of the lighthouse, and you are grateful. Life after all is bountiful (Behar, 1996, 3).

Katly Hancock (2010)

Caveats

In this report a summary and description is provided of the results of the interviews and survey data collection. Stakeholders and prisoners articulated various views, perceptions, concerns and understandings of a range of matters concerning mental illness and mental health service provision in prisons across Western Australia. These are reported as the perceptions and views held by these individuals. Any analysis of these findings is the responsibility of the researcher.



Abstract

One consequence of the deinstitutionalisation of psychiatric care and increase in community care is the rising number of mentally ill people in prison populations where there are insufficient mental health professionals and services to address the treatment and rehabilitation needs of psychiatrically unwell prisoner patients. People with mental illness are over-represented in prison populations, and the provision of mental health services is a difficult task in an environment where discipline and safety take precedence over health treatment. This research investigated attitudes, perceptions, and experiences of prisoners, health professionals, and correctional staff in relation to mental illness and mental health service provision across eight prisons in Western Australia. The research aimed to gain a deeper understanding of experiences within prisons. Perceptions, attitudes and experiences of participants were explored using a mixed methods approach; both qualitative and quantitative methods were employed to gather information in a 'two phase sequential design' (QUAL/QUAN) (Creswell and Plano Clark 2007). The Phase One key informant interviews (n=17), and the key themes identified in the literature review, informed the development of the Phase Two quantitative survey questionnaires (n=168). These Phases acted as two different ways of exploring the research questions.

Health professionals in prisons suffer from a systemic lack of recognition, support and leadership from both the health and justice spectrums and report they are merely 'crisis managing' prisoners. In addition, correctional staff are seriously undertrained to manage and care for mentally ill individuals and experience role conflict due to the changing demands of the prison officer role. Prisoner patients have varied experiences of incarceration and attitudes towards current mental health services that are dependent on a range of factors including the prison location, ability to form positive and therapeutic relationships, diagnosis, level of bullying and harassment, and isolation. There is a need to develop multifaceted and team approached services that are personalised to the individual needs of the mentally ill. Moreover, there is a need to develop a correctional approach to health and mental health care delivery as the present reliance on a community medical model is ineffective. This research provides unique insight into the prison mental health experience through the voices of those who live and work in this complex setting and will inform future health and correctional policies.

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List of Abbreviations, Terms and Acronyms

- ❖ ARMS - At Risk Management System (a system used to manage prisoners who are at risk of self-harm or suicide)
- ❖ CCU - Crisis Care Units
- ❖ Clean skin - a prisoner who is new to a particular prison or the prison system
- ❖ Graylands - Graylands Psychiatric Hospital
- ❖ Mental health/mentally ill prisoner/patients - this is the language/phrase used by staff when talking generally about prisoners with psychiatric/mental illness. This term, and others, are used throughout the thesis and is interchangeable with the following terms that are also used - psychiatric illness, mental illness, mental health, mental disorder, mentally ill prisoner /offender (please refer to Appendix B for further information regarding the definitions applied in this research).
- ❖ Forensic - a forensic patient is defined by the legislation and the WA Act and is generally an individual housed in a State Psychiatric facility. This individual may also be in prison or be transferred back to forth between facilities. The majority of the prisoners in this study were mainstream prisoners who have mental health disorders. When this thesis uses the word forensic is generally refers to forensic psychiatric mental health services.
- ❖ MPU - Multi Purpose Unit
- ❖ IOU - Intensive Observation Unit
- ❖ PCS - Prison Counselling Service
- ❖ PD - Personality Disorder
- ❖ Screws - Prison Officers
- ❖ SHU - Special Handling Unit
- ❖ The Department - The Department of Corrective Services in Western Australia

CHAPTER ONE: AN INTRODUCTION TO THE RESEARCH

“Central to the advancement of human civilization is the spirit of open inquiry. We must learn not only to tolerate our differences; we must welcome them as the richness and diversity which can lead to true intelligence.”

Albert Einstein

Introduction

There is a paucity of work both in Australia and overseas that captures the voices, perspectives and experiences of individuals involved in the criminal justice system, particularly with regard to mental illness. It is claimed that research into the mental health of prisoners is an under-researched area both in Western Australia and nationally (Kraemer, Gately and Kessell 2009). The majority of those research projects that focus on mental illness in corrections often only provide quantifiable data, data on the prevalence rates of specific disorders; or on the link between mental illness and offending rates. These studies show that the prevalence of psychiatric disorders among offender populations is higher than in community samples (Butler et al. 2006; Butler and Allnut 2003; Herrman et al. 1991; Glaser 1985; Hurley and Dunn 1996). What is lacking in many of these studies is in-depth and contextual information regarding prisoner experiences and levels of satisfaction; perceived effectiveness and availability of mental health services; and health professional and correctional staff experiences of working in prisons and with the mentally ill, providing the services presently available and those required in the future. “The subject of jails, and the people who live and work in them, has generally been neglected to the periphery of scholarly interest” (Ruddell 2006, 119), and prisons seen as a dumping ground rather than a potential place for psychiatric treatment and recovery. This thesis aims to bridge a gap in the literature, and highlight the insight, richness, and diversity of individual experience in Western Australian prisons, by the use of a mixed methods approach.

The aim of this chapter is to provide a guide to the structure of the thesis. Furthermore, it provides the genesis of this research, that is, an overview of the researcher’s professional experience in corrections, and a brief background to the research issues: Deinstitutionalisation; over-representation of people with mental illness in prison populations; and the prison context. This is followed by an overview

of the research methodology; significance and objectives; as well as the research instruments and procedures. Finally, this chapter outlines the structure of the thesis.

Researcher's Positioning

According to the concept of reflexivity (Lane 2000; Bourdieu 1977) it is important for researchers and sociologists to conduct their research with conscious attention to the effects of their own position, structures and background and how these are likely to alter or prejudice objectivity. The researcher's presence as a social performer and what this means for the research is central (Lane 2000; Bourdieu 1977). As the researcher, it is therefore important for me to outline my orientation to this research, and my background within the criminal justice field.

I commenced this research as both a student who has an interest in forensic mental health, psychiatry, criminology, psychology, social work and penology, and an employee of the Western Australian (WA) Department of Corrective Services (herein referred to as the Department). In other words, I have previous experience in this field as an academic, evaluator and researcher, and service provider, and therefore have some already held assumptions regarding the mentally ill in prison populations. Whilst working as a Mediation Officer for the Victim-Offender Mediation Unit I undertook protective and reparative mediation work in Western Australian prisons and the community. This provided me with a dynamic experience and background, at the beginning of my professional career, and gave me insight into prisoner and victim experiences in the justice system. I later began working as a Research and Evaluation Officer, evaluating a number of Department initiatives and establishing a broad contact base across the Department. These contacts have been instrumental in allowing me to undertake this PhD and I have utilised these networks in the recruitment of participants and to gain support for the research. However, it has also meant that I have had to be aware of possible conflicts of interest, to manage my professional and student role carefully in order to maintain integrity in the research, and to inform all participants of my role within the Department.

I am also aware that I am a young and attractive female who frequently works in a male dominated environment and in male maximum security prisons; this has any

number of inherent challenges and raised a few issues for data collection. I did not have my normal 'Department' staff member hat on and was entering the prisons as an independent researcher. I had to renegotiate this space from a different position and in some cases found this difficult. One difficulty was when I encountered prison officers name calling/teasing mentally ill prisoners when calling them up for interviews with me. These were difficult situations to negotiate. I had a number of interviews to undertake, across two phases, and it would be very likely that I would at some stage interview these officers as part of my work for the Department. However, it was important to me that I did not let this behaviour slip by. I immediately told the officers, in an assertive but not confrontational way, that I thought they were being inappropriate. I later discussed this issue with nursing staff who experience similar situations on a daily basis. In the past, I thought I had negotiated the prison environment very fluidly and easily, that is, as a Department employee on Department business. What this situation made me realise was that I was now entering prisons by a different kind of personal choice, with an individual passion and an avid interest in my research topic, to explore these nuances, and for the first time I realised that prisons are incredibly challenging environments for all who enter them. It was like seeing them with fresh eyes.

These understandings led me to recognise that this research emerged from a very practical standpoint. In the course of working with prisoners and staff within the Department I had become consciously, yet also somewhat seemingly subconsciously, aware of the challenges both groups faced and of the subculture of prisons that operate like a community within a community. This unexplored interest obviously led to a decision to investigate this topic further via this PhD. It was also fuelled by increasing public attention and media focus on mental health issues as I began writing my research proposal in 2005 (for a reminder of some of the interesting media attention please refer to Appendix A). I currently work for the Department's Strategic and Executive Services Division as a Senior Research and Evaluation Officer. All participants were made aware of this. My position within the Department could possibly have afforded me privileges I may not have otherwise have been afforded. However, it may also have contributed to participant's wariness as they generally mistrust people who 'work for the system'. The findings of this research and the themes to emerge are shaped by my position and experiences within this context.

Research Background

Today, it is widely recognised that thousands of people who were institutionalised, and therefore closely supervised and controlled, now have much more independent lives. This independence has led to the unintended consequence of criminalisation and incarceration (French 1987, Torrey 1992). The literature argues that deinstitutionalisation significantly influenced this increase and has impacted on the lives of those with psychiatric illness, and on methods of treatment (Accordino, Porter and Morse 2001). Society poses many challenges for the mentally ill who were more familiar with a supervised institutional environment. The change from institutionalisation to community care is not helped by chronically inadequate and uncoordinated community service provision, which often results in individuals being unsupervised and poorly cared for. This change to community service provision poses new challenges for service providers who struggle to cope with the changing demands on services as public institutionalisation (in the traditional sense) is now a limited treatment option. These changes have also resulted in new challenges for families and the wider community as health departments and governments grapple with psychiatric illness in our communities.

Mentally ill people in the community are at greater risk of being unemployed and therefore living on welfare and in poverty. They may reside in temporary accommodation and be marginalised by the wider society who, even today, stigmatises the mentally ill. Individuals who experience mental illness often have a lack of social support and opportunity, have less regular contact with family and friends, leading some people to homelessness, isolation, often substance abuse and trouble with the law (ABS 2009). These are all factors that may impact on a person's likelihood of re-offending. Prison is all too often the final destination in the social welfare and justice lines and, unfortunately, in today's society, it is often seen by Emergency Departments, Police and Courts as an easy solution where mentally ill people will get, at least, some service provision. Prison is very often society's answer in an inadequate and overburdened system of mental health service provision.

As can be seen above, many explanations have been provided to account for the increase and over-representation of people with mental disorders in prison populations. These fall into four broad categories: 1) changes in legislation, 2) the

development of psychotropic drugs, 3) the subsequent introduction and increase in community care, and 4) increases in drug related crime (Fagan and K.AX 2003). In addition, many other cultural and social factors come into play.

In the literature, a common justification for the research of people with mental health disorders who are involved in the criminal justice system and specifically in prisons is their over-representation within this environment (Fagan and K.AX 2003; Kupers 1999; Mullen 2001). The number of criminal offenders with mental health problems has been increasing steadily and correctional settings have taken the place of state psychiatric facilities as the primary sites for the treatment of mentally ill individuals (Fagan and K.AX 2003). Kupers (1999) estimates that 20-25% of adult prisoners have significant mental health issues, however other research estimates that this range could be from 15% to as high as 90%, (Birmingham, Mason and Grudin 1996; Brink, Doherty and Boer 1997; Fazel and Danesh 2002; Magalette et al. 2009; Ricketts, Brooker and Dent-Brown 2007; Van Marle 2007). These estimates vary depending on research methodologies, definitions of mental illness, and inclusion/exclusion criteria, for example, whether personality disorders are included or excluded¹. Essentially trans-institutionalisation has taken place, that is, we have seen a shift of individuals from one institution (the psychiatric hospital) to another (the prison).

Prisons are complex environments that have their own unique identity and composition. This environment can be challenging for any individual prisoner. This is particularly so for those with mental illness, and for the staff who work within these often under-resourced and challenging walls. The provision of services, and in particular health and mental health services, is a difficult task in an environment where discipline and safety take precedence over health treatment. This is made more difficult due to a lack of research utilising methodologies aimed at exploring and understanding the experiences of health professionals, correctional staff, and service users (prisoners) (Ruddell 2006).

¹ A number of interchangeable terms are used in this research. For additional information on the background information explored and the definitions adopted please refer to Appendix D.

Most research investigating the mentally ill in prison populations tends to focus on prevalence studies, with findings showing escalating numbers in Australia and internationally (Ogloff et al. 2007). It is now common knowledge that there is an over-representation of people with mental illness in prison populations (Whiteford and Buckingham 2005), and there is concern in the literature that people with mental illness are disadvantaged in this environment (Kupers 1999). The human rights of psychiatrically ill people could be called into question when one considers the over-representation, treatment and warehousing of the mentally ill internationally and in Australian prisons (Kupers 1999).

As in other states in Australia, the Western Australian Department of Corrective Services (the 'Department'), and other government bodies (e.g., Legal Aid, Disability Services Commission, Mental Health and Health Services and the Western Australian Police) have expressed an interest in formulating policy, legislation and services that are more responsive to people who are diagnosed as having a mental illness. In particular, these agencies are beginning to recognise the need for a whole-of-government response that delivers suitable health services, programs and continuing community care. However, despite a lot of talk, to date, this has not translated into tangible outcomes.

Any research that can explore pertinent issues that may contribute to knowledge, improve service provision, and our understandings of this group of offenders, is of benefit not only to the academic community but also to offenders themselves, service providers and the community at large. It is imperative that the voices of individuals with mental illness and the staff who care for them are given expression, as their insights and experience of prison life are likely to provide us with meaning, answers, and no doubt more questions, about how and why we are facing this issue in the first place. This research provided an opportunity for those voices to be heard. In addition, it improves the context of academic examination and provides a benchmark of existing staff and prisoner experiences and perceptions in metropolitan and rural prisons in Western Australia; this may be beneficial retrospective information to have if services change in the future.

Research Overview

This research owes its origins to the concern that people with a diagnosed mental illness are over-represented in Western Australian prison populations; a consideration for the staff who work with these prisoner patients; and a desire to listen and investigate these experiences in the voices of those most closely affected. The **objective** is to investigate the experiences of prisoners, health professionals, and correctional staff in relation to psychiatric illness and mental health service provision. The purpose or **aim** of this research is to gain a deeper understanding of mental health services; expand on current knowledge and understandings in the area; generate meaning by exploring different forms of data; provide a 'snap shot' of staff and male prisoner experiences in relation to mental illness and mental health service provision in eight Western Australian prisons by using a sequential mixed methods design. The research also aimed to generate new knowledge to assist in making informed policy decisions to ensure sufficient and comprehensive psychiatric services in the future.

Significance of this Research

It is acknowledged that the cultural and local parameters in Western Australia are unique, and cannot be directly converged on other settings. However, uncovering perceptions and experiences among correctional staff, health professionals and prisoner patients may contribute to new approaches to care and service delivery and therefore mitigate the adversities of insufficient mental health care in prisons and the community, the high rate of incarceration of the mentally ill, the burnout and turnover of staff in corrections, and the possible human rights abuse of mentally disordered people in our communities. This research is highly significant at the State, national, and international level as mental illness, its treatment and services are a key focus of debate, and there is a recognised shift in thinking about those suffering from mental illness in our community. This thesis will contribute to these discussions. In Western Australia, and indeed throughout Australia, there is considerable debate relating to de-institutionalisation, community care and treatment of individuals suffering mental illness in the prison setting. The field of forensic and correctional mental health is exploring these topics and, in doing so, is changing the way we characterise past and future understandings of mental illness in correctional settings.

Several Australian State Governments are directing their attention to mental health and in 2006 the Australian Parliament set up a Steering Committee to report on all aspects of mental health (Parliament of Australia Senate Select Committee on Mental Health). The Committee's Terms of Reference related to a number of areas of investigation with the one most pertinent to this research being - "the over-representation of people with mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people" (cited in internal Department of Corrective Services memorandum, 8). This review found that there is a need for increased research and improved practices in corrections.

This research will contribute to a broader and deeper understanding of the experience of living with mental illness in prison environments, for groups such as the Australian Steering Committee reporting on health and mental health; people diagnosed with a mental illness; researchers and practitioners in the fields of mental health, social work, psychology, psychiatry, medicine and nursing; government and non-government agencies; researchers and practitioners in prison and criminal justice fields; and to the wider community.

Research Questions and Objectives

Central research question: What are the experiences of staff and prisoners in Western Australia in relation to mental health/psychiatric service provision and mental illness in the prison environment?

Research objectives/aims:

1. To investigate and provide insight into the issues facing prison staff when working with prisoners who experience mental illness².
2. To investigate and gain insight into the attitudes and feelings of staff in relation to current services, treatment and facilities.

² That is, prisoners identified by the Department of Justice as having a Psychiatric Alert on TOMS.

3. To investigate the issues, experiences and needs of prisoners who are diagnosed with mental illness in custody in Western Australia.
4. To investigate and develop an understanding of experiences in urban and regional prisons in Western Australia.

Mixed Methods Considerations:

1. To what extent do the staff and prisoner findings support each other across the qualitative and quantitative Phases? What insights can be generated, and meanings drawn-out, by merging and exploring both forms of data?

Research Approach

To enable the investigation of the research question and objectives a mixed methods approach was utilised, applying both qualitative and quantitative methods to gather data. This research procedure can be viewed as what Creswell and Plano Clark (2007) refer to as a 'two phase sequential design'. These phases provided an opportunity to explore the topic in two different ways, thus enhancing the scope and depth of the findings.

The methods applied are mainly exploratory. In Phase One, qualitative (QUAL) techniques were applied, using semi-structured interviews to consult with health professionals and correctional staff (n=9), and prisoner patients (n=8), about their experiences of mental health service provision and mental illness across four prisons in Western Australia. This Phase allowed for an in-depth exploration of the topic with a key informant sample, and for themes/constructs to be developed to inform the findings, and Phase Two. In Phase Two, the Phase One key informant interviews, and the key themes identified in the literature review, informed the development of two quantitative survey questionnaires; one for staff and one for prisoner patients. A mail out of surveys to eight prisons in the State was carried out for staff (n=120), and face-to-face survey questionnaire completion was undertaken in four prisons in the State with male prisoner patients (n=48). A total of 184 participants took part in Phase One and Phase Two combined with all participants gathered using non-probability (purposive) sampling methods. These phases acted as two different ways of exploring the research questions with the findings integrated in the discussion. It should be

noted that equal weight was given to the phases and findings. This approach has been diagrammatically presented in the methodology chapter and was adapted from Creswell and Plano Clark (2007).

The Thesis Structure

This thesis consists of eight chapters, which in general represent the stages of the research: to establish context, background and process of this research (chapters 1-4), to present findings of both phases (chapters 5-6), and to present the analysis and discussion (chapters 7-8).

Chapter Two and Three review the relevant literature and background material. Chapter Two provides a historical overview of mental illness and the changing face of mental health service provision. This chapter forms part one of the literature review and background material section and focuses on deinstitutionalisation, evidence for the links between mental illness and crime, and how those with mental illness have ended up in prison populations. Furthermore, it explores some key illnesses or groups (and issues) that are represented in global prison populations.

Chapter Three forms the second part of the literature review and background material section and explores the prison system and experience, the role various staff play, both correctional and health staff within this environment, the current state of correctional mental health services, and the Western Australian prison context where this research took place. The analysis of this literature and background documentation provides a strong framework and context for this research position and provides a firm foundation for the research process.

Chapter Four outlines the methodology and methods used to conduct this research. This includes the research approach (a sequential mixed methods framework), methods of sampling and data collection, ethical issues, and data analysis. This chapter also outlines the constraints and limitations of conducting prison based research, and identifies the ontological and epistemological underpinnings of the research.

Chapter Five presents the Phase One qualitative research findings. The findings are presented with supporting quotes from the research participants organised under four broad overarching themes; resources and funding; education and training; management, consultation, and context; and current service provision. The findings are presented excluding the analysis and interpretation which will be conducted in chapter Seven's discussion.

Chapter Six presents the Phase Two data. Firstly, the chapter outlines some relevant data analysis and significance testing information. It then presents the research results. The data is presented in relation to the overarching themes/constructs that were identified in Phase One, further explored in Phase Two and presented above. The chapter is broken down into six sections as follows: Section One presents the general demographic information; Section Two presents prisoner patient and staff results that relate to the resources and funding construct; Section Three presents the prisoner patient and staff results that relate to the education and training construct; Section Four presents the prisoner patient and staff results that relate to the current service provision construct; Section Five presents the prisoner patient and staff results that relate to the management, consultation and context construct; and, Section Six presents the qualitative findings from the free response questions at the end of the survey questionnaires.

Chapter Seven's discussion is devoted to interpretation and analysis of the Phase One research findings and the Phase Two data. The purpose of this chapter is to explore and merge the findings across both phases and to address the research questions and objectives. This chapter analyses the staff and prisoner findings separately and makes some comparisons in the findings across both phases.

The thesis is concluded in chapter Eight. This chapter presents a summary and draws to a conclusion. It also offers my reflections and concluding remarks and some recommendations for future research, for practitioners, government/policy, for non-government organisations and for all those wishing to improve the provision of mental health services in prisons and the community.

CHAPTER TWO: LITERATURE REVIEW

*I know not whether Laws be right,
Or whether Laws be Wrong;
All that we know who lie in jail
Is that the wall is strong;
Oscar Wilde*

Introduction

The available literature on mental illness, offending rates, imprisonment, psychiatry, social work, criminology, nursing, psychology, epidemiology, and health care is wide-ranging. These fields all impact and contribute to the background of this research, and although it will not be possible to outline all of the influential and significant views and theories, an introduction to the relevant topics will be offered here. This chapter aims to provide an overview and offers a glimpse into the vast bodies of research that impact on this research.

Chapter Two is divided into two sections. Section One demonstrates the prevalence of mental health issues in the criminal justice system and shows that mentally ill people are over-represented in today's prison populations. The section then provides a brief historical overview, discusses the role of deinstitutionalisation and transinstitutionalisation, and looks more specifically at the link between offending behaviour and mental illness. In Section Two the focus shifts to the nature of mental disorders among offenders and the section outlines the different types of mental illnesses and contributing factors that are relevant for the link between mental illness and incarceration. These diagnostic groups have been chosen because existing research shows they are prevalent particularly challenging to manage in the prison environment. An understanding of these disorders was therefore necessary to focus the research questions and the qualitative research guide.

Chapter Three focuses on the research setting: the prison system and mental health services; the role and experiences of staff who work in prisons; prisoners' attitudes and experiences of imprisonment and mental health services; and Aboriginal imprisonment as it relates specifically to Australia and Western Australia. These two

chapters, together with the subsequent methodology chapter, create a guide for this research.

Section One: Over-representation (where we are now and how we got here)

The Current Situation: Where are we now?

There is substantial international research showing that people with mental health issues are over-represented in the criminal justice system, and are being warehoused in prisons (Butler et al. 2006; Brinden, Stevens and Mudler 2002; Butler, Allnut and Yang 2007; Carter 2002; Diamond et al. 2001; Herrman et al. 1991; Lamb and Bachrach 2001; Maden, Swinton and Gunn 1994; Ogloff et al. 2007; Ricketts, Brooker and Dent-Brown 2007). Arboleda-Florez (1999, 679) commented that in many countries “the large number of mental patients in local jails has made the jail a practical extension of the general mental health services.”

Increases in the number of individuals diagnosed with mental illness in today’s criminal justice system can be attributed to a number of factors. Changes in legislation, ‘get tough’ attitudes towards crime (e.g., such as three strikes policies), the development of psychotropic medications in the 1950s, which resulted in deinstitutionalisation (Torrey 1988; Torrey, Strieber and Ezekial 1992), and an increase in the number of drug related crimes has seen a prominent increase in the number of imprisoned individuals with mental illness in Australia, Europe, and America (Fagan and K.AX 2003). The increases could also relate to improved knowledge and classification of mental illness, changes in the way we define mental illness, or ways of counting.

Prevalence of Mental Health Issues in the Criminal Justice System

There is an increasing body of literature looking at the rates of mental disorder among offender populations with much of the research focusing on prison populations.

“In some few jails are confined idiots and lunatics, - many of the bridge wells are crowded and offensive, because the rooms which are designed for prisoners are occupied by lunatics. The insane, when they are not

kept separate, disturb, and terrify the other prisoners. No care is taken of them, although it is probable that by medicines and proper regimen some of them might be restored to their senses and usefulness in life" (Howard 1784, 10-11, cited in Reed 2002, 118).

This quote was cited by John Reed (2002) in his article on delivering psychiatric care to prisoners and gives his view that, at least in terms of the presence of mentally ill people in prisons, the situation in 1784 is paralleled today.

The term 'mental disorder' incorporates psychotic illness, neurotic disorders, substance misuse and personality disorder and related behaviours, notably (in the prison context) self-harming behaviour (Paton et al. 2002). Current research has used varying definitions and methods to explore the prevalence of these conditions and so the estimates fluctuate (Van Marle, 2007). However, all the findings consistently demonstrate that prevalence rates are higher in prison populations than in the community. Prisoners have between a two and ten-fold excess of psychiatric illnesses and major depressions, and a ten-fold excess of anti-social personality disorder (Paton et al. 2002). Offenders with mental disorders are more likely to be imprisoned for misdemeanours than the non-mentally ill and are likely to be held in prison for longer periods. Findings show that mental illness is the most significant factor in the risk of suicide (Singleton et al. 1998; Gunn, Maden and Swinton 1991; Lader, Singleton and Melzer 2000; Reed 2002; Fazel and Danesh 2002; Longato-Stadler, Von Knorring and Hallman 2002).

Australian and international research shows that rates of mental illness in the criminal justice system are disproportionately high (Lamb et al 2004; Reed and Lyne 2000; Birmingham, Mason and Grubin 1996; Bland, Newman et al. 1998; Brinded et al. 2001; Butler et al. 2006; Karras et al 2006; Wright et al. 2006; Motiuk and Porporino 1991; Fazel and Danesh 2002; Hardie et al. 1998; Herrman et al. 1991; Ogloff 1996, 2002, 2006; Parliament of Australia Senate Select Committee on Mental Health 2006). The literature indicates that the prevalence of severe mental illness in correctional settings is approximately 15%-20% in comparison to a prevalence rate of approximately 3% in the wider adult population (Greenburg and Neilson 2002; Birmingham, 2001). It is difficult to establish definitive figures on the number of

prisoners in Western Australia with mental illness, due to a lack of existing research focusing in mental illness or prevalence statistics. However, the Department estimates that 30% of male prisoners and 40% of female prisoners have, or have had, a diagnosed mental illness (DCS, TOMS database). Actual figures from a snapshot of the Western Australian prisoner population on the 30th June 2005 show that approximately 19% of the total adult prisoner population are recorded as having a psychiatric alert on their medical status. Birmingham (2001) suggests that prisons are much more likely to have to manage and treat mental illness than in the general community.

The following section presents a mixture of information (both statistics and research) to show the current situation in some countries and the research that emanates from them. This information demonstrates that rates of mental illness are very high in global prison populations.

Meta-analysis of Research from various Western Countries

Fazel and Danesh (2002) completed a comprehensive review of 62 surveys of mental disorder among prisoners in Western countries and found that one in seven prisoners in Western countries were diagnosed with psychotic illnesses or major depression and about one in two male prisoners and about one in five female prisoners with antisocial personality disorder. More specifically their findings show that in prison populations, 4.0% of women were diagnosed with psychotic illness, 12% with major depression, and 47% with a diagnosis of personality disorder, including 21% with antisocial personality disorder. Of the men, 3.7% were diagnosed with a psychotic illness, 10% with major depression and 65% were diagnosed with a personality disorder, including 47% with antisocial personality disorder. The results show that prisoners are more likely to have a diagnosis of psychosis and major depression and are approximately 10 times more likely to have anti-social personality disorder than the general population.

Research from New Zealand

Research from New Zealand by Simpson et al. (1999) has found similar results. The findings suggested, "a markedly elevated rate of mental disorder over that in the general community" (Simpson 1999, 58). The report noted that prisoners on remand

are deemed to pose a greater mental health concern than sentenced offenders. This may be a result of initial contact with court processes and “experiencing the first shock of incarceration” (Simpson et al. 2005, 5).

Research from the United Kingdom

Research from the United Kingdom shows an increasing number of individuals with mental illness involved in the criminal justice system (McGilloway and Donnelly 2004). Brugha et al (2005) conducted a survey of 13,250 adults in British prisons and households by screening them for psychosis and then followed up with a diagnostic interview for those with positive results. The findings demonstrated that the prevalence of psychiatric morbidity was over 10 times greater in the prison samples than in the community samples. Soderstrom (2008, 4) claims that the “consistent conclusion drawn from these types of studies is that the prevalence of mental illness is much higher in correctional populations than in community populations indicating a dire need for increased awareness and resources directed at treatment and prevention.”

A systematic review undertaken by Brooker et al. (2002) found the four most commonly occurring mental disorders in UK prisoners are personality disorders (78% in male remand prisoners), neurotic disorders (40% in male sentenced prisoners), drug dependency (34% of male prisoners), and alcohol dependency (30% in male sentenced and remand prisoners). Moreover, 7% of male prisoners have attempted suicide in the last 12 months and 6% of male prisoners present with schizophrenia or delusional disorder. A smaller percentage of male prisoners have self-harmed during their current sentence (5%), and 1-2% of prisoners are diagnosed with affective psychosis. The research found a significant over-representation of all mental health disorders in the prison population when compared to the general community.

Research from the United States of America

In the United States Weedon (2005) found that compared with the general public, offender populations have four times the rate of mental health disorders. He claimed that these large numbers could and should be treated in hospitals and community-based programs rather than in the criminal justice system (Weedon 2005). However, he argues that community services are unable to coordinate comprehensive services

that would ensure the treatment of such individuals, due in part to a lack of funding for community mental health services. "According to the Bazelon Center for Mental Health Law (United States), total state spending for treatment of the mentally ill is one-third less now than in the 1950s" (Weedon 2005, 1). The Bazelon Center claims that the situation is similar worldwide.

The lack of funding in the USA can be associated with a decrease in the number of psychiatric facilities and deinstitutionalisation causing an increase in the number of mentally ill in the community and in USA jails and prison. "Today, there are nearly five times more mentally ill people in jails and prisons than there are in state psychiatric hospitals" (Weedon 2005, 1). These figures are supported by Gunn et al. (1978) where over one-fifth of prisoners were found to have a major psychiatric condition, and by in research by Andrews and Bonta (1994) where a third or more of prisoners have been diagnosed with some form of mental disorder.

Research by III-Equipped (Human Rights Watch, 2003) showed that one in ten of the two million prisoners in the United States had a mental illness. Many of these prisoners suffered from serious mental disorders such as schizophrenia, bipolar, depression, psychosis related disorders and major depression. The rate of mental illness in the prisons was reported to be three times higher than that of the general population (New Freedom Commission on Mental Health, 2004). This is higher than reported by Teplin (1990), who studied 728 remandees in America. Teplin (1990) ascertained that 6.4% of the remandees in the study had severe mental disorder of whom nearly half had a diagnosis of schizophrenia. This was over twice the rates evident in the general population, however these figures are less than those reported above by Weedon (2005) who found rates to be four times those of the general public.

Research and Statistics from Australia and Western Australia

In 2007, one in five Australians aged 18-85 years had a mental disorder and almost one in two (or 7.3) million people had experienced a mental disorder at some point in their lives (ABS, 2009). A meta-review by Mullen (2001) suggested that prisoners

experience major mental disorders at a rate of two to four times that of the community.

New South Wales

The prevalence of mental health disorders among prison populations and the capacity of the prison sector to provide mental health services have recently been reviewed in both New South Wales and Victoria. The NSW study by Butler and Allnut (2003) suggests that the prevalence of mental illness in that state's correctional system is substantial and consistent with international findings. Overall, the study showed that 74% of those assessed had at least one psychiatric disorder (psychosis, affective disorder, anxiety disorder, substance misuse disorder, personality disorder or neurasthenia) in the twelve months prior to interview (compared to 22% in the general community). In addition, the prevalence of psychosis was 30 times higher among NSW prisoners compared to the community. For most diagnostic categories, the prevalence of 'any psychiatric disorder' was higher in those recently received into custody (80% vs. 64% in the sentenced group) and higher among females than males (86% vs. 71%, recently received into custody). In addition, it was reported that personality disorders among reception and sentenced prisoners are 43.1% and 37.1% respectively (NSW Corrections Health Service 2003).

Victoria

The Victorian Prisoner Health Study (2003) found similar results with the overall pattern of findings showing that the prevalence of all major mental illnesses is overwhelmingly higher in the prison population than in the wider Victorian population. Earlier research in Victoria by Wallace et al. (1998) measured the level of prior contact that 4,156 (3,838 males) convicted in the higher courts between 1993 and 1995 had with public mental health services in the State. Over 25% of these offenders had had previous contact with the mental health services on the register used. Schizophrenia, affective psychosis, affective disorders, and personality disorders were over-represented in the male offender sample and violent offences (homicide) in particular. A recorded comorbid substance diagnosis was robustly linked with offending. A diagnosis of schizophrenia with a co-existing diagnosis of substance abuse in males showed them to be twelve times more likely to be convicted than a member of the general population compared to less than two for those without a co-

occurring substance abuse diagnosis (substance abuse is discussed in more detail in the next section).

Western Australia

In the Western Australian Attorney General's '*Report on the Investigation into Mental Health and DSPD Services for Prisoners in England*'³ (July 2005) it is stated that as at 30 June 2005, the percentage of Western Australian adult prisoners with a serious and treated psychiatric illness was 20% (679). Of these prisoners, 32% were Aboriginal and 68% non-Aboriginal. Of the 679 identified prisoners, 55% had previously served a short term of imprisonment (these figures are not representative of all prisoners who suffer mental health problems). The report outlines that these figures are 5-7 times higher than the general population prevalence rates.

Using hospital admission data, Hobbs et al. (2006) in a Western Australian study, reported that 16.4% of all prisoners had a hospital admission or mental health service contact with mental health problems as the primary condition (this study is explored in more detail below). This is over five times that of the general Western Australian adult population.

Pre and Post Prison Mental Health Service Contact in Western Australia

The following data highlights the rate of mental health service contact by prisoners' pre and post imprisonment. This data shows that in many cases prisoners' rates of mental illness and contact with services increase post release. It may be that if appropriate services were provided in prison a decrease in post release service could be expected (more research in the area is required to confirm this). However, it is also possible that prisoners are more familiar and comfortable with accessing services and therefore utilise community services at a higher rate post release.

³ This report was an investigation by the Attorney General into the United Kingdom's prison based mental health services. The idea was to bring back the 'lessons learned' in the UK and apply them in the WA setting. The report also contained information on psychiatric services provided in Western Australia.

Table 1: Place of treatment of mental disorders before and after release from prison: percentage of prisoners with health service contact

Place of treatment	Before/After	Aboriginal Male	Non-Aboriginal Male
General Hospital	Before	9.5%	11.8%
	After	14.9%	12.5%
MHS outpatient	Before	4.9%	9.5%
	After	8.8%	11.5%
MHS hospital	Before	3.1%	4.8%
	After	1.5%	1.7%
Any GH + MHS	Before	12.6%	17.5%
	After	17.9%	17.3%

Table taken from Hobbs et al. 2006

The Australian mortality and morbidity in prisoners report (Hobbs et al. 2006), and table 1 above, indicates that 12.6% of Aboriginal males and 17.5% of non-Aboriginal males had contact with any mental health system prior to first release from prison and 17.9% of Aboriginal males and 17.3% of non-Aboriginal males after date of first release. The majority of these contacts were with general hospitals.

Table 2: Principal diagnostic groups in mental health patients with health service in the five years before and after first release from prison: percentage of prisoner with health service contact

Principal Condition	Before/After	Male Aboriginal	Male Non-Aboriginal
Alcohol, drug related psychosis	Before	3.7%	2.8%
	After	5.7%	4.0%
Other psychosis	Before	3.2%	4.4%
	After	5.8%	5.5%
Other drug and alcohol related	Before	7.2%	7.6%
	After	9.7%	7.5%
All other mental conditions	Before	4.0%	9.5%
	After	5.7%	8.8%
All mental conditions	Before	12.6%	17.5%
	After	17.9%	17.3%

Table taken from Hobbs et al. 2006

Data was collected regarding the principal diagnosis for mental health admissions before and after imprisonment. As indicated in table 2 the primary cause of mental illness was related to drug and alcohol abuse there was, however, a high proportion of individuals admitted for psychotic illnesses.

For most conditions there was an increased number of prisoners diagnosed with mental health conditions following release from prison than prior to prison. There are a number of possible explanations. It appears that incarceration may be a diagnostic point for male prisoners. It may be that the assessment process in the prison highlights prisoners' mental health disorders, that education in prisons raises health awareness amongst prisoners lending them to take better care of their mental health on release. It could also highlight the damaging effects of imprisonment on mental health or the over diagnosis of mental health conditions in this environment.

With mental health services already limited there is reason to believe that these trends will continue into the future. The Western Australian Burden of Disease Study "estimates that by 2016 mental illness will become the major cause of disease burden for females and the second highest cause of disease burden for males and that mental disorders will be among the most expensive conditions in Western Australia" (Nowrojee et al. 2005, 5). The bulletin goes on to say that traditional models of health service delivery fail to take into account many factors that will result in the underestimation of the burden of mental illness on the community. This will have direct implications for prison populations who will have an influx of prisoners experiencing a range of mental health disorders.

Historical Overview: how we got here!

*To Cure, Occasionally
To Relieve, Often
To Comfort, Always
Anonymous (16th Century)*

The differential housing and treatment of individuals and criminal offenders with mental disorders has a long and recurring history around the world (Roberts 1997). As early as the 1600's in Europe there are documented cases in which relatives confined

family members to workhouses in order to remove them from sight and not blemish the family name (Spierenbu 1995). The Americas began confining groups of people in the 1800's - including criminals, the mentally ill, orphans, delinquents, and the chronically unemployed - in their prisons and jails (McShane and Williams 1996). Over time, this practice came to be very costly, there was a decrease in the quality of care after, and living conditions became appalling. People called for reform and the hope of treatment rather than punishment for those suffering from mental health problems. With the changes in legislation came the establishment of separate mental asylums and the removal of many non-criminal individuals with mental disorders from prisons and jails (Fagan and K.AX 2003).

With the rapid spread of mental asylums throughout Europe and America, and the rise of the psychiatric professions, another class of mentally ill individuals emerged. These individuals were diagnosed mentally ill but were also criminally dangerous. Over time a range of services in both prisons and asylums became available for these people (Morris 1995). Prison administrators struggled to manage these individuals in the wider prison population. The criminally mental ill were therefore separated into special housing units, isolation units, or secure hospital wings within the prison. Many of these practices continue today (Fagan and K.AX 2003).

In the early 1900s, medical and behavioural scientists began to play a more prominent role in the study and practice of corrections. This saw a shift in the diagnosing and treating of crime which started to be treated like a medical disorder. Over time, and with increasing experience of offender populations, it became apparent that offenders needed to be classified not only on their security requirements but also on their mental status (Rotman 1995). This saw a reinforcement of the segregation of individuals with mental disorders within society and in institutions (Fagan and K.AX 2003).

The medical model prevailed through much of the 20th century, with a focus on diagnosis and treatment of the mentally ill and the criminally mentally ill (Fagan and K.AX 2003). The mid 1970s saw a shift in thinking with a growing understanding that the present system was having little effect on criminal recidivism and on the rate of treatment of offenders. Research at the time triggered debate about treatment and

correctional recidivism and shifts in correctional policy took place. These changes moved away from the medical model towards psychological and programmatic interventions (Fagan and K.AX 2003). Prisons have also adopted what is seen by some as 'new age' or 'alternative' treatments. The literature shows that these alternative forms of treatment, particularly art therapy, have been shown to have significant decreases in depressive symptoms for prisoners (Gussack 2004, 2006, 2007; Hanes 2005; Kornfeld 1997).

Canadian research in the 1980s and 1990s helped to create a more balanced view about criminal justice programs and treatment. The Canadian research was more balanced as it drew on a number of fields, social work, psychology, nursing, and psychiatry, in its approach to treating mental illness. The Canadian social scientists Gendreau, Cullen, Ross and Goggins (Cullen and Gendreau 1989, 2000; Gendreau 1996; Gendreau and Goggins 1997; Gendreau, Goggins and Smith 1999; Gendreau and Ross 1979, 1987), drove this research with their findings demonstrating that correctional programs were effective at reducing recidivism rates. Programs and psychologically based interventions now play a significant role in both correctional and community treatment of offenders (Fagan and K.AX 2003). However, there is often limited funding provided to prison programs creating problems for some offenders who are given longer sentences and may have trouble accessing parole (Fields 2006).

Today, health professionals play an important role in the provision of mental health services in correctional settings, It is now widely recognised that prisoner populations encompass some of the most stigmatised and underprivileged people in the community. Individuals from disadvantaged backgrounds, poor educational accomplishment, and histories of joblessness, Indigenous populations, and those with mental illness are over-represented among prisoner populations in Australia and around the world, thus increasing the need and importance of taking a balanced and multi-disciplinary approach to health care.

Deinstitutionalisation

Prisons and jails throughout the world have become the largest mental asylums and providers of psychiatric services. The deinstitutionalisation of public mental health systems, combined with changes in many countries of laws pertaining to mental illness, and the level of consideration given to mental illness as a mitigating factor, has seen an unprecedented number of individuals with major psychiatric problems involved in criminal justice systems (Kupers 1999; Lurigio and Fallon 2007; Ruddell 2006).

Deinstitutionalisation created a drive to release patients from mental hospitals and the number of hospitalised psychiatric patients worldwide has fallen dramatically since the 1950s. In the 1950s, the antipsychotic medication Thorazine and others were widely available for the first time. Due to the widespread availability of pharmaceuticals clinicians began to think about sending some of the large number of chronically ill mental patients home. Furthermore, there was pressure from human rights groups who protested against the practice of involuntary mental hospitalisation, involuntarily medicating mental patients, and forcing them to undergo electroconvulsive therapy in institutions (Foucault 1967, Szasz 1961, 1963, 1970, 1973). This shift in thinking was accompanied by a shift in funding with a move from funding hospitals to funding community based services. This aimed at helping the mentally ill to live as fully as possible in the community. However, budget conscious governments in many countries did not follow through with adequate funding for mental health services in the community.

In addition to pressure from human rights groups, there was also questioning of politics and power during the 1960s spurring the rise of the feminist movement, anti war demonstrations and advances in medical technologies. This created attention and debate in sociological circles with thinkers such as Michael Foucault releasing *Madness and Civilisation* in 1961. Foucault was an influential critic of both psychiatry and psychiatric institutions with his main concern the separation of the mad from the sane rather than poor conditions and abuse in these asylums. His concern was primarily the physical removal of the mentally ill from society and with the classification system which he viewed to be neither intellectually justified nor motivated by beneficence. It can be seen that definitions of mental illness and the

mentally ill are especially important in a compartmentalised system like an institution. He claimed that separation, which he called 'the great incarceration', was underlined by the power of the rising bourgeoisie. According to Foucault the bourgeoisie needed a disciplined and compliant workforce and were increasingly intolerant of deviance in any form that is, in both conduct and thought. In Foucault's vision, all human institutions, including those with avowedly beneficent intent, are expressions of the will to power which he believes underlies all human activity. This line of thinking inspired other critics of psychiatry and the medical profession as a whole who were viewed by academic and professional circles to be struggling for power. This struggle for power contributed to the view of asylums as chambers of horrors.

In Australia, the deinstitutionalisation movement began later meaning that the asylum era ended 20 years after the UK and 10 years after the US. In Victoria in 1975, patients suffering from schizophrenia had an overall length of stay in hospitals of 165 days. This was down to 90 days by 1985 where the length of stay for first admissions was 30 days (Mullen 2000). The shift in care that has taken place over the last forty years has resulted in individuals who present the greatest risk of involvement in the criminal justice system spending most of their time in the community rather than in hospital care (Mullen 2001).

No doubt Foucault's arguments, along with other thinkers such as Goffman, Wolfensberger and Szasz, further enhanced the process of deinstitutionalisation which began in stages from the early 1950s and gained considerable momentum. In the first instance, the embryonic stages of deinstitutionalisation saw faster patient turnarounds with decreases in the length of stay for first admissions from months or years to weeks. This progressed into the gradual transfer of long term, and usually chronically institutionalised patients, back into the community (in the UK this occurred in the 1960s, in the US in the 1970s and in Australia in the 1980s) (Mullen 2001). The majority of those sent back into the community in the early stages of deinstitutionalisation were young people with acute illnesses who spent less time in hospital and more time in the community. It can be argued that the demographic of individuals who are over-represented in offending statistics today are young men and women with acute and dual diagnoses illnesses.

From Hospital to Prison

Although it benefited many mental health patients, deinstitutionalisation has created a sub-group of individuals who are frequently imprisoned as a consequence of repeated offending. There are several reasons why individuals within this group might find it particularly difficult to maintain healthy and positive lifestyles in the community. This may in part be due to co-occurring issues of substance use and the increase in use of soft and hard drugs, unemployment, and social and family breakdown, changes in community mental health care, lack of compliance with treatment regimes, increased homelessness. This list is by no means exhaustive but these issues indicative of a need for more structured support systems that can assist this group of people to live holistically in the community (Lamberti et al. 2001; Van Marle 2007). In Western Australia, almost 30% of those on the Department of Health's Mental Health Register are recorded as having a criminal offence. Without adequate support systems in place many of these people face imprisonment.

Implications for Prisons

Prison administrators and those providing mental health care in prisons across the Western world have drawn attention to the numbers of mentally ill and intellectually disabled people in prisons. In Australia, there has been a dramatic increase in the numbers of prisoners referred on admission to prison for further exploration of psychiatric problems and of the numbers of acutely psychotic prisoners requiring treatment (Mullen 2001). In part this may be due to an increased awareness of the issues mentally unwell prisoners face and of the need for improved services; it almost certainly reflects a willingness to imprison the mentally ill (Mullen 2001).

The systemic issues that influenced the rapid increase in prison populations and a seeming willingness to imprison the mentally ill have specific implications for people with mental health problems. Offenders with a mental illness are more likely to commit crime, be at greater risk of arrest, commit violent crimes, and have significantly higher rates of recidivism (National Institute of Justice 1991; Sigurdson 2000). Factors such as specific police practices can unintentionally target particular groups of offenders such as the mentally ill. Due to behaviours, characteristics, and social disadvantage associated with their disorders, the mentally ill are more likely to

end up in situations where their behaviour is noticed by police and they are more likely to be arrested, questioned, and detained for minor public nuisance crimes.

When the mentally ill reach court, they are at a disadvantage and may experience poorer outcomes, specifically when there is a general increase in the use of imprisonment (i.e., get tough on crime attitudes). In general, mentally ill people are more likely to have difficulty understanding police and court procedures and are prone to vulnerability within the system. There is an increased likelihood that they will receive terms of imprisonment due to a lack of available community services that can provide adequate supervision - hence there is little likelihood that they will meet the requirements for supervision orders. "In addition, their inability to control impulses or misperceptions of threat can result in violent offences and crimes against the person, which are more likely to be punished with a sentence of imprisonment" (McGinty 2005, 9).

If it is true that offenders with a mental illness are more likely to commit crime, are at greater risk of arrest, are more likely to commit violent crime, have significantly high rates of recidivism, and are less likely to be released at their earliest opportunity (Sigurdson 2000), and if, people with mental illness are more likely to be arrested and convicted than non-mentally ill individuals and are significantly over-represented in the criminal justice system (Olsen 2001), then prisoner populations are likely to contain a disproportionate number of offenders with mental health problems. Mullen (2000, 28) claims this increase could be due to a number of factors. According to Mullen increases in numbers of the mentally ill in prisons:

"...could reflect a greater willingness to imprison certain groups of offenders among whom the mentally disordered are over represented (e.g. public nuisance, social security fraud and repeat thefts). It could represent a break down in formal and informal diversionary programs aimed to move the mentally disordered away from the criminal justice system back into the mental health system. It could paradoxically reflect the use of certain non-custodial disposals, such as suspended sentences and supervision orders, which the mentally disordered are more likely to breach. It could reflect increasing numbers of prison sentences handed

down for drug related crimes to which the mentally disordered are more prone. It could reflect a shift in public and judicial attitudes to mental disorder as a mitigating factor when it comes to sentencing.”

Much of the historical mental health literature highlights the significance of linkages with deinstitutionalisation, and a lack of adequate community care for the mentally ill (Forshaw, cited in Soothill, Rogers and Dolan 2008; Kupers 1999; Lamberti et al. 2001). In 2005, the ABC Four Corners Program aired a television report looking at mental health service provision in Australia. The program outlined that the deinstitutionalisation of mental health services including the reduction in hospital and hostel accommodation for people with mental illness, and the disintegration of services are inversely correlated with rising prison populations. The result has been trans-institutionalisation - the movement of people with serious mental illness from community psychiatric hospitals into jails and prisons (from one institution to another). The next section will look more specifically at some key literature relating to the link between mental illness and offending rates.

The Link between Mental Illness and Offending

“One of the most pressing problems of the mentally retarded is that by default, as it were, their legal rights are often ignored, disregarded, or simply violated” (Haggerty, Kane and Udall 1972, 60).

The relationship between mental disorder and crime has received much attention over the years and has been of particular interest to penologists, criminologists, lawyers, and psychiatrists. This long and extensive debate has focused on the links between mental disorder and offending behaviour, in particular violent crime. This debate, which spans more than a century, has had a profound impact on community perceptions of the mentally ill.

Due to the varying nature of the fields that show interest in mental illness (e.g., psychiatry, psychology, sociology, criminology, law, nursing, medicine, social work) many divergent methodologies have been employed (Hodgins 1992; Torrey 1994; Monahan and Steadman 1994; Mullen 2001, 1997). This results in a division of theories, that is, those that show traditional medical adherence and others from the

social and/or psychological streams. Over time, a broad research base has emerged. Without being attached to a particular ideological or professional commitment the correlations between offending behaviours and mental disorder are explored below. It should be noted that the research findings in this area are varied with the outcomes of studies showing mixed results. Some have found that people with mental disorders are more likely to commit crime and be arrested and others have found only marginal increases in offending behaviour.

Evidence for the Link between Mental Disorder and Crime

Offending Rates of the Mentally Ill

Research has investigated the rate of violent and criminal behaviours in mentally ill individuals prior to admission, once admitted to hospital, on first contact with services, and following discharge in the community (Binder and McNeil 1998; Blackburn 1993; Hodgins 2008; Fottrell 1980; Hollin 1993; Karson and Bigelow 1987; Ogloff et al. 2007; Powell et al. 1994; Sheridan et al. 1990; Tardiff 1982; Walker and Siefert 1994). This research shows that criminal behaviour in psychiatric populations is higher than in the general population and when mental illness is unmanaged individuals are more likely to commit crime, be arrested, and have the highest rate of recidivism of any other group of offenders (Hollins 1993). Hollins (1993) suggests that incidence of serious crimes, such as robbery and rape, is higher in psychiatric populations.

This finding is supported by the research of Sheilagh Hodgins (1990, 2008) and colleagues who used Denmark's population registries to compare the criminal records of individuals with a history of hospitalisation for psychiatric illness to the criminal records of individuals without a similar history. They found that individuals with a history of psychiatric hospitalisation were more likely to have been convicted of a criminal offence than persons with no history of psychiatric hospitalisation. This finding was consistent for both women and men. The report goes on to say that individuals with a history of hospitalisation were three to eleven times more likely to have a criminal record, than those individuals without a history.

In support of the above findings is a study conducted by Belfrage (1996), where an exceedingly high rate of offending was recorded for patients diagnosed with mental illness. In a follow-up study of 893 of the original 1056 participants, Belfrage found that 28 percent of the subjects were found to have a criminal record. The Swedish patients were diagnosed as having paranoia, schizophrenia or affective psychosis. Consistent with the findings from the Hafner and Boker (1982) study, schizophrenics had a higher offence rate than subjects with other forms of mental illness. In addition, he notes, the most frequently committed crimes were violent ones.

Research in Australia by Mullen (2000) traced the criminal histories of just over 1000 people who had been diagnosed as schizophrenic and who had been first admitted to hospital in either 1975 or 1985. Patterns of offending behaviour of these individuals were compared with matched controls with those for age, gender and residential area. The findings showed that those diagnosed as schizophrenic had higher levels of convicted criminal activity than the matched controls.

“Over 20% of males with schizophrenia had been convicted of a criminal offence with over 10% having a conviction for violence compared to 8% of controls who had a recorded offence with 2% violent convictions. A co-existing diagnosis of substance abuse was significantly associated with a chance of acquiring a conviction (49% vs. 8.6%) including convictions for violence (17% vs. 2%)” (Mullen 2000, 8).

In 2004 in the United Kingdom 72 per cent of patients subject to a restriction order and admitted to hospital were diagnosed as having a mental illness, and a further 13 percent were diagnosed as having a psychopathic disorder (Ly and Forster 2005, 5). Figures from the end of 2004, among restricted patients at the hospital show that 49 per cent (1,613) had been convicted, or charged with acts of interpersonal violence. In addition, 249 had been charged with murder and 420 with other homicide.

Research by Jamieson and Taylor (2004) focused on 204 patients discharged from one of the three English high security hospitals in 1984, allowing a maximum follow-up period of 12-years. The findings show that 38 per cent of participants were re-convicted. They went on to outline that those with personality disorders are

significantly more likely to re-offend and that additional and more intensive services are required to manage this demographic of offenders.

In contrast to the findings above, which show increased rates of offending, are the studies below that have found no or marginal increases in offending by individuals with mental illness. Rabkin (1979) found that research prior to 1965 consistently showed patients were less likely to be arrested after they had been released from a mental hospital in comparison to members of the public. This is supported by the findings of Steadman, Coccozza and Melick (1978) and Steadman and Coccozza (1978), where a fifteen-year follow up of schizophrenic patients released from Stockholm hospital in 1971 found that offence rates were only marginally higher in the patient population compared to the general population. They concluded that serious mental disorder did not significantly increase the risk of offending behaviour.

The MacArthur collaboration was a large scale study that examined the link between violent and offending behaviour and having a mental disorder (Steadman at al. 1998; Monahan at al. 2000). The study sampled over a thousand people from Pittsburgh, Kansas City and Worcester Massachusetts in the United States who were admitted to public psychiatric inpatient facilities. For a period of 12 months after discharge, the sample was comprehensively evaluated, and followed up every 10 weeks with 72% of the sample completing at least three follow up interviews. The findings show that those with a major mental disorder (including depression, dysthymia, schizophrenia and other psychotic disorders) were less likely to be overtly violent than those with other mental disorders (personality or adjustment disorders), the latter often complicated by co-occurring substance abuse and prone to higher levels of violence.

The 'MacArthur study' (Camilleri and Webb 1999) used self report measures and clinical and official records that informed researchers of individuals' offending behaviour. The results show that 27.5% of subjects reported overt acts of violence with 22.4% revealed by self-report and official records. Violent behaviour ranged from hitting to attacks with weapons (3 subjects committed homicide) but excluded other forms of aggression, such as pushing, shoving and slapping, behaviour that was identified as 'other aggressive behaviour'. When included these behaviours increased the percentage of perpetrators to 56%.

What makes the MacArthur study more credible than other research in the field lies in its attempt to include a control group of non-disordered individuals who share other characteristics with the subjects. Forty three percent of the control subjects completed the applicable assessments and although a low number, it does allow for some points of comparison. These comparisons show that patients with major mental disorders (those listed above), but without substance abuse, were no more likely to be violent than similar others who also did not present symptoms of substance abuse. Substance abuse was however, a common finding amongst patients (31% vs. 17%) and the level of violence amongst this group of substance abusing patients was much higher than similar others.

In support of the above research are the findings from the 'Baxstrom study' (Cocozza and Steadman 1974). The Baxstrom patients were assessed by psychologists and psychiatrists as 'dangerous mental patients' and were committed to maximum-security psychiatric hospitals. The study arose when an inmate (Johnnie Baxstrom) took his case to the United States Supreme Court because he was transferred from prison to a hospital for the criminally insane after being diagnosed as mentally ill. His lawyers argued that without evidence of his dangerousness he should be released. The court transferred Baxstrom and 976 other patients who were housed in similar hospitals back to prison. Cocozza and Steadman (1974) followed 246 of the offenders' progress via patient records whilst they were in hospital, and later traced 98 of the patients who had been released into the community. The follow-up period took place over a two and a half-year period. The results show that 20.4% were rearrested, 11.2% were re-convicted and only two of the 98 offenders committed violent offences. From these findings, Cocozza and Steadman (1974) concluded that the Baxstrom patients were not especially dangerous. Of the 98 patients released only 14 displayed behaviour that could be considered dangerous. This is supported by Thornberry and Jacoby (1979, cited in Andrews and Bonta 1994), who traced 354 mentally disordered offenders released into the community and found only 14.5% re-offended.

The prevalence of violence exhibited by persons with mental illness who are untreated has been shown to be four to ten times greater than the general population (Mouzos 1999). Mouzos (1999, 2) undertook a review of existing international

literature on mental disorder and homicide. Her findings show that “the prevalence of mental disorder amongst homicide offenders ranges from as low as 2 per cent to as high as 53 per cent.” In relation to Australia, Mouzos (1999) found that approximately 4.4 per cent of homicide offenders were recorded as having a mental disorder at the time of the offence (data from the National Homicide Monitoring Program 1989 to 1998).

Findings from these studies need to be interpreted carefully as they focus on rates of conviction and hospitalisation. It may be that offending behaviour in mentally disordered groups is not higher but that they are more likely to be caught and convicted. Additionally, those suffering many depressive disorders are never admitted to hospital but those who are, are the ones likely to show increased patterns of social, interpersonal and substance abuse problems.

Section One Summary

Based on the evidence there does appear to be a link between mental disorder and crime, however the relationship between cause and effect is not so clear. The research shows that a connection between mental disorder and crime can be established on an individualistic level, however an ability to generalise this relationship across all persons and mental disorders is not firmly established in the literature with some findings supporting a strong link and others only a weak association. Many of the studies are carried out using prison samples, which pose problems when trying to generalise the findings to the general population. It is hard to determine if these individuals showed signs of mental illness whilst committing the offence, or if these disorders manifested in prison. The prison or hospital environment may be conducive in the formation of mental illness. In addition, studies fail to take into account factors such as: race, education level, socio-economic background and anti-social behaviours that stem from childhood, so one must be careful when interpreting these findings. Furthermore, most studies do not utilise matched control groups for comparison.

What is clearly demonstrated by the literature is that individuals with mental illness are over-represented in prison populations. Many explanations are reported for the

high numbers of mentally ill people in prisons. These include: deinstitutionalisation of psychiatric facilities and the subsequent movement of the mentally ill to the community; homelessness; the high threshold for admission to general psychiatric facilities; the reluctance of general psychiatric services to accept mentally ill patients from the courts; inadequate specialist community forensic psychiatric services; inadequate rehabilitation of forensic psychiatric in-patients; society's intolerance of deviant behaviour by the mentally ill; a lack of adequate diversionary options in the community and the greater likelihood of the mentally ill being arrested. The increased use of illicit substances in the general population and among the mentally ill has likely made a significant contribution to an increase in all types of offending (Butler and Allnutt 2003). Research into community samples of the mentally ill supports the above findings (Arseneault and Colleagues 2000; Brennan et al. 2000, Hodgins et al. 1992, 1996).

Section Two: Mental Health of Offenders

“The transformation of prisoners into patients has never done more than relieve jails of the obviously disordered. They have always had to cope with the residual problem of the prisoner whose degree of disorder, though marked enough to interfere with discipline and communication, is not sufficient to satisfy the psychiatric criteria of the day” (Walker and McCabe 1937, 38).

Introduction

Section One demonstrated the link between mental illness and offending behaviour, the ease of arrest of those with mental illness due to the nature of their offending, and their subsequent over-representation in prison populations. The following section turns to the association between various disorders, or particular matters of concern, and the criminal justice system. In the first instance, a brief overview of the prevalence of certain illnesses is provided. More in-depth information is then presented on various disorders. The disorders selected and discussed in this section are only a small spectrum of the recognised diagnosable mental illnesses. These particular conditions were selected as they each play a pertinent role, either due their high prevalence, or difficulty to manage in prisons. Suicide is touched on briefly in this section. Suicide in corrections is not discussed in any depth here, as it was not a focus of the research, it is a topic in and of itself, and has received a vast quantity

of research. However, it does warrant a brief mention in this review⁴. Following on from this, chapter Three will discuss the research setting; prisons, staff roles, and prisoner attitudes to mental health services.

Substance Abuse

*For long you live and high you fly
But only if you ride the tide
And balanced on the biggest wave
You race towards an early grave
Pink Floyd*

There is a long history of association between substance abuse, mental disorders and offending behaviour. The co-existence of substance abuse with a mental disorder increases the level of the association with offending behaviour considerably (for a review see Soyka 2000; Scott et al. 1998). Individuals suffering from mental disorders have been found to have increased rates of substance misuse (including alcohol, cannabis, sedatives, stimulants and opiates) in Australian and international research (Chiles et al. 1990; McMurrin 2008; Mueser et al. 1990; Fowler et al. 1998; Smith and Hucker 1994; Teplin 1994; Williams 2007). Research by Cantwell et al. (1999), and Bourtos et al. (1998), shows that individuals suffering from mental illness are more frequently engaging in drug and alcohol use. Australian research shows the rate of substance abuse among first admissions to prison had increased significantly from 10% in 1975 to 35% in 1995 (Wallace, Burgess, Mullen, unpublished, cited in Mullen 2001). Research from 2006 shows that five percent of police detainees reported that they had spent time in psychiatric facilities (at least an overnight stay), and in 2004, 30 percent of police detainees were found to have mental health problems. Furthermore, a strong overlap was recorded between drug use, particularly methylamphetamine and cannabis, and mental illness (Mouzos, Smith and Hind 2005).

Studies from the USA paint a similar picture to Australia showing that there are more people with severe mental illness in U.S jails than in State hospitals (Torrey et al.

⁴ For further information on suicide in correctional settings, refer to Howells, Hall, and Day 1999; Liebling 1999; McHugh 2000; Morrison 1996; and the Royal Commission Report 1991, listed in the references.

1993). Furthermore, nearly three out of four of these people have a co-occurring alcohol and/or drug related problem (Abram and Teplin 1991). Those with mental illness are over-represented in USA arrest statistics when compared to the general population (Teplin 1994; Rock and Landsberg 1998), and those with co-occurring substance abuse disorders, are amongst the highest group to be found for arrest, homelessness, violent behaviour and other social problems (Borum et al 1997; Drake et al. 1993; Monahan 1995; Rachbeisel, Scott and Dixon 1999; Steadman et al. 1998; Swartz et al. 1998).

Similar findings are reported by Soyka (2000, 348) who concluded his review by noting, "there is substantial evidence for substance misuse being a major risk factor for violence and aggression in patients with mental disorders particularly schizophrenia." However, despite the research evidence, Mullen (2001, 17) warns us to hold some reservation...

"about the too ready assumption that substance abuse causes offending behaviours in the mentally disordered. To a greater or lesser extent substance abuse may reflect, rather than cause, such factors as anomie, impulsivity and recklessness which contribute to offending behaviour. Thus in part it may be that those who tend to offend are also those who tend to abuse drugs and alcohol when available, rather than it always being drug and alcohol abuse which ushers in offending behaviours. Only properly conducted studies which examine independently the fluctuations in substance abuse and offending can answer this question..."

Personality Disorders

Personality disorders receive a huge amount of attention in penology research and some studies estimate that between 60% and 90% of prisoners has a personality related disorder (Brooker et al. 2002; Fazel and Danesh 2002; McMurrin 2008; Singleton et al. 1998). The sample used in this PhD research (n=1 PD diagnosis and n=4 mixed/dual diagnoses) indicated that personality disorders warrants special attention as it is a growing area of concern and research in Western countries.

There are many categories of personality disorder (the International Classification of Mental and Behavioural Disorders (ICD-10) provides 9 categories of personality disorder and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) provides 10 categories of personality disorder) and most personality disordered persons exhibit symptoms of multiple categories. Three broad clusters are identified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and are presented with the definitions in the appendices.

Personality disorder in adults frequently has its origins in childhood disturbance. Adults who present with antisocial personality disorder have often been subjected to severe neglect and abuse and are likely to have a parent or caregiver who has a psychiatric disorder and has difficulties in parenting (Kupers 1999).

Studies suggest that 10-13% of the adult population are personality disordered. They are more likely to suffer alcohol and drug problems and experience adverse life events. Antisocial personality disorder has a prevalence of 2-3%. There is a very high prevalence of anti social personality disorder among the prison population (McGinty 2005).

Previous research has often referred to large and increasing numbers of prisoners with personality disorders (Jamieson and Taylor 2004; NSW Corrections Health Service 2003; Wallace et al. 1998). However, the vast amount of literature in this area shows that both the nature and treatment of personality disorders are highly contested. A number of studies call into question the effectiveness of the screening instruments used, with many instruments resulting in the over-estimation of the prevalence of personality disorders (Brinded and Mulder 1999). In a study reviewing estimates of personality disorders in adults in prisons, prevalence ranged from 10% to 61.7% using the Diagnostic Interview Schedule. A comparable broad range of estimates of the prevalence of conduct disorder exists in relation to adolescent offenders - with a range from 41% to 90% quoted (Kazdin 2000). Indeed, Hodgins (1992) emphasised that measures used in identifying mental disorders have not produced precise information about the nature of the disorder.

Others have suggested that it is difficult to establish the boundaries and treatability of personality disorders (Eastman 1999; Cawthra and Gibb 1998), and the psychiatric sector faces difficulties when deciding whether to treat. This is clouded with issues of compulsory treatment in some countries. In England and Wales, the Mental Health Act (1983) requires a person to receive obligatory treatment if they are deemed to have a psychopathic disorder. Cawthra and Gibb (1998) claim that many psychiatrists believe that the management of personality disorders requires extensive and intensive treatment interventions which are of marginal benefit and that these treatments are often costly and damaging for staff working within them.

In 1951, Sir David Henderson (cited in Cawthra and Gibb 1998, 91) remarked:

“...socially everyone knows that the persons who form this group constitute a very serious problem. The reason is that neither medicine nor the law nor our social organisations have been able to make adequate provision for them in our daily work. In the ordinary mental hospital, such persons are a source of constant trouble and anxiety. They disturb the other patients, they upset the medical and nursing staff and they lead a selfish, individualistic existence which brings them into conflict with their fellow patients.”

There is little evidence to suggest the situation has changed since this statement was made in 1951.

It is unsurprising that the United Kingdom’s Mental Health Bill (2004) was hotly contended and debated when first introduced. Birmingham (2002) reports that the compulsory treatment of personality disorder, including severe personality disorders deemed dangerous had been widely condemned and described as ‘glaringly wrong and unethical’. Similar concerns have also been expressed over the treatment of dangerous and severe personality disorder (DSPD).

Definitions of DSPD are variations of personality disorder and many of the most serious and potentially dangerous offenders or prisoners are classified as DSPD.

However, the definitions themselves do not discriminate potential levels of dangerousness amongst the personality disordered (McGinty 2005).

As in the United Kingdom, prisoners who may be described as having DSPD present significant problems for the criminal justice system, the Mental Health System and the community in Australia. From a legislative viewpoint, the management of persons with DSPD is usually the responsibility of the criminal justice system as they frequently are persistent offenders and there are limitations to effective treatment options under the Mental Health Act (1996). Prisoners who are described as DSPD are both difficult to manage and difficult to treat.

Not surprisingly, the question of how to treat, manage, and return DSPD prisoners safely to the community is the subject of significant developmental work in England and is becoming a focal topic in Australia with considerable attention in Western Australia. It is estimated that at any one time there may be up to 100 dangerous prisoners with severe personality disorders in Western Australia (Hare 1991, 1996, 1999). These prisoners are a challenge to manage as they are more likely to have committed assault, caused serious injury, used a weapon, damaged property, or be linked to making a weapon whilst in prison.

At present, there is no specific treatment or management regime in place for personality-disordered prisoners in Western Australia. This is currently under review in Western Australia and on-going research and development will result in significant progress in the future. It is important to recognise that the debate about whether or not personality disorder, and related behaviours such as self-harm, are or are not psychiatric issues is by no means simply a theoretical one. The debate is also a political one as the definitions given to disorders and indeed mentally disordered offenders defines who has responsibility (prisons or health care?), whether prisoners can be held for indefinite periods of time at the Attorney Generals discretion, and also encompasses considerable policy and financial implications.

Schizophrenia

The sample of those prisoners diagnosed with Schizophrenia comprised the largest sample group in this PhD research project (n=19 schizophrenia diagnosis alone and n=6 multiple diagnosis). Schizophrenia is a complex disorder, which usually begins early in life and can often lead to bizarre or disturbed behaviours. People suffering from schizophrenia often display social withdrawal, breakdown in thought patterns and emotions, disorganised thoughts and cognition and a loosening of associations (Bartol 1980; Brown and Barlow 2007; Lawrie et al. 2002a and Lawrie et al. 2002b).

Evidence for a link between schizophrenia and criminal activity was found in a study by Lindqvist and Allebeck (1990) that looked at the criminal history of 644 schizophrenic patients who had been discharged from a hospital in 1971. The researchers used a longitudinal design and were able to access police records to see what offences had been committed by their sample during the period 1972-1986. Their findings show that of the 644 patients discharged 45 out of 330 men and 9 out of 314 women had committed offences. When these figures were compared to the general population, the crime rate was very similar for men but double for women. The results for women need to be viewed with caution, as there was only a small sample of women used in the study. When the specific offence committed was compared to the general population it was found that violent crimes were four times more frequent among schizophrenics than in the general population. However, it should be noted that the number of these violent acts were small in nature (although the severity was not measured) and that the majority of individuals diagnosed as schizophrenic are not violent (Lindqvist and Allebeck 1990).

Hafner and Boker (1982) conducted a study looking at the links between homicide and mental disorder in people who were excused of criminal responsibility because of serious mental disorder (schizophrenic or affective psychosis, organic brain disorder, mental retardation). They found that in comparison with non-offender patients, schizophrenia was over-represented in their violent mentally disordered group. The risk of violence in schizophrenia was 0.05% (i.e. 5 of every 10 000 schizophrenics are likely to become violent).

This figure is not very high, but of all the disorders tested, schizophrenia has been highlighted as the illness posing the greatest risk of violence. These researchers found that the presence of delusions, and urges to kill including hallucinatory instructions meant that some patients with schizophrenia attacked suddenly and in frenzy. These delusions appear to be the most frequent correlate of violence in these patients.

In summary, existing research shows a possible link between schizophrenia (particularly paranoid) and criminal behaviour. There is an increased risk for individuals with schizophrenia to behave violently, however this relationship is limited and is only displayed by a minority of people with the disorder. In order to understand the relationship between crime and schizophrenia, research needs to take into account all the factors that interact to produce the illness and the offence, and it would be useful to have further research that provides comparisons with other diagnostic categories.

Self-harm and Suicide

Another specific area receiving growing research interest is that of prisoners who self harm, attempt and complete suicide. This is due to the high prevalence of such behaviours amongst prisoners and the difficulties such behaviours present for prison administrators (Senior and Shaw 2008). This review will not focus on self-harming behaviour or suicide in any depth as the literature is vast. It will provide a very brief overview, as self-harming behaviour and suicide was touched on by some participants in the research and is an important area in the literature (for a thorough overview on suicide and self harming please refer to Liebling 1992). Like personality disorders, the area of self-harm and suicide is much contested and there is little empirical data in Australia relating to self-harm in prisons. This has created a reliance on using international findings by Australian researchers and authorities which often produces uncertainty (McArthur, Camilleri, and Webb 1999).

There is a distinct lack of clarity in the terms used to describe the behaviour/s and its scope. *Self-harm* or *self-injury* refers to a range of behaviours that involve inflicting pain, injury or damage to one's body, for example cutting, scratching, use of sharp objects, or tying ligatures. The term most commonly used in the research literature is

'*deliberate self harm*' though *intentional self-injury* is also used. This behaviour is distinguished from *attempted suicide* since there is no apparent intention on the individual's part to die, however, in some situations, people have mixed motives and death may well be an unintentional consequence of severe self-harm (Babiker and Arnold 1997).

Research within prison populations in England and Wales suggests that up to a third of prisoners have engaged in deliberate self-harm at some time in their lives (Maden 1994; Maden, Chamberlain and Gunn 1994), and that 10% of sentenced women and 7% of sentenced men harmed themselves without suicidal intent during their current prison term (Singelton et al. 1998). Numbers that one would consider high given the nature of the behaviour. It has further been estimated that for every prison suicide there are 60 incidences of self harm (McArthur, Camilleri and Webb 1999).

Self-harm and suicide research in Australia has focused on the causes, contributions and predictors of Aboriginal self harm and suicide in prisons with the Report of the Royal Commission into Aboriginal Deaths in Custody (1991) (RCIADIC) providing a comprehensive investigation of the subject.

The RCIADIC report concluded that Aboriginal deaths in custody occur due to the interaction of various factors. These factors relate to the individual, the custodial experience, and factors relating to the way in which custodians exercise their duty of care to Aboriginal prisoners. The report observes that a large proportion of Aboriginal suicides had a previous history of self harming behaviour or previous suicide attempts and in some cases these behaviours are related to underlying mental health issues (further information on Aboriginal mental health is provided below). 'Sorry cuts' are a part of Aboriginal culture and self-inflicted knife wounds may be committed on one's self when grieving for death or injury of kin. Any discussion or research focusing on Aboriginal self harming must take account of cultural perspectives in order to minimise ethnocentric biases and this cross-cultural difference must also be considered in the prison context.

Within the wider population, 'deliberate self-harm' (a term used by researchers to incorporate all acts of self-harm, whether or not suicidal in intent) has been a major

problem for the past three decades (Hawton et al. 1997). The behaviour is particularly apparent in adolescents and young adults. Longitudinal research in Oxford UK shows that the overall rate of self-harm rose by 50.9% over a 10 year period (rate for females 42.2% and males 62.1%) (Hawton et al. 1997). These rates have continued to rise in the ten years to date. The striking increase in young male rates has been clearly paralleled by recent trends in deaths from suicides. It is possible that these rising trends, in both deliberate self-harm and suicides in young men, provide partial explanation for the rising rate of self-inflicted deaths in prisons.

At the time of mutilation behaviour, self injurers frequently report feelings of numbness, feeling 'out of touch' and 'unreal' and feeling 'empty'. Self mutilators often claim that the behaviour and the pain and blood associated with the injury restores their feelings of identity and control, and this sense of depersonalisation is commonly cited as a cause of self harming (Cookson 1977).

Ivanoff (1992), reports that self harming behaviour reflects an identity breakdown, often resulting from crisis and feelings of doubt, fear, hopelessness and abandonment. The prison context is often seen as manifesting these emotions as prisoners lack their freedom and an ability to access mechanisms to cope with stress. In addition, other stressors are placed on prisoners such as limited privacy and autonomy, harassment, violence and bullying, and noise. Individual coping mechanisms vary and although some prisoners may ask for help, others lash out at themselves or others as a means of coping. Ivanoff (1992) claims that it is in this context that self harm occurs in prison. This is supported by the findings of Butler, Allnut and Yang (2007) who argue that mentally ill prisoners are vulnerable in prison populations. This was reflected in their study where prisoners reported "increased fears for their safety."

Medical literature also attributes self-harming behaviour as symptomatic of personality disorder, particularly borderline personality disorder. A reduction in self-harm is used as an outcome measure in broader studies of the natural history and treatability of personality disorder of which it is seen to be a symptom. In England, the Department of Health and Home Office (1994) and the NHS Executive (1996) have both undertaken national reviews that have considered treatments for severe

personality disorder. These studies came to different conclusions, with one (the Reed report on forensic psychiatric service) favouring the use of therapeutic communities and the other (review of psychotherapy) favouring dialectical behaviour therapy. There is a long and on-going debate among psychiatrists about the treatability of personality disorder and the costs of doing so (Moran 2000).

Self harm and suicide are very difficult issues to manage in the prison environment. Goulding (2004, 52) notes that these issues are challenging for prison authorities as these behaviours “have many complex contributing factors often external to prisons, but likely to be exacerbated by the life crisis which imprisonment signifies.”

Chapter Summary

This chapter has provided a general introduction and critical review of the prevalence of mental illness in the criminal justice system and clearly demonstrates the over-representation of people with mental health disorders in global prison populations. This account has included a brief overview of the history of the deinstitutionalisation of mentally ill individuals, and argues that the move to community mental health services has essentially resulted in the transinstitutionalisation of many people suffering from mental illness. Further, the chapter has looked specifically at the link and relationship between offending behaviour and mental illness. This review suggests that there is indeed a link between offending rates and mental illness, however, there appears to be limited understanding regarding the relationship between cause and effect. Moreover, the literature review gave an overview of the key disorders that are both prevalent and difficult to manage in the prison context. The mentally ill incarcerated in today’s prisons display a range of complex illnesses that have an impact on offending rates, treatment options and management regimes.

This chapter provides an understanding of where we are now in relation to over-representation of the mentally ill in prison populations, and how we arrived at the current situation. The offending behaviour and subsequent arrest and detention of individuals with mental illness can provide an opportunity for intervention and treatment, and in some cases, may be the only opportunity certain individuals have

to receive mental health care (Weedon 2005). Whether the prison environment is a suitable place to receive this care is debated worldwide.

The next chapter will provide an introduction to the prison setting and background of this research, while the subsequent chapter will outline the methods employed in the research.

CHAPTER THREE: THE RESEARCH SETTING

*And I will show you something different from either
Your shadow at morning striding behind you
Or your shadow at evening rising to meet you;
I will show you fear in a handful of dust.
T.S. Eliot*

Introduction

The main purpose of this chapter is to provide a brief background to the research setting. As with the previous chapter, this chapter is broken down into two sections. Section One describes the prison system, environment and purpose, examines forensic and correctional mental health services and presents a historical overview and legal context of the mentally ill in Western Australian prisons. In addition, the section presents information on Aboriginal imprisonment and mental illness as it is particularly relevant to Western Australia. Section Two then presents prisoner patient's experiences of living in prison with a mental illness and their attitudes to correctional and forensic mental health services. Further, it briefly discusses the work of Michel Foucault and explores correctional staff and health professionals' attitudes and experiences of working in prisons. These factors all influence the provision of health and mental health care in the prison context and the experiences of those who work and live in Western Australian prisons.

This chapter will present a combination of research literature, information and statistics from government reports and the Departments website, and research material in relation to the nature and purpose of prisons and mental health service delivery. Again, due to the vastness of fields of inquiry in this area, theories, literature, and influential and significant views only a selection of ideas, experiences, attitudes, statistics, and information can be presented and discussed here. Utilising a range of sources offers a broader approach and insight and is necessary to draw the relevant elements together. This section constitutes layers of framework from both theoretical and practical levels and the material provides an understanding of the milieu of this research.

Section One: The Prison System and Mental Health Services

“Institutions that insist on uniformity undermine self respect and foster apathy and dependence. They encourage pliability, but they do so by making the sick sicker and the helpless more helpless” (Toch 1977, 120).

The Role and Purpose of Prisons

For the purposes of this research it is important to understand, as best as possible, the environment in which prisoners and prison staff are living and working. This is a difficult task without a) committing an offence and actually living in prison, and b) having a diagnosed mental illness. In addition, in order to understand mental health services in corrections it is important to have an idea of context; it is necessary to have an understanding of a prison’s purpose and of some its unintended consequences on the self. In the strictest sense, Norris and Rothman (1998) assert that the prison is for the housing and confinement of those convicted as punishment for their offences. Hicks and Alpert (1978) share this idea and claim that the prison and its function of confinement is the societal consequence for those who engage in offending behaviour. According to others prisons “by their very nature, generate struggle and resistance” (Zdenkowski and Brown 1982, 3).

This section looks at the purpose of prison and how this impacts on the mental health and wellbeing of prisoners.

Prison Purposes

Norris and Rothman (1998) observe that the use of prisons in today’s society appears to centre on four main applications:

1. Incapacitation: relates to the prisoner being confined within the prison grounds for the duration of his/her incarceration, and therefore for this period the community is safe from the acts of this individual.
2. Deterrence: the proposition that prison acts as a deterrent or reduction for criminal behaviour in the wider community. Research on deterrence is unclear and whilst imprisonment may act as a deterrent for some individuals, it may confirm the criminality of others.

3. Retribution/Expiation: The communities' level of vengeance changes over time and the principle behind a system of law argues that imprisonment is preferable to citizens taking the law into their own hands. The legal system creates distance between offenders and victims of crime, and establishes guidelines for particular offences and for the punishment of perpetrators. Imprisonment is viewed by some as a meaningful and measured punishment and by others as lenient towards offenders.
4. Reformation: Prisoners continue to learn and develop law abiding ways of living and are to contribute to the community through work, education and rehabilitative programs. Whether this reformation occurs or is likely to occur in the prison environment is debated in the literature.

Attitudes towards punishment change over time as does the nature and culture of incarceration. There is a substantial quantity of literature looking at prison culture and how the environment of such an institution develops its own operations and structure (e.g. Bonta and Gendreau 1990; Carriere 1980; King 1999; Lawrence and Andrews 2004; McCormick and Visano 1992; Wright 1985; Zdenkowski and Brown 1982). Much of this literature focuses on coping mechanisms, communication, and the psychological and sociological dynamics of prison life. Group identity of staff and prisoners is also explored (e.g. Sykes 1958; Mathieson 1965).

Self, Imprisonment, Institutionalisation and Mortification

Research looking at institutionalised settings comes from a number of different sources, some direct (e.g., Lombardo 1981; Goldmeir and Silver 1988; Anon 1993) (i.e., research findings), and others from the sociological investigation of institutionalisation and institutional roles (e.g., Goffman's 1961 philosophical study of self and institutions). Goffman argues that an individual enters prison with a pre-conceived sense of self which is relational to "certain stable social arrangements in his home world" (1961, 14). These social arrangements help an individual to create meaning and a framework of their lives. Upon entry to a total institution, such as a prison or psychiatric facility, Goffman claims that an individual is 'stripped' of their personal possessions and social arrangements, thus contributing to what he calls the "mortification of self."

“The [new prisoner] comes into the [total institution] with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. [...] His self is systematically, if often unintentionally mortified. He begins some radical shifts in his *moral career*, a career composed of the progressive changes that occur in the beliefs that he has concerning himself and significant others” (Goffman 1961, 14).

Goffman claims that this confiscation of private possessions (e.g., the removal of clothes and jewellery, having to describe their personal history which is stored in personal files, showering in front of prison staff, and the loss of one’s full name), removes the person from individual identifiers and creates an institutional self. The point of such treatment is to mark a clear separation between the inmates’ former selves and their institutional selves.

Due to the removal of the individual’s social framework an individual may have trouble making meaning of his or her life which is now restricted in social, mental and physical terms. This stripping of basic rights and relationships has negative consequences, and prisons are often experienced as places of “low trust, high vigilance, uncertainty and discomfort” (Toch 1977, 42), where the prevalence of the ‘perceived threat’ demands constant personal caution against danger. It is worth noting here that Toch (1977, 44) proposes that there is additional stigma attached to prisoners who are segregated in protection units. This may exacerbate physical danger if these protected prisoners come into contact with prisoners from the general prison population.

Essentially transitional stress “is caused when an individual is placed in an alien environment such as prison where his or her prior life experience is largely irrelevant and unhelpful” (Goulding 2007, 42). In many cases this results in increased feelings of abandonment, embitterment, isolation and loneliness. These feelings can trigger depression and a sense of helplessness and may contribute to health problems, including mental illness. Over time, these feelings may be reduced or exacerbated

depending on the individual, their coping skills, the type or 'mood' of the institution, and their institutionalised experience (Goffman 1961).

Differences in prison 'mood' are commonly reported in the research literature - "some prisons seem quiet and reserved, others noisy seem noisy and active, whereas others seem safe and predictable. Within prisons, environments also vary from cell block to cell block, or from one program or work setting to another" (Adams and Ferrandino 2008, 919). According to Toch (1992) it is possible for prisoners to find niches in the prison environment that may best suit their needs and where they are likely to function better. These positive niches will reduce stress or other detrimental experiences. An obvious example of this is increased aggression and frustration. Research has shown that there are distinct environmental triggers, such as, heat, overcrowding, direct insults, and increased frustration that will exacerbate aggression and violence (Ax et al. 2007) with prisoner diagnosed with mental illness over-represented in rule infractions (Carr et al. 2006). Lovell et al (2001, 484) found the following features as rated by prisoners to be the most positive in terms of reducing the incidence of psychiatric symptoms "architecture, freedom of movement, protection from the stressors of the general population and availability of activities."

Research by Whitehead, Linquist and Klofas (1987) (supported by Ben-David and Silfkin 1994) looks at another aspect of the prison setting: the relationship between staff and prisoners or as they put it the 'keeper' and the 'kept'. They state that a unique and extraordinary relationship between the 'keeper' and 'kept' emerges in institutionalised (prisons and psychiatric hospitals) settings where the keeper's behaviour is shaped by the expected reaction of the kept. Overall, the research shows that the "environment of a prison can be seen in a variety of ways: a total institution, a community, a rehabilitative and treatment environment all of which are often dictated by the interactions which go on within them" (Paton et al. 2002, 11).

In addition, the prison, as an institution and an environment, is manipulated by both inmate and prison staff as a way to pass time and to work at maintaining some individuality and identity within the prison system which as stated above, by its very nature, works to strip individuality. This can in many ways undermine the intended purpose of the institution. It can also create a dual culture, an 'us and them'

distinction, between the 'keepers' and the 'kept'. This disparity is even greater when one considers that prisoners have extremely limited contact with the world beyond the prison walls while staff come and go at their will, thus creating two diverse cultures within the institution. In order to understand the prison and its purpose, "we must see prison life as something more than a matter of walls and bars, of cells, and locks...we must see the prison as a society within a society" (Sykes 1958, 12), and as a culture within cultures.

Once sentenced and imprisoned a prisoner becomes subject to the operation and function of that institution. The social relations of prisoners are influenced by the manner of operation of a particular prison (Gillespie 2003) and this influence can be very powerful as this environment carries its own norms, moral codes, patterns of deference, and structural functions that are impressed upon each and every inmate, even those who may find these codes, patterns, structures and rules difficult to understand and follow.

The constant profanation of the self by the control mechanisms of staff and the coping strategies of the inmates to maintain a sense of identity are the main interactional dynamics in total institutions. A classic example of the power of the prison and the roles of individuals in shaping behaviour is the Stanford Prison Experiment conducted by Philip Zimbardo in 1971 (Zimbardo 2007). Zimbardo and his team selected 24 applicants to become participants in the experiment (all university students who were not suffering from mental health problems). Twelve participants would be guards; twelve would be prisoners in a simulated prison that was set up in the basement of the psychology department at Stanford University. The experiment would be videotaped and was supposed to last two weeks but had to be stopped after six days.

Upon arrival at the 'prison' the prisoners were subjected to a kind of stripping of identity - strip searches and delousing and being put in a uniform and chained at the ankle. They were also not allowed to use their names and instead were given an ID number. The students acting as the guards were all dressed in a uniform, were wearing sunglasses (to promote anonymity), and were given a whistle and billy club. The guards were instructed to maintain order whatever it took, within some limits.

The findings show just how quickly the roles shaped behaviour and the power of dramaturgy. The guards imposed arbitrary and degrading punishments whereas the prisoners became accustomed to their impersonal status and endured escalating humiliations from the guards. For their part, the prisoners exhibited pathological and withdrawn behaviour. The guards were quick to dispel any rebellion or solidarity exhibited by the prisoners. Zimbardo's experiment lends support to Goffman's ideas of the stripping of identity in total institutions. Further, it highlights how quickly individuals 'become' the roles that they believe are expected and assigned to them. These findings show how easily the behaviour of American soldiers at Abu Ghraib in Iraq and Camp X-Ray in Guantanamo Bay can get out of hand. The power of roles and social situations is enough to shape behaviour in an extreme manner.

Goldsmith (1997) argues that the prison is more than an article or structure of confinement; it is a tool of social control. This tool of social control aims to "reform the criminal, to change him from a social danger and an economic liability into a peaceful and useful citizen" (Norris and Rotham 1998, 12). This structure of confinement uses surveillance and punishment as its main form of control. This surveillance is constant, operating to "induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power" (Foucault 1977, 201). This positioning of power allows control of the many by a few. In Western Australian prisons all units have a middle control room that acts as a central point of observation, as well as cameras, central viewing platforms, and high-tech electric fencing. This is in keeping with the archetypal panopticon described by Bentham and what Foucault referred to as self regulation.

In today's prisons surveillance takes two forms: covert and overt surveillance. Goulding (2007) suggests that overt surveillance consists of actual staff presence, strip searches, body orifice searches, urine testing, the uses of observation cells, and the like. In addition, she suggests that covert surveillance involves more hidden forms. This includes the one-way flow of information where information is gathered to gain control over the observed (Goulding 2007). Record keeping, such as an individual's medical history, prison movements, and family background is one example of covert surveillance. This is information available to staff but not prisoners. Other forms of covert surveillance include surveillance cameras, listening

devices, and metal detectors, and in the future it will include biometric identification technology (Goulding 2007). These forms of surveillance impact on prisoner's personal and emotional lives and came up in the current research as I noted the hesitation of many prisoners to speak about personal matters, or their fear that people 'were in their heads'. This research therefore relates to Goffman (1961, 1969) in a modern context as it was found that control strategies impact on staff lives and prisoner health.

This total institutional environment frequently has unintended consequences as the experience often has "conflicting and undermining environmental factors such as isolation, violence, limited privacy, and dissemination of the criminal trade" (Goldsmith 1997, 110). The prison environment can often serve as a negative influence for prisoners (Stern 2006; Baldry et al 2006; Tony and Petersilia 1999) and encourage them to further 'learn the tricks of the trade', new criminal skills, or become more withdrawn, angry and possibly violent. Incarceration has been shown to make

"a person a target for re-arrest and re-imprisonment; it disrupts social connections and locks people into serial institutionalisation, does not guarantee good or appropriate treatment and often any treatment started is not continued in the community upon release; it makes homelessness more likely, creates connections with criminal culture, ensures the learning of prison culture to survive and often causes self-harm and depression" (Baldry 2008, 10).

Prison Violence and Mental Illness

There are many intertwined issues concerning the treatment of mentally ill prisoners and generally speaking the prison is not a positive environment for many prisoners, particularly those suffering from mental disorders. As the United States Treatment Advocacy Centre (2007, 4) pointed out,

"Illogical thinking, delusions, auditory hallucinations, and severe mood swings often lead to bizarre behaviour by individuals with severe brain

disorders who are in jails and prisons. Such bizarre behaviour is disquieting to other non-ill inmates who frequently react with violence against those with brain disorders, thereby making life in jail a brutal experience for them. A serious form of assault that sometimes occurs behind bars is attempted or actual rape. All inmates in jails or prisons are at risk for such attacks, but inmates who are confused by their illness and less able to defend themselves are more vulnerable.”

According to Kupers (1999), the stressors inherent with imprisonment often worsen psychiatric disorders, their prognosis, and any long-term chances for healing. He goes on to claim that many prisoners diagnosed with serious and long-term psychiatric illnesses receive inadequate treatment and suffer because of unforgiving and ruthless prison conditions. The Senate Committee on Mental Health in Australia (2006, 338) recently commented on the effects of incarceration on those with mental illness. The Committee reported anecdotally that prisons themselves and the control mechanisms in these environments can adversely affect inmates’ mental state. The use of disciplinary techniques including segregation units and safe cells were given particular attention and there was even mention of ‘prison-induced insanity’. Witnesses provided information that suggests that “prison in general and seclusion in particular may have deleterious effects on prisoners who already suffer from a mental illness.” These findings are supported by a recent Prison Reform Trust where it was noted that “too often, people with severe mental illness are held in segregation units, where they endure an impoverished regime” (Edgar and Rickford 2009, 166).

A lengthy report by Human Rights Watch (2003) supports that segregation exacerbates the symptoms of mental illness and increases the risk of suicide for all inmates, but more so for the mentally ill. Other research has argued there is a very fine line between punishment and treatment with regard to isolation and that prisoners who are chronically disruptive earn themselves problematic reputations, spend increasing amounts of time in administrative segregation (punishment) and pose difficult challenges to correctional and health staff (Cohen 2008; Kupers 2008; Toch 2008, Toch and Kupers 2007). Fellner (2006, 401) noted that “punishment is particularly counter-productive-indeed dangerous to the prisoner-when it consists of placing mentally ill prisoners in prolonged segregation.” These findings are supported by

Carothers (2003) who reports that the use of segregation is often associated with negative consequences for prisoners. According to Lovell (2008, 985), there is a need to “establish greater flexibility in prison classification and disciplinary procedures.”

In addition to seclusion and other disciplinary techniques mentally disordered prisoners are often labelled and victimised by other prisoners and staff, and in American prisons, they are called “*dings* and *bugs* on the yard” (Kupers 1999). In Western Australia, mental health prisoners are called *nuff nuffs*, *loopy*, *crazy* and other such terms. I frequently heard prisoner patients called these names during the data collection phase for this research project. Even though staff often used this language as a joke, a coping mechanism, or a way to minimise the emotional impact of working in such an environment, typically this language and name calling was not seen as a joke by prisoners, who did not understand why they were being called names, and could not comprehend the ‘joke’. The findings of Whitehead et al. (1987) (supported by Ben-David and Silfkin 1994) are particularly relevant here. If the nature of the prison environment is shaped by the interactions between prisoners (‘kept’) and staff (‘keeper’) it is important that healthy interactions are fostered that will function to define relationships and create a positive treatment environment. Kupers (1999), reports that due to this objectification by prison staff many mentally ill prisoners withdraw into themselves and their cells, where isolation worsens their symptoms. Many create a scene and end up in isolation (punishment) due to behavioural problems creating more issues for their mental health as they are less likely to receive psychiatric treatment and where “the sensory and social deprivation make them even more rageful and delusional” (Kupers 1999, 16).

The prison environment can have a damaging effect on prisoners and according to Kupers (1999) this deleterious effect is inclusive of prisoners having trouble coping with the prison ‘code’. Many prisoners are “intimidated by staff into snitching or they are manipulated by other prisoners into doing things that get them into deep trouble. They are disproportionately represented among the victims of rape, they are extra-sensitive to the everyday traumas of prison life, and they are massively over-represented among the prisoners in punitive and administrative segregation or ‘lock-up’ units” (Kupers 1999, 17). Similar findings were reported by Adams (1983) and were further supported by Toch and Adams (1989), Gillespie (2003), Walsh (2004) and

Goulding (2007) where prisoners were over-represented in rule infractions and disruptive behaviours. Hodgins and Cote (1990) found higher rates of mental illness among inmates who were persistent management problems. These prisoners were taunted and targeted for cigarettes, money and drinks, and were generally taken advantage of by other prisoners.

A recent study by Goulding (2007) in Western Australia further clarifies this sense of the prison 'code' and an individual's need to protect himself against prison violence. Goulding (2007) interviewed a number of long-term prisoners about their experience of imprisonment and reintegration into the community. The quote below highlights the position of violence with prison subculture:

"The pecking order in jail is simple. Once again it's a survival thing and if you want to do your time in some degree of comfort, and by that I mean physical safety without worrying too much, then you have to display mental and physical toughness. In here that means you have to show that you're capable of looking after yourself physically, so when you're threatened, you react with violence. Sometimes it's even necessary to be the aggressor to keep your position of strength. You don't have to act violently all the time, just enough to be seen by others as someone who it's best not to mess with..." (Goulding 2007, 89).

This harsh and violent environment must be very challenging for all prisoners, but even more so for those with mental illness. This differential treatment and discrimination against mentally disordered offenders may result in limited opportunities for recovery and reintegration (Porporino and Motiuk 1995), and may result in prisoner patients leaving prison worse-off (more unwell) than when they arrived.

The mentally ill in prisons presents many challenges. Prisons are not designed to be therapeutic communities - a problem that many politicians and society struggle to understand as prison is now seen as a solution to remove people from society and rehabilitate them. The use of prison to solve multi-layered and complicated social disadvantages has intensified over the last two decades due to the rapid increase in

“the growth of imprisonment of those with mental, cognitive and multiple disabilities, the homeless and Indigenous persons” (Baldry 2008, 7). The section below will discuss more closely the provision of mental health services in correctional environments.

Correctional Mental Health Services

Mental Health Screening in the Prison Setting

In most countries when an offender is first detained in a prison they are subjected to a brief health screen and are usually seen by a doctor within the first 24 hours of reception. It is important that the screening adequately assess a prisoner’s mental health condition, substance abuse history and suicidal tendencies (Birmingham et al. 2000). According to Stein and Alaimo (1998), the initial screening should involve a structured interview by a mental health worker. They suggest the following minimal requirements be obtained: medical history; psychiatric history; history of past self damaging/harming behaviour and current self destructive plans and intentions; history of substance abuse; victimisation history and any history of suggestive intellectual deficits with testing for intellectual disability if indicated; history of brain damage and disorder and some evaluation of the likely coping mechanism and response to incarceration.

It is hoped that any mental or other health issues will be detected at the time of this assessment. Faulk (1994) suggests that this process generally catches the majority of seriously mentally disturbed offenders but that some will fall through the net. Research at Durham Prison investigated the assessment process for psychiatric morbidity over a seven-month period with new remands. The results show that the prison health screen identified only about a quarter of men with significant mental health problems (Birmingham et al. 2000; Grubin et al. 1998). It is concluded that the opportunity provided by these initial screenings to detect and address the psychiatric needs of prisoners is often missed with an elusive group of men who suffer high rates of serious mental disorder.

Research by Birmingham et al. (2000), focusing on the screening process itself, produced similar findings. The study compared two screening methods; one

commonly used by Durham prison (UK) and the other an independent research tool. Birmingham concluded that the health screen for new prisoners needed considerable revision and improvement if it was to capture a higher proportion of mental health problems. Research shows both positive and negative accounts of initial screenings with anywhere between three quarters and one quarter of mental health problems recorded (Faulk 1994; Birmingham et al. 1996, 2000; Grubin et al. 1998). There is a considerable amount of research that points to the need for improvement of general psychiatric screening measures and also for the development of specific screens to identify and measure rates of personality disorder (Davison 2002).

Davison (2002) suggests that given the high prevalence of personality disorder in most prison populations many of these prisoners must pass through the initial screening undiagnosed or misdiagnosed with other disorders. If problems are detected during the screening process, the appropriate service provision becomes crucial to the prisoner's well-being.

The Current State of Services

The literature that exists on correctional mental health services predominantly focuses on the aims of mental health services within prisons, the number of prisoners with mental health problems and the effectiveness of providing such services within the prison setting. Banerjee et al. (1995) examined the transfer of mentally disordered inmates from prison to specialist psychiatric units, in a scheme known as the 'Belmarsh Scheme', which contracted mental health services to Belmarsh prison in the United Kingdom. The scheme found that 4.3% of new remands required hospital transfer and the Belmarsh Scheme secured in-patient psychiatric care rapidly for all those identified as needing it. In a later study, Murray, Akinkunmi and Lock (1997) conducted an in-depth study focusing on service provision for mentally disordered remand prisoners. The findings show that the services could be improved and that adequate services could be provided if the resources were made available. They later did a follow-up study of mentally disordered patients transferred from prison mental health services to National Health Service (NHS) care. The conclusions drawn were that the prison service had been a major contributing factor in the increase in identification of serious mental illness, in the speed of assessment and in the transfer

of patients to hospital care. It highlighted that the identification of mental illness was reliant on having adequate numbers of mental health professionals available as the referrals came from mental health professionals and not prison officers.

Mental health services in prisons, and in the community in Western Australia, are underpinned by the medical model (Morgan 1993). The medical model emphasises the importance of drug treatment in the management of mental health symptoms and features along with diagnosis of disorders and illness being predominant. The current services provided to the mentally ill who come into contact with the criminal justice system in Australia are diverse, however, according to the literature above appropriate services can be provided, however, there are still many gaps in this service provision (for a full review refer to appendix V 'Forensic Mental Health services in Australia' in Mullen 2001). This thesis aims to help bridge the knowledge gap by focusing on the experiences of staff and prisoners in order to improve understandings of current services and how to improve services in the future.

According to Mullen (2001, 38), mental health services need to be provided at different levels of the criminal justice system and should comprise:

1. "Services at the first point of contact: Many individuals who appear in court have had prior contact with mental health services. There needs to be adequate provision of services to the courts to allow effective mental health assessment, assistance and diversionary schemes.
2. In the Criminal Justice System: As identified above prisons are housing an increasing number of mentally disordered men and women." The provision of mental health services to these people presents many problems and challenges (Metzner 1993; Steadman et al. 1998; Gunn and Maden 1991; Gunn 2000; Glaser 1996). Patients who are suffering from acute episodes are often transferred from prison to inpatient psychiatric facilities, however, this is only one component of the care required (Mullen 2001). In order to effectively manage the mental health crisis behind bars there needs to be a provision of treatment inside and outside of the prison walls."

Inside the prison walls prison culture presents considerable challenges for therapeutic treatment with rigid routines and the necessary enforcement of rules and procedures

over the treatment of individual needs and illness. The prison context adds a layer of impersonality and further isolates already vulnerable people. Mental health, and indeed medical services in general, “often succumb to the dominant correctional culture which overwhelms the smaller and less assertive mental health” (Mullen 2001, 36) and patient culture. This is problematic for mental health services with the psychiatric literature asserting the importance of implementing a therapeutic culture (Conning 1991). Mental health units in prisons remain a very important element but it is always a struggle for medical facilities within prisons to sustain a therapeutic environment.

Prisons by their very nature are designed to punish prisoners and it is argued that prison cannot be a therapeutic community as they -

“cannot serve both punishment and therapeutic purposes because they are antithetical and prison’s primary focus is security not therapy. Prison by its very nature, excludes normal society, promotes prison living skills and actively erodes community living skills, the very skills the de-institutionalisation movement aimed to restore to those with mental health disorders. Most of these persons need long-term social and health assistance and support, which are not achievable whilst cycling in and out of prison” (Baldry 2008, 10).

Effective mental health services (in the eyes of correctional administration) are very often responsive to the needs of management over the needs of the prisoner patient, thus enhancing the difficulty of maintaining holistic and therapeutic treatment. Patient confidentiality is vitally important and needs to be negotiated carefully to allow information sharing but to also respect the rights of the prisoner patients. “Information is power and all too often correctional services demand for sensitive medical information is primarily about asserting power and control over health professionals, and through them over the prisoner” (Mullen 2001, 37). The issue of coercion of prisons to treatment has also presented problems in the past and today the compulsory powers of mental health legislation to compel prisoners to accept treatment is outlawed in most states and territories in Australia. Problems still persist with issues of under and over-medication of prisoners who seek oblivion. Prisoners

can also be transferred to mental health hospitals, where once on the grounds, they can be compelled to take medication and receive treatment. Prisoners can only be housed in psychiatric facilities and subject to involuntary treatment under extreme circumstances and the legal system in any given place provides the framework by which this treatment takes place. The legal context is important to understand as it defines who and why some prisoners are in secured psychiatric treatment and others are in mainstream prison populations.

A Brief History - the Prison System in Western Australia and the Legal Framework for Mental Health and the Prisons in this Research

Historical Overview

Prisons in Western Australia have a long and interesting history. The first prison built by settlers in Western Australia the 'Round House', which was built in Fremantle in 1831 two years after the colony was founded. This building was a place of detention, a courthouse, and place of execution. Rottnest Island was also used as a penal establishment for Indigenous people from 1838 - 1936 (Rottnest Island Penal Establishment for Aboriginal People). On 1 June 1855, the first convicts were transferred into what was later to become Fremantle Prison (Department of Housing and Works 2006). Fremantle Prison was built between 1852 and 1859 using convict labour and was designed to hold more than 1000 prisoners. The first Royal Commission into the Prison System in Western Australia (1889-99) was concerned with:

“the existing condition of the penal system of Western Australia, and to report on the method now in use for the punishment of criminals, their classification, the remission of sentences, and the sanitary conditions of Fremantle Gaol, as well as to enquire into all contracts for supplies of food and other materials for uses in the said gaol” (Thomas and Steward 1978, 52, cited in Department of Housing and Works 2006).

Upon the recommendations of various Royal Commissions, since the Jameson Royal Commission of 1898, Fremantle Prison was decommissioned in 1991, (however, not before a riot broke out in the early 1980s and after 130 years of operating as the

State facility), and was replaced by Casuarina Prison. There are now 13 prisons in Western Australia including one private prison which began operating in May 2001. For an overview of the prisons included in this research please refer to the appendices where a brief description of each prison is provided.

Prisons are probably best understood in relation to the objectives and outcomes that the relevant time and society wished the prison system to achieve. Prison systems in Australia have gone from brutal places of punishment, to the warehousing of prisoners, to the present day system of, what is called, 'managing' prisoners (Cullen, Dowding, and Griffin 1988). This management style is the system adopted in Australia, England, Canada, New Zealand and various parts of the United States of America. In other parts of the world, a warehousing philosophy still prevails whereby prisoners are confined from the beginning to the end of their sentence, and in many third world prisons torture and punishment still goes on (Irwin 2005).

Legal Framework

With colonisation, Western Australia inherited the common law of England. The Swan Australian River Colony was established on 29 February 1829. At that time, there was little sensitivity to the needs of people with mental illness and many Acts and Laws were passed in relation to the rights and treatment of 'lunatics'. The culmination of these 19th century developments was the enactment of the *Lunacy Act 1890 (UK)* (Forshaw 2008).

The first enactment locally was the *Lunacy Act 1871* which, in substance, established many of the procedures for commitment or restraint of the person which are still in force in the *Mental Health Act 1962*. Today, the provision of mental health services for prisoners, as prescribed by legislation, mandates the Department of Health (DOH) to provide services in some circumstance and the Department of Corrective Services in others. Involuntary treatment and mental health care, when ordered by a court or under the *Criminal Law (Mentally Impaired Accused) Act 1996 (Western Australia)* is provided by the Department of Health. The wider groups of prisoners experiencing mental health disorders are the responsibility of the Department of Corrective

Services and are provided mental health services under the *Prisons Act 1981 (Western Australia)*. The Relevant Acts include:

- ❖ "*Mental Health Act 1996 (Western Australia)* - this act mandates requirements for the provision of involuntary treatment including those referred to or from Courts or prisons.
- ❖ *Criminal Law (Mentally Impaired Accused) Act 1996 (Western Australia)* - covers the provision of services for people referred from courts to an authorised hospital for assessment as well as psychiatric care for those on custody orders and found unfit to stand trial or not guilty by reason of unsoundness of mind.
- ❖ *Bail Act 1992 (Western Australia)* - provides the legislative basis for the provision of services to people granted bail on the condition they receive psychiatric treatment.
- ❖ *Prisons Act 1981 (Western Australia)* - covers health services in prisons (including psychiatric services) and the transfer of mentally disordered offenders to psychiatric facilities.
- ❖ *Young Offenders Act 1994 (Western Australia)* - covers the provision of orders for psychiatric assessment of juveniles at an authorised hospital referred from courts and the psychiatric care of those on custody orders who require hospital treatment" (McGinty 2005, 5).

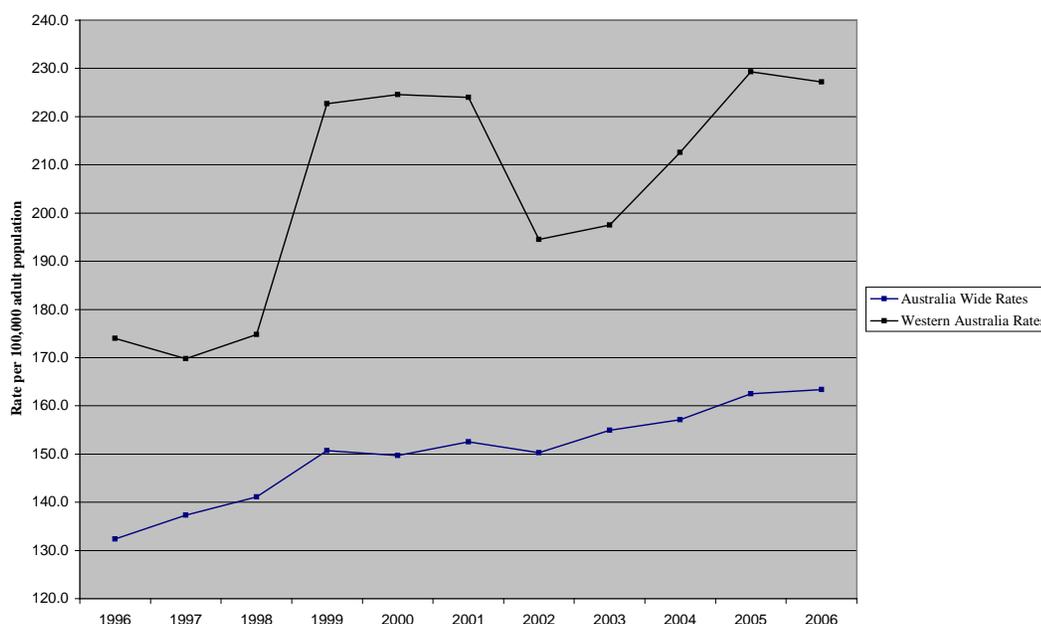
Both the criminal justice and the health legislation give the power to detain people in custody. The *Mental Health Act 1996 (Western Australia)* and *Criminal Law (Mentally Impaired Accused) Act 1996 (Western Australia)* have provisions to ensure an individual is detained in hospital and provided with treatment. These individuals are released when they are assessed as not being a risk to themselves or the community. If an individual is considered a danger to society when released the *Sentencing Act 1995 (Western Australia)* provides for indefinite imprisonment of that individual (McGinty 2005).

The legislation is designed to provide protection to the public and to those suffering from mental illnesses. One area currently under debate in Western Australia is that the legislation does not mandate treatment to individuals with mental health problems unless it is so serious as to warrant involuntary treatment. This raises

questions for the treatment of prisoners suffering from Dangerous and Severe Personality Disorder who may have either indefinite or finite sentences and other prisoners with finite sentences who have mental health problems that are contributing factors to repeat offending. There are schools of thought that would like to see a shift to allow for the mandatory treatment of individuals. The argument here is that mental health issues need treatment and prisoner management is more effective if mental health issues are addressed. This raises many human rights issues and the discussions and outcomes will be an interesting debate to watch unfold.

Imprisonment Rates - Australia and Western Australia

Figure 1: Australian and Western Australian Crude Imprisonment Rates 1996 to 2006 (data collected for this research in 2005)



Over the past 25 years Australia’s prison population has almost tripled. In 1980 the average daily prisoner count was 9746. By the June quarter of 2008 this average daily number had increased to 27, 615. This represents an increase of 1% (391) from the June quarter 2007 (Australian Bureau of Statistics 2008). ABS data for this quarter shows similar trends to previous years with Western Australia continuing to rank second behind the Northern Territory in rates of adult imprisonment. The rate of imprisonment for Western Australia was 230 prisoners per 100,000 adult population,

second only to the Northern Territory (610 per 100,000 adults). The Australian average for the same period was 169 prisoners per 100,000 (ABS, Catalogue 4517.0, Corrective Services, June Quarter 2008). Figure 1 highlights the increasing trends in imprisonment rates in Australia and Western Australia from 1996 to 2006 (Data sourced from ABS Catalogue 4517.0 - Prisoners in Australia, 2006). Over the ten year period, from 1996, the Australian prisoner population has increased by 42%.

Most alarmingly, the Western Australian Aboriginal incarceration rates are even higher than the national average, with the Aboriginal rate of imprisonment standing at 2828 per 100,000; more than 20 times that of the non-indigenous imprisonment rate (ABS, Catalogue 4517.0, Corrective Services, June Quarter 2008). Additional information on Aboriginal over-representation is provided in the indigenous prisoners section further below.

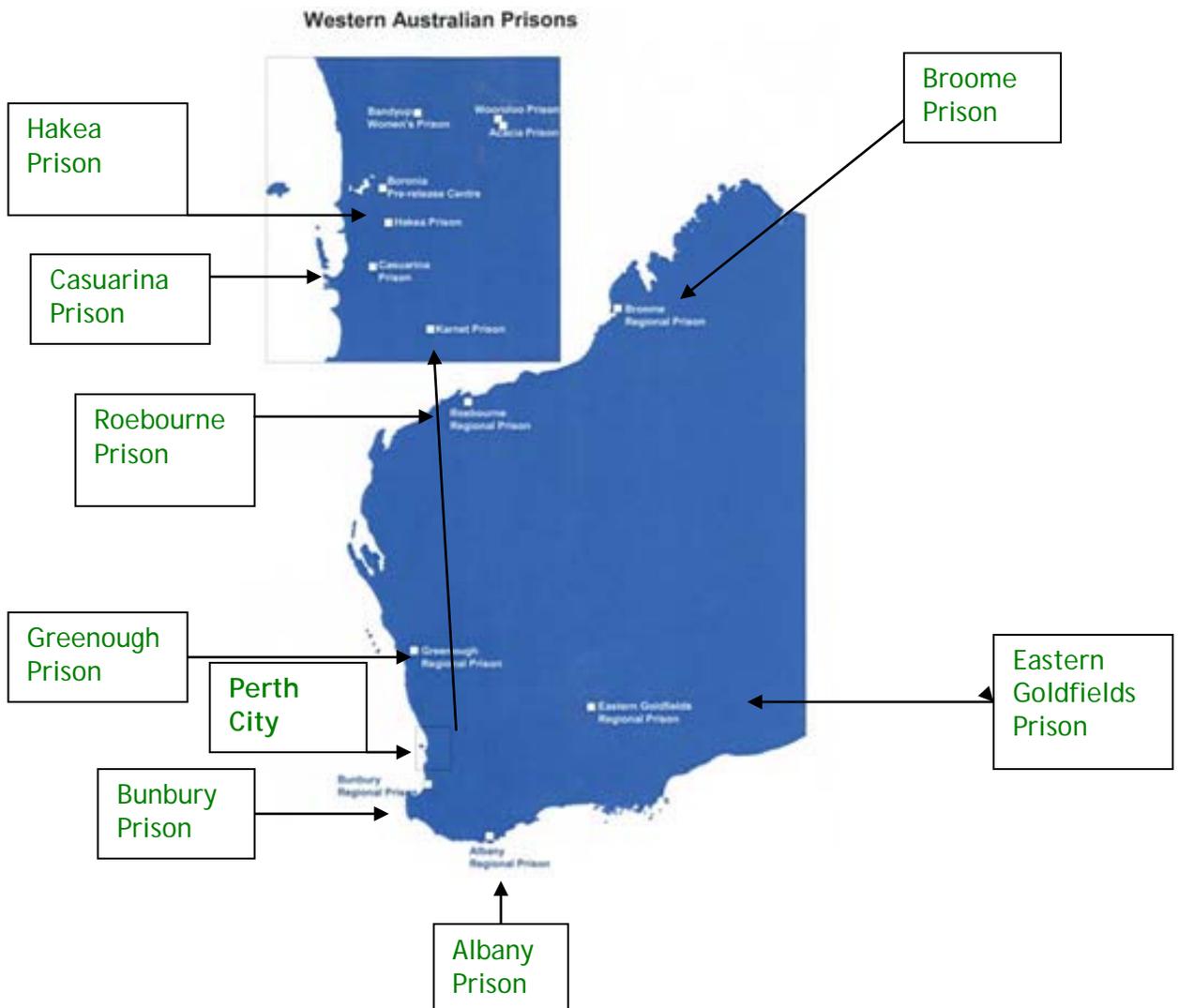
The Prisons included in this Research

Albany Regional Prison manages maximum, medium and minimum-security prisoners and holds a significant number of long-term prisoners. The prison population is male only. The prison was first opened in September 1966 with a capacity of 72 minimum security cells. It was upgraded to maximum security in 1979 and expanded to a capacity of 126 in 1998. Today, the prison design capacity is for 186 prisoners and the work camp capacity is 32. The prison is located 8km west of Albany, 408km south of Perth. Education, recreation and work opportunities are available to prisoners as well as a modern medical centre that is staffed by full-time registered nurses. A doctor is available for weekly consultations and the psychiatrist is available for one half day once a month. The prison does not have a qualified mental health nurse on staff. Correctional staff, health professionals and prisoner patients participated in both phases of this research.

Broome Regional Prison manages male and female prisoners of all security ratings from across the Kimberley region. The prison manages a very high percentage of Aboriginal prisoners and is often termed one of the 'Aboriginal Prisons' due to the high number of Aboriginal inmates. The prison began operation in 1894 and operated for 48 years before being reopened as a police lock-up. It reverted back to a prison in February 1945 and is now the only prison located in the Kimberley region. Broome is

the oldest prison in the State still functioning as a prison. The prison has a design capacity for 66 and a work camp capacity of 46. The prison is located in Broome, West Kimberley, 2415km North of Perth. Education, recreation and work opportunities are available to prisoners. Nursing staff handle most medical needs on a daily basis. Prisoners requiring specialist treatment are sent to the local district hospital. A psychiatrist and psychologist are available. Correctional staff and health professionals participated in phase two of this research.

Figure 2: Prison Geography in Western Australia



Bunbury Regional Prison manages prisoners in single cells in the main prison or in a minimum-security block. The minimum security section is self-contained where prisoners are responsible for all aspects of their care, except for meals. The prison also has a short-term maximum security section for managing people who are remanded in custody to appear in court. The prison opened in 1971 and the minimum security block was commissioned in 1982. A major upgrade was done in 1992 and the self care accommodation was added allowing prisoners to do their own cooking and cleaning. The prison has a design capacity of 188 and houses a male population. The prison is located 11 km south of Bunbury, 180km south of Perth. Education, recreation and work opportunities are available to prisoners and health care is provided by nursing staff, prison counselling service, doctors who visit the prison twice weekly, as well as a psychiatrist who attends fortnightly. Correctional staff and health professionals participated in phase two of this research.

Casuarina Prison is the main maximum-security prison for male prisoners - particularly long-term prisoners - in Western Australia. The prison has a special handling unit (SHU) for intensive high-security supervision of offenders. Most prisoners are housed in six living units - with some units devoted to protection and disturbed and vulnerable prisoners. Casuarina replaced the 130-year-old Fremantle Prison as the State's main maximum-security prison in 1991. The prison design capacity is for 397 prisoners and the prison is located 30km south of Perth. Prisoners are expected to work or study full-time and a range of prison facilities are available including: an induction and orientation unit; a library; a chapel; an education centre; a programs centre; a visitors reception facility; families for the care and protection of vulnerable and at-risk prisoners and an infirmary staffed by medical professionals. The prison infirmary is the biggest prison medical facility in the State and has a similar capacity to a small country hospital. Nursing staff provide 24-hour care and a doctor works full-time, along with psychologists employed by the Department. The prison has a fully equipped dental surgery and x-ray facilities as well as mental health nursing team, safe cells and Crisis Care facilities. Correctional staff, health professionals and prisoner patients participated in phase one and phase two of this research.

Eastern Goldfields Regional Prison is an integrated minimum-security facility, which has a capacity to manage higher security male and female prisoners for a short term. The prison manages a high percentage of Aboriginal prisoners and is

sometimes referred to as an 'Aboriginal Prison'. The Eastern Goldfield Prison replaced the Kalgoorlie Regional Prison in December 1980. The prison is designed to have a capacity of 100 prisoners and the work camp has a capacity of 24. The prison is located in Kalgoorlie-Boulder, 614km east of Perth. There are a variety of employment and educational activities available. There is qualified medical staff available on a daily basis and a doctor visits twice a week. A local doctor's surgery and the regional hospital are available for emergencies. A local community psychiatrist contracts to the prison and provides psychiatric services. Correctional staff, health professionals and prisoner patients participated in both phases of this research.

Greenough Regional Prison manages the Midwest region, extending from Exmouth in the north to Moora in the South, and as far east as Wiluna. The prison maintains a large Aboriginal population. Greenough can manage up to 29 female prisoners and the rest of the population is made up of male prisoners. The prison was built as a minimum-security prison in 1984, replacing Geraldton Prison and was upgraded to a medium-security prison in 1990. The prison has a design capacity of 219 prisoners and is located 15.6km south of Geraldton, 420km from Perth. The prison offers a variety of vocational and educational opportunities. The prison provides nursing staff, and an on-call service is available from the regional hospital and the Aboriginal Medical Service. Doctors visit the prison three days a week and a psychologist is available daily. Correctional staff and health professionals from Greenough participated in phase two of this research.

Hakea Prison is Perth's remand prison and manages prisoners remanded in custody to appear in court or those who have just been sentenced. Newly-sentenced prisoners are assessed at Hakea before being placed at other Western Australian prisons. This assessment and arrival process requires special management as prisoners are often stressed and worried when they first arrive at prison. The Canning Vale Prison was first established in 1982, managing 248 prisoners. From September 1991, Canning Vale operated as a maximum-security prison until it merged with the remand centre in 2000. The Canning Vale Prison and the CW Campbell Remand Centre merged to become Hakea Prison in 2000. The prison has a design capacity of 617 and is for male prisoners only. Hakea is located 27km south from the Perth CBD. The prison has a variety of employment, recreation and education facilities. The medical centre is staffed 24-hours by qualified medical staff and is serviced by a clinical nurse manager

and a mental health nurse manager during business hours. A doctor attends the prison and provides an on-call service. A visiting psychiatrist attends weekly. The Prison Counselling Service provides psychological and social work expertise. A 15-bed crisis care unit serves the needs of a small group of acute and, at times, chronic risk offenders who require specialised treatment and support interventions; specifically but not exclusively those at risk of suicide or self harm. Staff and prisoner patients from Hakea participated in both phases on this research.

Roebourne Regional Prison manages prisoners from the Pilbara and Kimberley regions. The prison manages a high percentage of Aboriginal prisoners. The prison was opened in 1984 after the old Roebourne Gaol was closed. The prison originally managed 70 minimum-security prisoners, but was upgraded to a medium-security facility in 1995. The design capacity is for 116 and the work camp for 8. Prisoners are required to work or attend a number of activities. Correctional staff and health professionals from Roebourne participated in phase two of this research.

Snapshot of Offenders in the Research Settings 2005-2009

A snapshot of adult prisoners taken from the TOMS database in Western Australia on 30th June 2005 (when this PhD research began) reveals that 688 adult prisoners had a recorded psychiatric alert on their medical status report (19% of the total prisoner population). A second snapshot taken of prisoners in Western Australia on 30th April 2009 reveals that 649 adult prisoners had a recorded psychiatric alert on their medical status report (15% of the total adult prison population). A breakdown of prisoners with a mental illness or condition, for the prisons included in this research, at these times is shown in Table 3.

Table 3: Snapshot of mentally ill offenders in custody in Western Australia 2005-2009

Prison Location	30 th June 2005		30 th April 2009	
	% of prisoners as a % of the individual prison population	Number of Prisoners	% of prisoners as a % of the individual prison population	Number of Prisoners
Albany Regional Prison	27%	55	26%	59
Casuarina Prison	27%	146	22%	59
Bunbury Regional Prison	24%	48	17%	41
Hakea Prison	21%	135	18%	140
Greenough Regional Prison	16%	38	13%	32
Eastern Goldfields	14%	13	8%	10
Roebourne Regional Prison	13%	22	8%	14
Broome Regional Prison	7%	7	6%	7

These figures show a 4% reduction in the number of prisoners with mental illness over the research period; these figures are still in line with current estimates of the prevalence of mental illness in global prison populations (also note that these figures do not include personality disorders). However, leading up to the research data collection, pre 2006, there were media reports of increasing numbers of individuals with mental illness in the criminal justice system. It is difficult to determine exact figures and the reliability of the data can be questioned. For example, in 2009 the figures for 2005 were re-run in the Departments TOMS database. The figures were different, albeit marginally, than the figures pulled in 2005. I have taken an average of the figures in this thesis.

The Department of Corrective Services - Managing Prisoners and Health Care

The Department is responsible for the supervision and management of remanded and convicted adult offenders in Western Australia and all prisoners involved in this research. The Division adopts a 'management' approach to prisoners, which requires a balance between management and discipline. This management system emphasises persuasion rather than punishment and is founded on four objectives that the Department has established for its prison system. These are:

- ❖ **Custody** - "Prisoners are to be kept in custody for the period prescribed by the Court at the level of custody (security) commensurate with the risk they pose to the safety and security of the community and others;
- ❖ **Duty of Care** - Prisoners' care and well-being are to be maintained;
- ❖ **Reparation** -Prisoners are to continue to contribute to the community through work and make good the harm done by their offending behaviour;
- ❖ **Reduce Re-offending** - Prisoners are to engage in programs and activities that reduce re-offending" (Mahoney 2005, 48).

Prison Security Ratings in Western Australia

Many factors are taken into consideration when allocating prisoners a security rating of maximum, medium or minimum. Some of these include the length of sentence; the nature of the offence including its seriousness; whether the offence involved violence, was sexual in nature, or was a serious drug offence; any previous escape record; previous performance in prison; and apparent adaptation to the current sentence of imprisonment (Grant and Luciani 1998).

A *maximum security* rating pertains to prisoners who are considered a serious risk to the community or who have a sentence greater than 24 months. This threat may relate to a risk of escape or that the prisoner requires a high level of protection, in the interests of the community or the prisoner. All prisoners are initially rated as a maximum rating but on further assessment, the rating may vary. A *medium security* rating applies to prisoners who pose, or are measured as posing a minor threat to the community. These prisoners are further deemed to be of minimal escape risk and if an escape were to occur, they would pose minimal risk. A *minimum security* rating concerns prisoners who require the least supervision as they are considered a very

minimal risk to the community. Research has shown that prisoners diagnosed with serious mental health problems are less likely to be considered for a lower level of security (Porporino and Motiuk 1994).

Health Services

In Western Australia, the Department's Health Services Directorate provides the majority of prisoner mental health services. This service is provided through a process of assessment, diagnosis and on-going treatment and utilises a community model in managing prisoners. Doctors, Nurses, Dentists, Psychologists/Clinical Psychologists, Social Workers and other staff working on contract are employed by Prison Health Services to provide health treatment across each of Western Australia's prisons. If necessary, arrangements can be made for prisoners to obtain treatment in the public health system.

Mental health treatment within prisons uses a community (medical) model of service delivery with three of the main metropolitan prisons (Casuarina, Hakea and Bandyup) providing services utilising Mental Health Teams consisting of Mental Health Nurse Specialists and Consultant Forensic Psychiatrists. A Forensic Case Management Team provides support to the Mental Health Team with Psychologists, Occupational Therapists and Social Workers providing on-going management of offenders with mental illness. These prisons also have crisis-care units which are staffed seven days a week by Mental Health Nurse Clinicians. Crisis care units are primarily used for the observation and management of prisoners who are at risk of self-harm but due to a lack of alternative services and facilities, these units are also used to manage and monitor mental health clients even when they are not at risk of self-harm.

The Mental Health Team offers the following services:

- ❖ identifying prisoners with a mental illness, gathering a medical history of the prisoner by liaising with past care organisations and delivering appropriate treatment until the prisoner is to be discharged back into community care upon release;
- ❖ assessing all prisoners who are referred for inappropriate behaviour. If a mental illness is detected, then they are treated as above;

- ❖ assessing prisoners for court and Prison Review Board to assist in determining an appropriate sentence or parole condition;
- ❖ providing mental health promotion and education to prisoners; and
- ❖ liaising with other health professionals, including working closely with the Frankland Unit at Graylands Hospital.

Recently (2008) a Clinical Specialist in Co-Morbidity position was introduced into various metropolitan prisons. This position will assess and manage patients with mental illness and or addictions problems, provide education and support, and promote through care for patients.

In addition to the specialised hospital and psychiatric facilities and Prison Health Services treatment prisoners with on-going psychiatric care needs can be released to Graylands Hospital for re-socialisation services prior to release to the community.

The Prison Counselling Service (PCS) provide a team of psychologists and social workers that offer a service to most prisons throughout Western Australia. The service's primary objective is to improve the psychological wellbeing of offenders in custody. The aim is to improve prisoners' chances of adopting law-abiding lifestyles on their return to the community, and to create a safer environment within prisons. PCS conducts Risk and Needs Assessments on prisoners to identify self-harm, suicide and other clinical or behavioural risk factors. The team conducts crisis counselling, critical incident debriefing and interventions designed to enhance the rehabilitative outcomes and adjustment in prisons and prepare offenders re-entry into the community.

Secure Units and Forensic Mental Health Services

The State-wide Forensic Mental Health Service provides care and treatment for mentally ill persons involved in the criminal justice system. The Frankland Centre is a medium secure unit in the grounds of Graylands Psychiatric Hospital. It provides 30 in patient beds for:

- ❖ Acute cases of prisoners becoming mentally ill;
- ❖ Persons referred for assessment by the courts;

- ❖ Persons found not guilty by reason of unsoundness of mind or unfit to plead (McGinty 2005).

Prisoners referred to the Frankland Centre from prison have an average turn around time of 10 days, before returning to prison. The preferred treatment cycle would be 4-8 weeks. At present, this is not possible for most prisoners as there is very high demand for beds at the Frankland Centre creating high turn over times and reducing the average length of stay. This reduction in length of stay for prisoners has made it difficult to hold prisoners for the time required for effective treatment (McGinty 2005).

Initial Screening and Assessment in Western Australia

In Western Australia all new prison arrivals are assessed at the Prison Assessment Centre (Hakea Prison) by reception staff. This involves a risk assessment interview. Prisoners then undergo a health assessment by nursing staff where it is expected that the screening will detect any mental health history and issues. If mental health issues are identified, prisoners are referred to a mental health nurse or a general practitioner for further assessment or to the visiting psychiatrist for a comprehensive psychiatric assessment and ongoing treatment. If missed during the initial screening, prison staff may refer inmates for diagnosis and treatment when their mental health issues become apparent.

In addition to the initial assessment and screening the Department in Western Australia provides educational and vocational assessments Educational, Vocational and Treatment Assessment, the At Risk Management System (ARMS), Peer Support Teams, Prison Chaplaincy Service and Prison Based Individual Counselling for offenders with mental health problems.

Indigenous Prisoners, Over-representation and Mental Illness in Western Australian Prisons

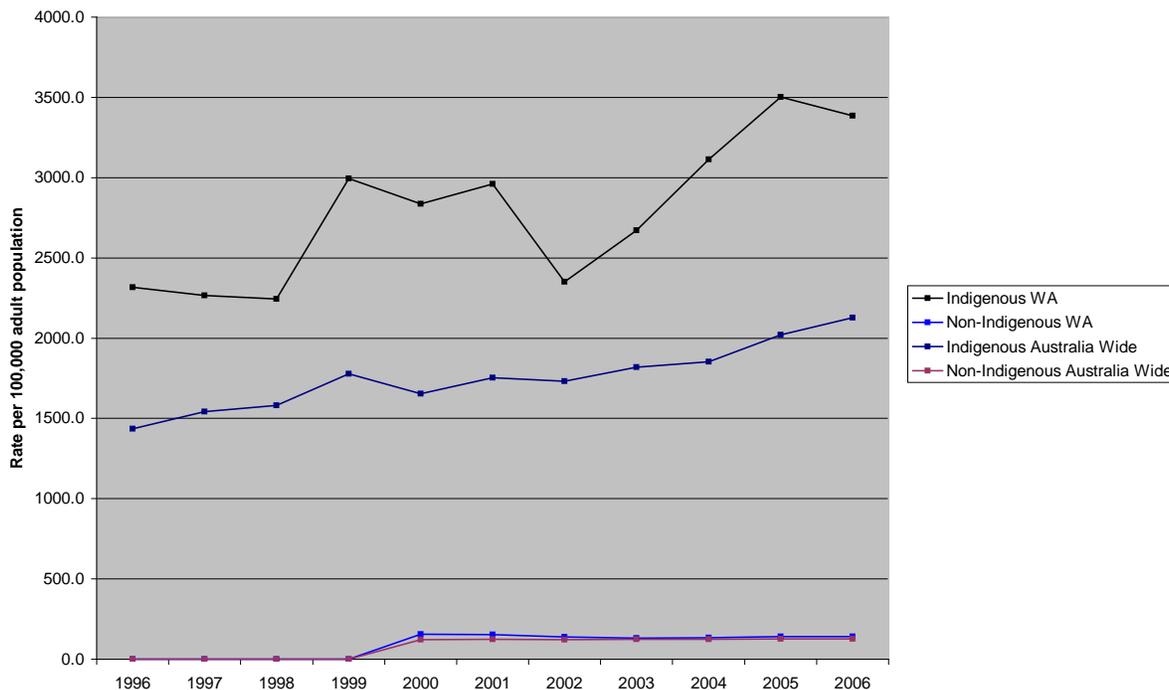
“Whatever else prisons may be for, they have always housed large numbers of the poor, the unemployed, the unemployable, the homeless, the physically ill and the mentally disturbed. From time to time...these staples of the prison population have been augmented by large contingents of other ‘problem’ populations such as ethnic minority groups, political protesters, and...unemployed youth...as commentary on the blatant inequities of the criminal justice system” (Carlen 1994, 309).

Indigenous Imprisonment Rates

Aboriginal and Torres Strait Islander people are the most disadvantaged of any group in Australia. On all major indicators, such as health, housing, education, employment and contact with the justice system, Indigenous people are significantly worse off than other Australians (Kirmayer, McDonald and Brass 2000; McDonald 1996; McKendrick and Thorpe 1996; Swan and Raphael 1995).

Increased contact with the criminal justice system has resulted in a large proportion of Aboriginal prisoners in Australia, and Western Australia is no different (Cunneen, Luke and Ralph 2006; Edney 2001; Gray and Sputore 2001; Loh and Ferrante 2003; MacWilliam 2001). Western Australia has one of the highest rates of imprisonment in Australia, particularly the over-representation of Aboriginal people. Although Aboriginal people comprise only 3% of the general population of Western Australia, they comprise approximately 40% of all inmates in prison. According to Loh and Ferrante (2003), Indigenous Western Australians are one of the most imprisoned peoples in the world and this trend is increasing.

Figure 3: Australian and Western Australian Crude Indigenous and Non-Indigenous Imprisonment Rates 1996 to 2006 (date collected for this research in 2005)



Indigenous offenders make up a high proportion of the prison population in Australia and research indicates they have similar needs to the mainstream population but also have their own set of culturally specific needs. Figure 3 shows the increasing trends in Western Australia imprisonment rates. According to the Australian Bureau of Statistics (ABS) 2008, the adult prisoner population has increased by 42% over the last decade and Aboriginal imprisonment has increased significantly.

An analysis of the more recent imprisonment of indigenous Australian's indicates that between 2005 and 2008 the rate of indigenous imprisonment raised from 11,561 to 11,769 per 100,000 adult populations. Western Australia has the highest incarceration rate of indigenous people and the highest disproportionality, with an imprisonment rate of 2828 and a disproportionality of 19.8 times. (Daly 2009, 2).

Statistics of the Adult Custodial population in Western Australia indicate that on the 9th of July 2009, a total of 1,627 indigenous males and 159 indigenous women were in custody. The recidivism rate of indigenous offenders in Western Australia for the

period 1 April 2006 to 31 March 2007 was recorded at 59.43%, this compared with a rate of 35.01% for non indigenous offenders (TOMS).

Management of Offenders in Custody Report

Below is an overview of some relevant data relating to imprisonment, Aboriginal imprisonment, arrest rates and sentencing as discussed in the 'Management of Offenders in Custody Report' (The Mahoney Inquiry, 207-279). This information highlights the challenges faced by Aboriginal people and by prison administrators who are managing increasing numbers of Aboriginal prisoners.

Imprisonment Trends

The Mahoney Inquiry reported increasing trends in Aboriginal imprisonment in Western Australia. According to the report, just under half of the adult prison population is comprised of Aboriginal offenders and this group of offenders have the highest rate of re-offending.

"From June 2002 to March 2005, there was a consistent trend of increasing rates of Indigenous imprisonment from 31.1% (872 persons) to 41% (1442). In this period, Indigenous imprisonment experienced a 61.4% increase while non-Indigenous imprisonment increased 5.3%. This means that the increase in imprisonment in Western Australia in the past three years is primarily Indigenous prisoners."

Distribution of Indigenous Population

About two thirds of the Indigenous population live outside the metropolitan area.

"The Department of Indigenous Affairs says that there are nearly 300 remote and town-based discrete Indigenous communities. In approximately 35% of these communities, the main language at home is an Indigenous language. In total, there are about 80 different Indigenous language groups across Western Australia." "The Indigenous prison population is distributed throughout the State with roughly half of Indigenous prisoners in the metropolitan prisons and half in the regional prisons. In 2004-2005, the average number of Indigenous prisoners in metropolitan prisons was 726 and the average number of Indigenous prisoners in regional prisons was 613."

Arrest Rates

Arrest rates have continued to increase for Indigenous people over the last 13 years.

“In 2003, Indigenous persons were arrested at almost 12 times the rate of non-Indigenous persons. In 2003 the Kimberley and Pilbara regions had the highest rates of Indigenous apprehensions. Indigenous persons comprised 22.3% of all finalised charges in the Lower Courts in 2003. Good order offences made up almost two-fifths (38.1%) of these charges while driving and vehicle offences accounted for one quarter (25.8%). Property and violent offences accounted for 16% and 11.6% of Indigenous charges, respectively.”

Sentencing and Imprisonment Rates

Indigenous people are more likely to receive custodial sentences for all offences with the exception of property offences.

Underlying issues which explain over-representation

Many factors contribute to offending and over-representation, and broad-brushed approaches at explanation have included analysis of different treatment by the criminal justice system, different offending patterns and different frequency in offending. Some explanations have looked to the similarities with non-Indigenous explanations for criminal behaviour and stressed criminogenic factors deriving from socio-economic disadvantage (Walker and McDonald 1995). Some recent explanations have looked at the effect of cultural conflict and spatiality (Broadhurst 1997), and the differential impact of criminal justice system policies on Aboriginal people because of their socio-economic position (LaPrairie 1997). Moreover, others such as Cunneen (2006) argue that “Aboriginal Australians’ experiences of removal, dispossession, exclusion from education and employment, as well as institutional discrimination” are factors that cannot be overlooked when considering the high rates of Indigenous offending and incarceration (Baldry 2008, 10).

There is a need for development in the literature from single causal explanations (such as poverty and racism) to multifaceted conceptualisation of Aboriginal over-representation. An adequate explanation involves analysing interconnecting issues

which include historical and structural conditions of colonisation, of social and economic marginalisation, and systemic racism, while at the same time considering the impact of specific (and sometimes quite localised) practices of criminal justice and related agencies (Cunneen 2001a, 2001b).

Some important and specific factors necessary to explain Aboriginal over-representation include the offending patterns and the over-representation of Aboriginal people for offences likely to lead to imprisonment; policing strategies and the impact of police discretion and 'over-policing' in Aboriginal communities; changes in legislation; judicial decision-making; environmental and situational factors; cultural issues and differences; socioeconomic factors; marginalisation and the impacts of past colonial policies (Baker 2001; Cunneen 2001c, 2006; Cunneen, Luke, and Ralph 2006; Cunneen and Robb 1987; D'Abbs 2001; Harding et al. 1995; Hunter 2001; Luke and Cunneen 1998; Walker and McDonald 1995).

Two of these factors, unemployment and poverty, and drug and alcohol issues are covered extensively in the literature and will be considered briefly below. According to the Human Rights and Equal Opportunity Council (HREOC) "mental illness amongst Aboriginal and Torres Strait Islander people is a common and crippling problems which goes undiagnosed, unnoticed and untreated" (HREOC 1993, p695). The HREOC reported an association between socioeconomic starts and undiagnosed mental illness often resulting in antisocial and self-destructive behaviours and involvement in the criminal justice system.

Cunneen and Robb (1987), Devery (1991) and Beresford and Omaji (1996) have documented the impact of high levels of socioeconomic disadvantage and unemployment and poverty on Aboriginal people. It recognises the association of social problems such as crime, with unemployment and income inequalities. They suggest that due to the lack of employment, educational and other opportunities, crime becomes problematic for communities. They further argue that social policies aimed at improving these conditions are likely to have a significant effect on the reduction of imprisonment rates (Walker and McDonald 1995). More recently, Hunter and Borland (1999) found similar results. They argue that high rates of arrest for

Aboriginal people is one of the main factors in reduced employment and that improving work options for Aboriginal people would in turn reduce rates of arrest.

Other researchers have looked at the impact of drug and alcohol issues on offending behaviour. On a per capita basis, non-Indigenous individuals consume alcohol at a greater rate than Indigenous people. Thirty two per cent of Indigenous people do not drink alcohol compared to 16 per cent of non-Indigenous people. However, Indigenous people are more likely to consume alcohol at more dangerous levels and are consequently more likely to be admitted to hospital (Hunter 2001). In addition, this alcohol consumption has been directly related as one of the largest single factors underlying overall Indigenous arrest rates. High rates of other substance use are reported amongst Aboriginal people (Hunter 2001).

The *Royal Commission into Aboriginal Deaths in Custody* (1991) and research looking at the impact of the Stolen Generation provide additional and comprehensive information regarding Indigenous people in custody and help to explain the issues behind their over-representation. The information on over-representation contained in these documents will not be reproduced here, however information relating to the prevalence of mental illness in Aboriginal populations is discussed below. For further information regarding over-representation, please refer to these reports for a comprehensive review.

Mental Illness and Cultural Meaning

Some anthropological studies have been conducted to investigate mental health and disorders in Aboriginal communities (Morice 1978, 1979). These studies report that there are a number of mental health issues common to most Aboriginal groups. Aboriginal communities are struggling with the interconnected problems of:

- ❖ “high rates of mental disorder combined with poor general health and extreme socioeconomic deprivation,
- ❖ Paucity of good-quality data about the extent and nature of mental disorders,
- ❖ Under use of mainstream mental health services, and
- ❖ The provision of culturally appropriate, high-quality, accessible mental health services” (McKendrick and Thorpe 1996, 140).

Qualitative research undertaken in Perth and the Kimberley region in Western Australia has highlighted major gaps in service provision to Aboriginal people (Vicary and Westerman 2004). In the study seventy Aboriginal people were interviewed about their beliefs and attitudes towards mental health, Western psychology and practitioners, and strategies for improving service delivery. The report found that Aboriginal conceptions of mental health, and in particular depression, differ to current Western Eurocentric perceptions. The findings show that significant cultural interpretations are made about an illness and its ability to be treated by Aboriginal people. One interesting finding from the study is the interpretation of an illness termed as *longing for, crying for, or being sick for country*, which showed similar symptoms to clinical depression. The cause of the disorder is removal from one's country, place of dreaming, or spirit for extended periods of time. In addition, the study found that participants had significant fear of the Western mental health system.

Other sensitive spiritual and cultural issues are identified in Aboriginal culture and recognised by the Department of Corrective Services, including being married *wrong way* and inherited mental ill health, being *caught out* at law time, *payback* which may be related to one not going through payback, fear of payback, payback not occurring in its traditional form or ongoing intergenerational payback. Others include gender specific syndromes, *sorry time*, self-harm, pathological grief, anxiety and hysteria, psychosis, shame, physiological reactions, transgressions of avoidance and skin relationships and love spells. The presence of these syndromes may be observed through the prisoner behaving in certain ways, either at reception, or at any stage during their prison sentence. Prisoners may talk or refer to spiritual visions and/or voices, dreams and visions or by responding strongly to symbols, such as, animals, feathers or birds. Prisoners may also ask to be relocated from one prison to another, exhibit heightened levels of anxiety, refuse to move between cells and/or living areas, attempt self-harm, may undertake burning ceremonies to deter unfriendly spirits, become withdrawn and isolated or stop eating. Prisoner hygiene may also deteriorate, they may paint their bodies or exhibit other health related problems (information adapted from Department of Corrective Services internal memorandum looking at disturbed and vulnerable prisoners, unpublished 2007). It is important to consider these culturally specific behaviours when diagnosing Aboriginal prisoners,

however as these behaviours are not classified by Western notions of medicine it is likely that they will be diagnosed as mental illness.

The 2005 Mahoney Inquiry into the management of offenders in custody reports that there is “insufficient custodial infrastructure in the regions to enable Indigenous offenders to be placed in the prison closest to their home...there were 343 Indigenous offenders placed in prisons other than the one closest to their home” (302). The report goes on to say “there is an even larger number of Indigenous people in the seven prisons other than the four ‘Aboriginal prisons’ (303). It is possible that this removal from land via imprisonment accounts for some mental illness diagnosed in Aboriginal offenders.

Other findings demonstrate that Aboriginal health workers in Aboriginal communities report increasing trends and effects of stress on Aboriginal people and that many of the patients have mental disorders or are significantly psychologically distressed (McKendrick, Cutter, McKenzie and Chiu 1992). Research reports that depression, anxiety, substance abuse and other high risk behaviours are prevalent and that Aboriginal men seem to be at greater risk of mental illness than Aboriginal women (Smye and Mussell 2001). According to Swan and Raphael (1995, 76-77):

“The mental health needs of Aboriginal men as a group are largely undefined, as more often, men tend to ignore their emotional needs, or respond to emotional distress by acting out or self-medicating with alcohol and other substances. That Aboriginal men do have special needs is evident from indicators such as their high rates of imprisonment, for a variety of offences, in some instances of a minor nature to more serious violence and sexual offences.”

The Mental Health of Aboriginal People in the Prison Setting

Indigenous people are over-represented in the criminal justice system in all jurisdictions in Australia (Cunneen 2006). In Western Australia Aboriginal people make up 40-50% of the prison population and the prevalence of mental illness is estimated to be higher in Aboriginal communities than in non-Aboriginal communities. According

to the Department of Corrective Services (2005) identifying the number of decision-making disabled and mentally ill Aboriginal persons in contact with the justice system is problematic due to four factors:

- ❖ the absence of sound statistical data regarding the extent of disability in the community (further complicated by the need to have culturally appropriate assessment tools);
- ❖ limited information on the extent of decision-making disabilities within the justice system;
- ❖ differing frameworks in Aboriginal and non-Aboriginal communities for defining and understanding decision-making disability and mental illness; and,
- ❖ the tendency for Aboriginal persons to 'mask' decision-making and other disabilities.

These issues are compounded by the fact that few of the services and programs available are culturally specific to Aboriginal people or geographically accessible in many instances. The Mahoney Report outlines the need for a prison for Indigenous offenders that "should be different, both in form and in administration, from a prison for non-Indigenous offenders...there may need to be different processes and structures to achieve the same outcomes as that intended for non-Indigenous offenders" (312).

Other literature reports major discrepancies in the mental health and emotional wellbeing of Indigenous Australians compared with non-Indigenous peoples (AIHW, 2006). The literature shows that Aboriginal offenders demonstrate higher rates of alcohol and drug related problems and high rates of mental illness (Kariminia, Butler and Levy, 2007; Krieg, 2006). Moreover, the findings from a recent prison based study show that Aboriginal people are less likely to have received treatment or assessment for an emotional or mental health concern than non-indigenous people (Kraemer, Gately and Kessell 2009). This could be due to concerns on the part of indigenous people to access mental health services or receive help from non-indigenous services.

Much of the relevant information available on Aboriginal Mental Health is from the Royal Commission into Aboriginal Deaths in Custody Report, which was briefly discussed in the self-harm section above. This section draws extensively on this report

because it provides a comprehensive approach to Aboriginal related issues in a custodial setting. The following information is adapted from volume three (chapters 23-25) of this report.

The Report points out that mental health is often the result of dynamic and interactive processes that involve situational, genetic and social determinants. Dr Joseph Reser from James Cook University points out [that]: “the question of Aboriginal mental health is embedded in a larger set of questions relating to culture and cultural differences, historic events, social and cultural change and coping” (ref. 23.3.8).

Sister Pat Swan stated [that]:

“200 years of unfinished business...the devastating experiences of Aboriginal parents and their families brought on by the removal of their children, the loss of control over their own lives, powerlessness, prejudice, and hopelessness have left many problems for us to deal with today, including dislocation, self esteem and identify problems” (ref. 23.3.9).

An understanding of Aboriginal mental health is further limited by conventional Western concepts, spirituality and medicine. As Professor Arthur Kleinman a psychiatrist and anthropologist, has pointed out:

“Concepts of mental illness and psychiatric care appear to reflect a value neutral science. These concepts are informed by a cultural construction of social reality that reflects a mixture of empirical knowledge, professional ideology and shared cultural bias...Any approach must be broad enough to recognise the importance of cultural differences and the diversity of aboriginal culture and other experiences...such an understanding is essential in assessing the meaning of specific behaviours. Without such an understanding, some behaviours may be interpreted erroneously as indicating mental illness. Some disturbed behaviours of Aboriginal and non-Aboriginal people may be a manifestation of mental illness, similar behaviour may be a reaction to social forces and not indicative of any underlying mental illness. Non Aboriginal viewers of Aboriginal emotional

responses and expressions may mislabel it as a mental disorder" (ref. 23.3.11).

Other researchers support Kleinman's concerns and warn that one needs to be careful of the increasing uses of Western diagnostic measures as these categories have a tendency to result in over-diagnosis and in some cases label difference as deviant. Cross-cultural interpretations of mental illness must be considered in order to minimise ethnocentric bias and to overcome limitations of the medical model (Thomson and Briscoe 1990). Hunter (2003) reminds us that psychiatry is a social construct and that psychiatric disorders cannot be understood in isolation, instead consideration must be placed on the social and cultural context in order for perceived behavioural aberrations to be understood.

The Report of the Royal Commission into Aboriginal Deaths in Custody (1991) outlined that the use of a Western non-Aboriginal viewpoint as a benchmark by which Aboriginal culture is to be measured is loaded with potential complications. Mental health problems are defined by the Psychiatric field in terms of referring to problems individuals have adapting to modern standards of living, whether individuals are able to cope in certain circumstances or whether there is an inability or deprivation. The application of this approach has clear limitations when applied to Aboriginal people as highlighted above with the outline of culturally specific symptoms. For further insight there is a desperate need for more research to deepen the understanding of mental illness among Aboriginal people.

Summary

This section has briefly discussed the prison environment. The literature and theory on prisons shows they are complex social systems designed for "incapacitation, deterrence, retribution and reformation" (Norris and Rothman 1998). The prison environment has been shown to strip individuals of their sense of self leading to feelings of abandonment, embitterment, isolation and loneliness (Goulding 2007). Prisons use a number of tools to assist in the management of prisoners, namely surveillance and control, which further impact on prisoners' personal and emotional lives. Furthermore, prisons have been shown to be violent and harsh environments

where prisoners must conform to the prison 'code' in order to get by. Many prisoners find it difficult to adjust and make meaning of their lives in this context and it would not be surprising if this was exacerbated when suffering from a mental illness. Mental health services are available in most prisons; however, the literature shows that the screening, assessment and treatment of mental disorders still has a long way to go. The over-representation of Aboriginal people in Western Australian prisons presents unique challenges to service providers and researchers in Australia. There is a need to focus on language and culturally specific symptoms in order to deepen knowledge and target services.

The following section will discuss prisoner's experiences of mental health services, living in the prison environment with a mental illness, and will discuss correctional staff and health professional's attitudes and roles.

Section Two: Prisoner Patient and Staff Experiences

Introduction

Section One above provided an overview of the prison environment which can be seen to be a difficult place for most people to live and work. Further, it presented information about mental health services, the opportunity for positive treatment to be provided in prisons, and what levels of service are required across the criminal justice system. The information on Western Australia shows that imprisonment rates are on the rise, that Western Australia faces unique challenges with the over-representation of Aboriginal people in prison, and although the Health Services Directorate has a focus on providing treatment, there is a need for improved understanding of mental illness in Western Australia prisons. The criminal justice system and prisons can be viewed as a service in transition; there is an opportunity to build services to adequately treat vulnerable members of our community whilst in prison, to reduce recidivism, and to strengthen community services to divert people from the system in the first instance. This section builds on the contextual information provided above and focuses on the people who live and work in prisons.

Prisoner Experiences and Attitudes to Mental Health Services

There is a diminutive quantity of research looking at the experiences, perceptions and attitudes of prisoners (especially reported in their own voices) who are incarcerated and suffering from a mental disorder. The limitation of this research is both international and within Australia. It was the recognition of this gap that prompted the journey of this research.

Kupers (1999, 16) provides an interesting anecdotal example of a prisoner he interviewed in a US prison: "Charles, a twenty-seven-year-old African American man, has been in the isolation unit for a year. He explained to me why he was first sent to lock-up:

'I was being scapegoated by the other prisoners. I complained to the guards but they didn't take me seriously, so I had to throw faeces at the guards to get myself removed from a very dangerous situation'....Charles's sensitivity and lack of impulse control prevented him from getting along on the mainline (the general population area of a prison). Other prisoners would taunt each other, perhaps they would begin throwing things, and then Charles would 'go off' and flood the range (tier of cells) by stopping up his toilet, or he would be the one to initiate the excrement slinging. Charles does not understand how the other prisoners can 'get rowdy', then calm down when the guards come by, and ask who started the ruckus. He is unable to calm himself. He remembers being 'thrown in the hole' soon after arriving at the penitentiary. The other prisoners soon learned they could cause Charles to be sent to lock-up by taunting him and then acting innocently when the guards came to investigate. Charles would not settle and was always sent to lock-up. Charles' mental state began to decline further and he started hearing voices telling him to kill someone. At this time, he wonders momentarily whether he is delusional but quickly reverts to insisting: 'There has to be a plot, why else would I be the one who keeps getting in trouble even though the other prisoners do worse things?' The pattern kept escalating until the guards began calling Charles 'cuckoo', and he began throwing excrement at them. That was before, after several years, he was seen by a psychiatrist and

diagnosed as paranoid schizophrenic...Charles stated 'I can't concentrate. There's a lot of noise. Other prisoners are always calling you something, hassling you, all night long. It makes my voices worse, they tell me to kill someone. Sometimes I get depressed, then I do something ignorant like yelling back or flooding the range'..."

The prison context often manages disruptive individuals through the use of segregation and seclusion (Cohen 2008; Kupers 2008; Lovell 2008) regardless of whether the disruptive behaviour stems from "bloody-mindedness, distress, mental disorder or even suicidal and self damaging behaviours" (Mullen 2001, 36). A culture of hierarchy and coercion can dominate the structure of correctional systems and be mirrored in the subculture of prisoners themselves (Mullen 2001). Mental disorders and related behaviours are seen as signs of weakness and vulnerability, which is never a safe position in the prison environment. Those who do seek mental health treatment are at risk of being seen by staff as attempting to evade the rigors of prison, and by fellow prisoners as weak. Prisons and jails by their very purpose are supposed to maintain a culture of punishment and often provide harsh and unforgiving environments which very often amplify distress and disorder (Cohen 2008; Kupers 1999, 2008).

In Australia and internationally, a disturbing and distressing picture is often painted by the literature, documentaries and other media of life within the prison walls. There are many examples of abuse and neglect of suspects and offenders with mental illness (as well as other groups of offenders), primarily by other prisoners and by the corrective services in general. It is argued that prisoners with mental disorders are identified as vulnerable and weak within the system. They often experience a lack of support with personal hygiene, are subject to sexual assault by other prisoners and by correctional staff (increasing their exposure to Hepatitis C). In addition, they may be abused or victimised in other ways such as having property stolen, or being used by more intelligent and functioning offenders to disobey institutional rules or undertake illegal activities (Denkowski and Denkowski 1985; Glaser and Deane 1999; Goulding 2007; Hall 1991; Osman 1988; Petersilia 1997; Smith et al. 1988; Walsh 2004).

Hayes and Craddock (1992) suggest the possibility of some prisoners committing suicide as the final sanction from the prison environment. It is difficult to determine the extent of victimisation of prisoners with mental illness, as official prison records are unlikely to cover all (or many at best) incidents, and victims may be reluctant to report abuse for fear of retaliation from other prisoners or being placed in isolation or protective custody (Finn, 1989). People with decision-making disabilities may not have the verbal or written skills to make a complaint, may withdraw complaints due to the pressures of questioning, and may not even be conscious that abuse is taking place (Hayes and Craddock 1992; Langford 2005; Steiner 1984).

Some researchers have been reluctant to gather the views and experiences of mental health prisoners claiming that their perceptions are unreliable (Lebow 1982), however more recently the body of research in this area has expanded and the view that mental illness does not preclude people sharing their experiences has developed (Lidz et al. 1995). Research further supports that many people with mental illness are in a position to comprehend and give consent to participate in research (Carpenter et al. 2000).

Research looking at patients' attitudes to mental health services shows that one of the most influential factors in perceived positive service provision is the establishment of a therapeutic relationship between the patient and service providers. If this relationship is not present, patients report a higher level of dissatisfaction with services (Byrt and Reece 1999; Ryan et al. 2002). Patients report that discipline and institutional controls are a negative aspect of care and are seen to be punitive (Hinsby and Baker 2004) as are concerns of restrictions on personal liberty (Morrison, Burnard and Philips 1996; Riordan, Smith and Humphreys 2002). In addition, prisoners reported that they would like more information and improved communication with staff (Skelly 1994a, 1994b).

Research by Visher et al. (2005) using qualitative interviews and a quantitative follow-up survey, reported that male prisoners (n=81) in Cincinnati had mixed experiences of mental and health care. Their findings supported the findings of Skelly (1994a, 1994b) with prisoners wanting increased access to health information particularly upon release. In addition, they reported that 75 percent of the sample

reported that they were not satisfied with the quality and 63 percent of the sample reported that they were not satisfied with the availability of health services/care while incarcerated (both physical and mental). Sixty five percent of the sample reported not receiving medical care they thought they needed and 41 percent reported not receiving necessary dental care. However, only 14 percent reported not getting mental health treatment and 2 percent reported not getting substance abuse treatment they needed. Approximately one-third of the sample agreed or strongly agreed that they had access to the nurse, doctor or dentist when needed, 42 percent felt they had access to medication, and a majority (70 percent) agreed or strongly agreed that they had access to the psychologist or psychiatrist when they needed it. Interestingly, prisoners reported that mental health treatment was more accessible than physical health treatment. The most frequent complaints noted in the study related to the long waits to access health staff when the problem was urgent (as one prisoner commented "sometimes you might need medical attention right then, and then they put you on a sick call list, and you're waiting and waiting and waiting and getting worse", 175), and that many of the doctors and nurses were insensitive and uncaring. Other prisoners reported that if they complained about their mental health medication they often risked being sent to solitary confinement (Visher et al. 2005).

In contrast to the above findings Caplan (1993, 29) found patients reported average levels of concern, helpfulness, support and comfort from peers and nurses, leading to the finding that relationships in a correctional and prison setting can be characterised as supportive, understanding, encouraging and helpful. The study found adequate access to services when required.

Goulding (2007, 66) asked prisoners about prison officers' role and received some interesting responses. For example one prisoner stated that "prison officers aren't welfare workers...how could an officer be a welfare worker when the next minute he could turn the key on you or put you in shackles...it's a conflict of interest...but as far as prison officers being prison officers, as it is, they are the enemy. That's it." Goulding (2007, 67) also asked prisoners if they might approach a prison officer for help with a problem of a personal nature, one prisoner responded in this way:

“I’ve never taken my problems to any representative of the powers that be. The way I see it, and it’s part of the survival thing as well, if you go and tell your problems to the powers that be they tend to use that vulnerability against you in a form of emotional blackmail. I learnt that at an early stage so then I just closed off to them and I wouldn’t tell them shit...I wouldn’t, due to the lack of confidentiality.”

The responses Goulding noted were centred on hostility and distrust of the system. This is in keeping with Goffman (1961, 83) where he outlined that prisons, as a particular type of the total institution, are structured to protect the public against intentional threat and, as such, they do not have as a primary purpose “the welfare of the persons thus sequestered.” It is interesting that Goulding’s findings are very different to the findings of Caplan noted above. It is easy to see how the prison environment could be a very frightening place for individuals suffering from mental health problems. Unable to handle the strict and regimented nature of incarceration they are more likely to step out of line, and end up in segregation, and be isolated from other prisoners often worsening their symptoms. Further research is needed in an Australian prison context looking at the environment, services and experience of imprisonment for mentally disordered offenders.

The Role and Experience of Correctional Staff

“The high wall, no longer the wall that surrounds and protects, no longer the wall that stands for power and wealth, but the meticulously sealed wall, uncrossable in either direction, closed in upon the now mysterious work of punishment, will become, near at hand, sometimes even at the very centre of the cities of the nineteenth century, the monotonous figure, at once material and symbolic, of the power to punish.”

Michel Foucault

Introduction

This section takes as its main focus the experiences of prison officers in correctional settings. The section also explores the experiences and perceptions of health professionals, although this is to a lesser extent due to the area being not as widely studied. The paucity of literature focusing on the experiences of staff in prisons was

another factor which contributed to my decision to gather and investigate the experiences, attitudes and perceptions of health professionals and correctional staff. This research helps to flesh out our knowledge and understandings of this area. The section below utilises a combination of research literature, prison theory such as the work of Michael Foucault, and in some cases it describes the current situation in prisons through longitudinal research, in order to explore the role and experience of staff.

Prison Officers in Correctional Settings

Discretionary use of Power by Prison Officers

In his book 'Discipline and Punish: The Birth of the Prison' (1975) Michel Foucault examines the social and theoretical mechanisms behind changes in penal systems including the use of power and punishment. Foucault's analysis of punishment, discipline, medicine and madness has relevance to the experiences of prison life. He claims that the 'Technologies of Punishment' have changed over time from the first type, 'Monarchical Punishment', which involved the control of the masses through public displays of punishment including execution and torture. In the modern era we have seen a shift to what Foucault calls 'Disciplinary Punishment' which gives professionals (prison officers and other professionals in corrections) power over the prisoner. This power involves the regulation of space as prisoners are watched and observed, the regulation of personal use of time and regulation of the individual over their bodily movements, and therefore, enormous power constraints are placed on individuals freedom which is already markedly limited due to their state of incarceration.

Prisons are conceptualised as socially constructed as are behaviours such as madness and illness, and deviance and criminality (Foucault 1967 and 1975). Foucault claims that these social institutions, the role of the 'expert', subjectivity and social practices are embedded and contingent on socio-historical constructions and are products of power and domination. These social practices 'define a certain pattern of normalisation' (Foucault 1975, 72) and are particularly relevant to prison officers and 'experts' as these are the individuals who problematise the behaviours of prisoners.

Foucault sees prison officers and 'experts' as central to the analysis of 'panoptic technology' as they probe and 'normalise judgement on prisoners':

"the judges of normality are everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the social worker-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviour, his aptitudes, his achievements. The carceral network, in its compact or disseminated forms, with its systems of insertion, distribution, surveillance, observation, has been the greatest support, in modern society, of the normalizing power" (Foucault 1975, 304).

For Foucault 'normalising power' involves the dimensions of physical and biological discourses and how these are inserted on the body. Within this context both prison officers and prisoners are located in a political field drenched with power relations. This is important as prison officers and custodial staff have the discretionary use of power as a tool or means of managing all prisoners but in particular prisoners with mental health problems. Prison officers play a key role in such power relations as they take responsibility for ensuring that prisoner's needs are regularly reviewed. This is a particularly challenging role, as we have seen earlier in this review that prisoners who experience mental health problems are less able to cope with the prison 'code' and are therefore more likely to find themselves in trouble. We have also seen that patterns of surveillance and control can divide the 'keepers' and the 'kept' and generate an 'us and them' culture within the prison. Prison officers have the 'leeway' to relax the rules slightly and not place prisoners on report or give them additional chances before sanctioning disciplinary action.

Research by Liebling and Price (2001) looked at the relationships between prisoners and prison officers and found that many prison officers use discretionary powers when deciding whether to report a prisoner for rule infractions. Parker (2006) claimed that the use of disciplinary action, overmedication and lockdown in prisons is common in an environment limited by "space, time and/or money" (Parker 2006, 37). Paton et al's (2002, 28) research looking at prison officers' experiences of working with mental

health problems in prison found that officers were split on whether they gave leeway to prisoners. One officer stated, "I don't go around with rose tinted glasses, you know. But I will give somebody more leeway if they have got a problem, or they have got an issue regarding mental health I would give them more leeway; you've got to manage them."

This finding is supported in research mentioned above by Ben-David, Silfkin and Cohen (1996) who found that some prison officers adopted an 'integrative or person style', that is more 'flexible and adaptive' when dealing with mentally disordered offenders.

Not all prison officers are integrative or flexible when dealing with mentally disordered prisoners. Paton et al. (2002, 28) found there to be two types of officers, the ones described above who use discretion and those who do not. As one officer stated...you "see a lot of officers; at the end of the day they see their role is to contain that inmate and make it do as it's told. But these inmates (inmates with mental health problems) don't, they go beyond the bounds, they're not capable of following a basic set of rules."

There are research findings to show that many prison officers fear what fellow prison officers and prisoners might say if they appear to be lenient, caring or sympathetic towards prisoners or not conform to the prison norm of what a prison officer is perceived to be (Paton et al 2002). This further illustrates why some barriers are raised in identifying prisoners who may have a mental health problem. The prison 'code', it seems, extends to all facets of prison life, even the conduct of custodial staff. Quotes from officers in Paton et al's. (2002, 29) study provides support for this. For example:

"I don't know whether it's a bravado thing...there are an awful lot of staff who take time to, they don't voice that they care about what goes on in here because that wouldn't really be the done thing in a male environment" (29) and "They (other inmates) would then, they would pigeon hole you as a sort of Care Bear 'oh go and see...' that would be a problem if you developed that sort of rapport on the wing, that problem

would come to your door...they know you are on duty, and would come seek you out."

As mentioned, the study by Paton et al. (2002) identified two types or categories of prison officers - those who would give prisoners who they perceived to have a mental health problem more leeway and those who would not. Upon further analysis, the researchers found that this had a significant impact on the methods used by prison officers to identify and manage prisoners with mental health problems. It was further noted that role conflict was expressed as a problem by more of the officers who saw leeway as a more appropriate method of managing mentally disordered prisoners than those who did not utilise this method. The researchers speculate as to the possible reasons for this and state that...

"being seen to 'give leeway' to some prisoners and not to others may be perceived as unfair by other prisoners. It may therefore make it harder for the officer to maintain underlying contract between officers and prisoners (whereby officers apply the rules fairly and consistently to all) and thus to maintain good order on the wing/unit. Maintaining good order on the wing is a key part of the officers' security role. The officers' desire to make special allowances for someone they perceive as disordered therefore invites role conflict. Those prison officers who evaded such strategies, by contrast, maintained a consistent role - that of custodian - and experienced less role conflict as a result." (31)

The use of discretionary power by prison officers and custodial staff has a very real impact on the level of care and understanding provided to prisoners who experience mental health problems, as well as on the experience of working as a prison officer. If prison officers are not appropriately trained to deal with high stress situations, role conflict and to effectively manage mental illness in people under their care, it is likely that prisoners will be punished and further ostracised. Officer recruitment and initial training should include units that role play the kinds and range of challenging behaviours that people can expect to manage. Many prisons in the US require all custody/security staff to receive training on managing mentally ill prisoners and

inmates with other mental health needs (Thigpen, Hunter and Ortiz 2001). However, the average length of this training was approximately 4 hours.

The Role of Prison Officers

The role of correctional staff has changed significantly over time. Historically, the role of prison officers was narrowly defined, and did not attract people with a high level of educational achievement, or professional qualifications. In the past, officers' primary role was to guard prisoners, lock and unlock cells, help to move prisoners from one area to another and enforce discipline (Seiter 2001).

The role of correctional staff has changed considerably in modern times and is shaped by efforts to diversify the workforce (Paton et al 2002). Adams and Ferrandino (2008, 924) indicates that many of the issues experienced by staff are due to a "larger set of ethical concerns when professionals have multiple roles with potentially conflicting role responsibilities." Prisons have become more complex in a variety of ways (e.g., focus on rehabilitation instead of punishment, availability of education, technology and other programmes, changing structure of the population, drug and other cultural factors, ethical issues in the treatment of human beings including the recognition of human rights for those incarcerated) and therefore so have the roles of prison officers. The American Correctional Association (1993, 60) states that the correctional officer is responsible for both custody and control which "requires extensive interpersonal skills, special training and educations..." The scope and multidimensional role of prison officers is important to recognise as the role takes on many different perspectives and has become more of a human services role (Toch 1978).

In Western Australia all welfare officers were replaced by prison officers under the current unit management regime. Under this system all prisoners are assigned to a unit, which is essentially a wing of the prison where the prisoners live. Goulding (2007, 67) notes that as "part of the unit management regime, it is expected that prison officers should carry out basic welfare roles." Exactly what these roles are is not specified. This is particularly relevant when looking at prison officers' role when

dealing with prisoners with mental health problems (as they will undoubtedly require extra time and care) and their experiences and attitudes to this ever changing role.

Research focusing on prison officers' roles and responsibilities shows that they often perceive their role as one of straightforward security and discipline, or as a role that has inherent conflict and complications. Research by Ben-David, Silfkin and Cohen (1996) defines the different roles that are identified by prison officers who work with inmates with mental health problems. Their findings show that the role ranges from disciplinary, custodial, supporting, counsellor and integrative style, and further required them to be flexible, adaptive and readily available for interaction with prisoners. Research shows that this duality of role is often perceived by officers as problematic and they often feel that mental health is not really their primary area.

Gilbert (1997) developed a typology of prison officers depending on their preferred approach to prisoners and defined officers as one of four styles. He characterised officers as *professionals* who were seen as open and non-defensive, *reciprocators* who tended to adopt a caring and social work like approach, *enforcers* who viewed their role to apply prison rules rigidly and as the enforcer of punishment, and *avoiders* who tended to minimise contact with prisoners. The type of style a prison officer adopts affects interactions with and attitudes towards prisoners (Liebling and Price 2001).

Longitudinal research by Bowers et al. (2005) looked at prison officers' attitudes towards personality disordered patients in a UK personality disorder unit. The study aimed to track attitudes over time and test any linkages between attitudes and behaviour. The results showed that over time prison officers' attitudes towards prisoners changed and became more positive. This occurred as officers became more acquainted with prisoners' history, background, response to therapeutic interventions, education, staff counselling, staff sharing support and skills, and having their views listened to, amongst other things. Negative attitudes were associated with fear and concerns about the expanding role of prison officers, negative prisoner behaviour and delays over treatment programmes. Education and training were shown to have a significant effect on officers' attitudes to and understanding of personality disorders. The only negative comments made during the study about education were the lack of access to enough training or a few reports

that the training which was available started at a level too difficult to understand. Officers stated that the training gave them the skills and knowledge to apply in difficult situations with prisoners and gave them a higher level of tolerance and confidence.

Research by Bowers et al, (2006) looked at prison officers' attitudes when working with prisoners who have dangerous and severe personality disorders. The research aimed to assess whether attitudes to prisoners were linked to job performance, perception of managers, personal well-being, burnout, and interaction rates with inmates. The results show that officers' attitudes change over time and that these changes were linked to positive or negative events experienced by the officers. Positive attitudes were correlated with decreased burnout, general health and happiness, job performance and favourable perception of managers. These findings are supported by research looking at stress amongst prison officers where it has been shown that correctional staff score significantly higher than control groups on levels of work place stress (Long et al. 1986; Tewksbury and Mustaine 2008). The findings show that stress is related to staff relationships, task pressures, and relationships with inmates, promotion factors, the work environment, overall job satisfaction, locus of control and social support (Owen 2006). It would seem that prison administrators have a duty of care to prison staff and prisoners to help manage levels of occupational stress in the workplace by increasing levels of staff support. This will in turn maintain healthy relationships and improve the ability of staff to manage prisoners. The literature shows that substantial returns can be yielded from relatively small investments in training (Parker 2006), including enhanced operations, bringing prison officers on board as part of a multidisciplinary team, and improved overall functioning of prisoners with mental illness (Adams and Ferrandino 2008). Similar findings were recorded by Lea, Auburn, and Kibbelwhite (1999) who examined the perceptions and experiences of staff who work with sex offenders. Their findings show that special staff training considerably influenced the attitudes and understanding of staff to patients. Similar results were recorded by Hogue (1993) where ongoing training provided staff with more confidence and positive attitudes when dealing with sex offenders.

Paton et al. (2002) investigated prison officers' experiences of identifying and managing mental health problems. The findings show that prison officers are able to identify a prisoner with mental health problems when the behaviour is overtly abnormal, but that the officers experience role conflict, as they are not specially trained to deal with mental health issues. Officers expressed the need for training in mental health issues and for sharing of information between health services and prison officers so that they are more prepared and armed with the correct information when dealing with these prisoners. These findings are supported by Bonner and Vandecreek (2006, 542) who noted that staff face "ethical quandaries because of the need to balance the mental health of offenders with control, security and the paramilitary structure of the prison system."

Prison staff may also experience difficulties when working with prisoners from differing cultural, religious and ethnic backgrounds, particularly Aboriginal prisoners in an Australian context. The 2005 Mahoney Inquiry reported that prison officers "generally do not understand or appreciate the Indigenous customs and culture...insofar as prison officers are required in case management to understand the problems of Indigenous prisoners and to foresee such problems, they are in a position of disadvantage or even impossibility" (Mahoney 2005, 300). It would seem that any training provided to prison officers (and indeed all staff within the Department of Corrective Services) should include comprehensive cultural skills training.

Rules, Procedures and Policy

The literature illustrates that prison staff often find offenders with mental disorders and other disabilities particularly difficult to manage, requiring greater consideration and more individualised attention in a setting where resources are often limited and staffing shortages and other inherent difficulties provide further limitations (Boothby and Clements 2000; Finn 1989; Glaser and Deane 1999; Santamour 1986). Prisoners with mental disorders do not often take into account prison rules and are over-represented in rule infractions. This is due in part to a lack of understanding for routine and procedure (Smith et al. 1988).

Prison officers often suggest that it is very helpful to have a clear set of rules and procedures to rely on in the management of prisoners with mental health problems (Paton et al. 2002). This is particularly seen in situations when inmates are in danger of self harm or becoming violent towards prison officers. Research by Sandell and Spurgeon (1993) supports these findings. They found that clear policy and procedures are mandatory otherwise staff are left to their own devices and must find their own solutions which invariably tend towards an emphasis on control and force in management of prisoners with mental health problems. A quote from a prison officer in Paton et al's. (2002, 30) research summarises this well "the easiest way to manage - so long as the doctor will back us - is to restrict their association and keep them locked behind their door for as long as possible." Research findings by Steven (1998) suggest that prisoner-staff altercations often result and can be related to the extent to which prisoners are involved in social relationships with other prisoners and staff. These altercations can arise when prisoners see staff or other prisoners as a threat to these relationships.

It is important for correctional administrations to consider the issues raised here and reduce prison officer burn-out. Seiter (2001, 9) claims that due to the increasing complexities in the prison environment it is important that two things occur -

"First, correctional agencies must recruit talented, educated, and experienced individuals to work in prisons and community corrections. These new staff must be trained and developed to meet the ever-changing situations they face. Second, correctional agencies must take advantage of their valuable staff resource by listening to what they have to say and involving them in decisions regarding policy and procedure..."

Prison officers have a unique role in correctional settings and play an important role in assisting in mental health observations and interventions. It is important that they are adequately trained and supported by correctional administrators and that there is collaboration between correctional officers and treatment teams. Appelbaum, Hickey and Packer (2002, 75) emphasise the importance of having a "foundation of mutual respect, shared training, and ongoing communication and cooperation...with these elements in place, correctional officers can assist the treatment team and make

important and constructive contributions to the assessment and management of offenders who have mental disorders.” It is important that correctional staff and health professionals share in a mutual understanding, support each other to make both security and health decisions and work together in multidisciplinary teams (Appelbaum, Hickey and Packer 2001; Cruser and Diamond 2000; Winter 2008). The next section discusses the prison and forensic setting as it relates to staff and the roles and experiences of health professionals.

The Role and Experience of Health Professionals

The Prison and Forensic Setting

The prison and forensic settings have been described in the literature as tense, dangerous and sometimes a difficult and brutal environment for both staff and patients (Whittington and Balsalmo 1998). The environment is often one of confinement, detention and punishment and these are valued over care, treatment and compassion (Mason and Mercer 1996, 1998). The environment is seen as overly harsh with excessive rules, insufficient or inappropriate education and training, fear and anxieties, overemphasis on dangerousness and security and an essentially masculine care ethos that is not supportive of compassion and sensitivity (Rae 1993). Fellner (2006, 391) recently delineated the problems of managing prisoners with mental illness as “an inherent tension between the security mission of prisons and mental health considerations. The formal and informal rules and codes of conduct in prison reflect staff concerns about security, safety, power, and control. Coordinating the needs of the mentally ill with those rules and goals is nearly impossible.”

Mental health professionals who work in correctional settings often face problems in adjusting to a work environment where services and treatment are considered secondary to the primary functions of a prison (Hardesty, Champion and Champion 2007). Unlike other mental health facilities where rehabilitation, treatment, and the alleviation of suffering are considered to be the primary foci for staff and patients, correctional settings are primarily focused on protecting society from criminal behaviour, and on punishing offenders by separating them from society. The role of nurses in this environment is often seen to be more about social control than caring (Mason and Mercer, 1996) and these staff must bear the stressors of two demanding

fields; corrections and health care (Hardest et al. 2007). Contradictions in the role have been reported (Peternelj-Taylor and Johnson 1995; Polczyk-Przybyla and Gournay 1999) and the research shows that for those professionals who do choose to work in prison settings, challenges within the correctional environment are experienced (Fagan and K.AX 2003). Moreover, the literature demonstrates that staff shortages, absenteeism and turn over in corrections are high (Garland and McCarty 2009).

What is more, the nature of the population presents challenges for nursing and clinical staff who choose to work in this environment, and for the many agency staff who do short stints in various settings. Prisoners often come from stigmatised backgrounds and cultural groups whose past behaviour and offences may evoke negative responses from service providers. But it is a nurse's professional responsibility to provide care and treatment to prisoners regardless of their personal attitudes and beliefs (Werlin and O'Brien 1984).

Research in the field shows that in order to improve their work life staff would like additional access to training, including security and safety education, an ability to undertake health promotion with prisoners (Flanagan and Flanagan 2001), and adequate contact, consultation and supervision from management staff (Garland, McCarty and Zhao 2009). Increasing these factors may positively impact on health staff experiences in prisons and in their attitudes towards mentally ill prisoners.

Health Professionals Experiences and Attitudes

There is not a great body of research dealing with the attitudes of mental health and custodial professionals, on what actually constitutes effective practice for mental health professionals in correctional settings. A review of the literature revealed few studies in relation to either correctional health care nursing practice or other psychiatric staff attitudes towards prisoners with mental health diagnosis. This is interesting as nurses comprise the largest group of health care providers in correctional settings (Moritz 1982).

Although not specifically focusing on the attitudes of correctional staff, a paper by Polczyk-Przybyla and Gourney (1999) looked at the role of psychiatric nursing in Belmarsh prison in the UK. The paper highlights the clinical and managerial challenges that clinical staff face in the prison system. In particular, they emphasise problems with nursing policies and practices claiming that they are often seen to be 'confused and divisive'. The researchers further highlighted problems in attaining suitably qualified professionals and the shortage of clinical and managerial supervision. The paper claims that these deficits reduce staff morale and promote general dissatisfaction, impacting on the experience of staff in the prison environment and no doubt the level of care staff can provide.

An early study by Khanna, Pratt and Gardiner (1962) explored the attitudes of 31 male psychiatric aides towards patients defined as criminally insane in a custodial setting. They reported a general lag in attitudes of staff working with these patients. They found that a number of factors were associated with staff attitudes including: age, education, length of employment, aid, status, performance ratings, intelligence, social service orientation and selected personality traits. They further found that a one-month training course did not significantly change attitudes towards criminally insane patients. However, Miller and Davenport (1996) reported positive changes in nurses' attitudes after further training and professional development. They found a growth in knowledge, skills and understanding improved attitudes towards patients.

Current research focusing on psychiatric professionals' attitudes regarding people who suffer from personality disorders shows that attitudes tend to be poor (Bowers et al. 2000; Lewis and Appleby 1998). A large scale study of attitudes towards the personality disordered among qualified and unqualified psychiatric nurses working in English high security hospitals was undertaken by Bowers in 1998 (Bowers et al. 2000; Bowers 2002). Semi-structured interviews and a self-rating of attitudes revealed that, generally, nurses' attitudes tended to be poor. Content analysis further showed factors that correlated with both positive and negative attitudes. Nurses with a more positive attitude tended to invest in developing relationships with patients, utilised opportunities to change patients' behaviour and had higher levels of respect for patients. Negative attitudes are associated with poor and manipulative patient behaviour, irritation at complaints, being let down and difficulties, lack of clinical

supervision and delays in appointing clinical staff. Further, negative attitudes are associated with organisational structure. The study highlighted the importance of organisational context for those working with prisoners with personality disorder, and possibly for any specialist or challenging field. The research found that positive attitudes towards prisoners are “likely to be made and maintained when the organization has a clear set of goals, achievable through an agreed set of actions and with timely implementation” (180).

Research by Shields and Moya (1997) supports the above findings that attitudes towards inmates are generally poor. Their findings showed that correctional nurse’ attitudes were lower, more negative, than the overall attitude scores of correctional officers, police officers, community members, and others. These attitudes and relationships are important as according to Appelbaum (2008) “the relation and interplay among mental health staff, security staff, and inmate-patients can have significant influence on the effectiveness of treatment” (Appelbaum 2008, 265).

The findings of Martin and Street (2003) are interesting and report on the nurse-patient relationship. The results show that nurses report forming therapeutic relationships with patients and that these relationships are very powerful. The following quote highlights an example of this relationship:

“The therapeutic relationship is a very powerful relationship. There are things that can occur within that relationship that can affect both the patient and the nurse. It is set up with a purpose and that is to help the patient through their illness, to gain insight and effectively to see them to the end when you can let go...Because this relationship involves trust and empathy and time, and a lot of investment of yourself. When you have got someone who is acutely ill and they are floundering, and they are a danger to themselves, danger to others. They’re incarcerated, that is the most marginalised group that you can get, and you meet them and you say ‘this is me. I am here to help you. Yes, you may have committed a crime but in the end you are a person and you have an illness and I’m here for you to help you through that illness and to learn about yourself, and I am willing to invest my time with you and I am willing to invest some of me for you to

help you through that process.’ It can be a very taxing relationship, particularly if you give a lot but you can also receive a lot as well” (546).

Nurses in the study reported that this relationship is often established through chatting with patients, going for walks around the ground and through other shared activities. The time to develop these relationships is important for treatment and understanding. Nurses also reported interacting with patients to provide them with education and counselling about their illness, medication, side effects and other treatment options. These findings are strongly supported by Lindqvist and Skipworth (2000) whose research highlights the importance of staff continuity and emphasises the importance of building sustainable and trusting relationships. These relationships help patients to develop confidence in themselves and others and to work on social skills which may be lacking due to the early onset of psychiatric illness (Childs and Brinded 2002).

Doctors in the Forensic Hospital and Prison Settings

In addition to focusing on nurses’ attitudes some studies have looked into doctors’ attitudes and practices. Doctors have a duty to provide the best possible care to their patients, including respect for their dignity and privacy, the same is expected of doctors in correctional settings (British Medical Association, 2006).

A survey of 184 doctors who worked with prisoners in a correctional or hospital setting was undertaken to determine doctors’ attitudes and practices towards prisoners. The doctors reported that prisoners were frequently assessed while chained to prison officers and that breaches of confidentiality were common. Only six doctors believed that such breaches never occurred, whereas 13 thought that they happened in all cases, and 162 sometimes. 111 of the doctors reported feeling comfortable working while examining prisoners (Dalrymple 2004).

An interesting anecdotal excerpt from a prison doctor in England highlights the current lack of services for prisoners and how this impacts on doctors’ experience of working in the prison setting.

“Everyday in my work as a prison doctor, I witnessed the effect of this lack of service provision...modern walls do not a modern prison make. Unearthly screams rent the air; foul smells offended the nostrils. Madmen threw their clothes through windows, started fires in their cells, tore up their sheets, wrapped towels around their heads, angrily addressed their hallucinatory interlocutors while standing stark naked on their beds, refused all food as poisoned, and spat at passers-by...(police and courts unable to cope due to lack of beds the offender is sentenced and sent to prison)...things do not go smoothly in prison. The doctors cannot find hospital beds for patients; the psychiatrists outside the prison consider that the patient is now in a place of safety - the prison - where he will not be deprived of medical attention, and he is therefore of lower priority for a hospital bed than a lunatic still at large in the community...recently I observed a psychotic patient for several weeks, who addressed the world night and day through his prison window in words of muddled religious exaltation, who refused all food on the grounds that it was poisoned, his flesh melting away before my eyes, who attacked anyone who came within reach, and who painted religious slogans on the walls of his cell with his own excrement, thus imparting a nauseating feculent smell...(Dalrymple 2004, 5).

This quote highlights a number of issues. Firstly, the doctor’s frustration with the police and courts for sending mental health patients to prisons where beds are unavailable and with psychiatrists on the outside making assumptions that the patient is now safe and receiving treatment and so therefore not in need of a hospital bed where s/he will receive further treatment. Secondly, the observation of the psychotic patient seems to be made as a way of outlining the lack of legislation to protect and treat mental health prisoners in prison hospitals. That is, the inability of the doctor to treat patients against their will even when they clearly need medical attention. It is little wonder, as Polczyk-Przybyla and Gourney (1999) have noted, that it is difficult to find staff to work in prisons with experiences such as the above.

Physicians who work full-time in prisons tend to be older, less specialised, less likely to be board-certified, and more likely to be trained outside of the country in which they are working (Lichtenstein and Rykwalder 1983). Questions about the quality of

medical care provided by these doctors have been raised. This compares to physicians who work part-time and who are reported to be younger, specialised and board certified. The study argues that in order to provide prisoners with quality medical care the professional characteristics of doctors should be explored (Lichtenstein and Rykwalder 1983).

The research shows that health professionals face many additional challenges working in correctional settings and it is important that all health and correctional prison staff are provided with adequate support and operational guidelines in this complex setting. The present research aims to add to this body of knowledge by focusing on the experiences of prison and health staff in Western Australia.

Chapter Summary

This chapter has provided an introduction and brief background to the research setting. It has examined the prison system, environment and culture, the experiences and stories of service users, the role and experience of staff in correctional settings, and mental health service provision. This literature is included here as it demonstrates a basis for the research and provides the reader with an understanding of the context of mental illness in today's prisons.

The prison system can be viewed to have a number of purposes, such as the incapacitation, deterrence, retribution/expiation and reformation of offenders. Whether or not prisons meet these purposes is debated the world over. With the current recidivism rates in Australia it could be argued that the reformation of prisoners is limited. Overall, the literature states that mental disorders of all kinds are highly prevalent in prison populations and that the current screening processes for mental disorders may allow prisoners suffering from a mental illness to enter prison undetected. It seems that there is an opportunity to provide prisoners with mental health treatment in prison; treatment they may not get anywhere else. However, it appears that there are considerable shortcomings in the services provided in most prisons today and there is a lack of understanding about the users and service providers. Further, the literature clearly demonstrates many challenges for both correctional staff and health professionals when working with mentally ill prisoner patients. Researchers such as Goffman and Foucault have highlighted the impact of

what Goffman called 'institutionalisation' and what Foucault called 'disciplinary power', which present a great challenge to change or reform within prison systems.

Although there is limited understanding of the perceptions and attitudes of services users and providers, there is no doubt that developments in the law and in correctional administration have improved the quality and level of medical care that prisoners receive. Nonetheless, the literature reveals many challenges in providing medical care in prisons. This includes finding well-trained professionals who want to work in the public forensic and mental health field, the absence of specialised medical departments in prisons, inadequate facilities and inadequate medical data systems that link with community medical services to provide ongoing treatment to patients (Battersby et al. 2001 and 2002). According to Mullen (2001), at the very least, prison mental health services should provide the following: Reception Screening Programs; Assessment and Acute Intervention Service; Assessment and Acute Care Unit; Medium Stay Units; Long Term Care Unit; Suicide Minimisation Program; and, Hospital Support outside prison.

These factors all influence the provision of health and mental health care in the prison context and the experiences of those who work and live in Western Australian prisons. An understanding of these issues is essential for this research and provides a contextual frame of thought for understanding that the incarceration of the mentally ill is influenced by a multitude of complex factors. This research thesis builds on the current literature by focusing on and investigating the experiences of those embedded within the system with a view to changing policy, overhauling services, and improving the lives of those who live and work in this multifarious setting.

The next chapter will describe the method by which the data for the research was collected, while the subsequent chapters engage with the qualitative and quantitative data collected, the perceptions and experiences of the research participants, and discusses the findings with reference to the literature.

CHAPTER FOUR: RESEARCH METHODOLOGY AND THEORETICAL FRAMEWORK

"The field is a 'sacred space' given wholly to the quest for knowledge and understanding."

(Josephides 2003, 58)

Introduction

This research was designed to investigate perceptions and experiences among prisoner patients, health care professionals, and correctional staff, and was situated within the mixed methodology framework, where a two-phase sequential design was engaged giving equal weighting to both phases. It is important to capture the perceptions, experiences and attitudes of these mentally ill individuals, health professionals and correctional staff as this will assist in making informed policy decisions to ensure sufficient and comprehensive mental health services in the future and the improved health and safety of the wider community.

This chapter will give attention to the key assumptions and influences that have been brought to bear on the methods used and will document the research design and approach, research settings, samples and sampling method, instrumentation, data collection phases, data analysis, ethical considerations, constraints and limitations. As stated in chapter one, the central research question and objectives were:

Central research question: What are the experiences of staff and prisoners in Western Australia in relation to mental health/psychiatric service provision and mental illness in the prison environment?

Research objectives/aims:

1. To investigate and provide insight into the issues facing prison staff when working with prisoners who experience mental illness⁵.
2. To investigate and gain insight into the attitudes and feelings of staff in relation to current services, treatment and facilities.

⁵ That is, prisoners identified by the Department of Justice as having a Psychiatric Alert on TOMS.

3. To investigate the issues, experiences and needs of prisoners who are diagnosed with mental illness in custody in Western Australia.
4. To investigate develop an understanding of experiences in urban and regional prisons in Western Australia.

Mixed Methods Considerations:

1. To what extent do the staff and prisoner findings support each other across the qualitative and quantitative Phases? What insights can be generated, and meanings drawn-out, by merging and exploring both forms of data?

Research Paradigms

“The design of a study begins with the selection of a topic and a paradigm. Paradigms in the human and social sciences help us understand phenomena. They advance assumptions about the social world, how science should be conducted, and what constitutes legitimate problems, solutions, and criteria of proof. As such, paradigms encompass both theories and methods. Although they evolve, differ by discipline fields, and are often contested, two are discussed widely in the literature: the qualitative and the quantitative paradigm” (Creswell 1994, 1).

A third emerging paradigm is also being discussed more frequently in the literature, that is, the paradigm of mixed methods research (Plano Clark and Creswell 2008, Creswell 2003, Creswell and Plano Clark 2007).

Green and Caracelli (1997, 8) go on to argue that, “past work (Greene, Caracelli & Graham 1989, Kidder and Fine 1987, Reichardt and Cook 1979, Rossman and Wilson 1985, and Smith 1994) shows there are *three* primary stances on the sensibleness and efficacy of mixing paradigms while mixing methods in evaluative enquiry.” The purist, pragmatic, and dialectical stances. The present research subscribes to the *Pragmatic* stance; however the researcher also recognises the importance and influences of the *dialectical* stance and acknowledges the value of the *purist* propositions.

Proponents of the *Pragmatic* stance acknowledge that philosophical differences exist between the two paradigms, but argue that it is because of these logically independent underlying philosophical assumptions, that they can be mixed in a study. Moreover, Green and Caracelli (1997, 8) state that the “paradigm differences do not really matter very much to the practice of social inquiry, because paradigms are best viewed as descriptions of, *not* prescriptions for, research practice.” In accordance with the pragmatic stance, the present research is a mixed methods study, employing elements of both the qualitative and quantitative paradigms.

Research Approach

As stated in chapter one, the methodology used for this research fell within the emergent research approach variously titled *mixed methodology* (Plano Clark and Creswell 2008, 5; Creswell 2003, 15), *mixed method evaluation* (Greene 2001; Greene and Caracelli 1997) and, *mixed model studies* (Tashakkori and Teddlie 1998, 19). This research applied both qualitative and quantitative methods to gather information and data, and was exploratory and descriptive in design. Greene et al. (1989, 43) reviewed 57 mixed method studies and devised a list of five main purposes for mixed method inquiry.

These are “triangulation, or seeking convergence of results; complementarity, or examining overlapping and different facets of a phenomenon; initiation, or discovering paradoxes, contradictions, fresh perspectives; development, or using the methods sequentially, such that results from the first method inform the use of the second method; and expansion, or mixed methods adding breadth and scope to a project.”

Each of these relates to Green et al’s. (1989) claim that in seeking knowledge mixed methods research combines the strength of both paradigms and presents a more complete view of the topic under study.

Ontology and Epistemology

When identifying an appropriate mixed methodology design for this research, notions of ontology, epistemology and assumptions about human nature were considered.

Ontology relates to assumptions held about the nature of reality, subject matter, namely, the social world, and therefore issues concerning *being* and with *what exists*. Assumptions can include both conscious and unconscious theories and includes beliefs about the location of reality, that is, either external to individuals or constructed by and internal to individuals (or perhaps both). Following from these assumptions, will be a defined relationship with reality held by the individual researcher (Burrell and Morgan 1985). Ontological questions ask things such as: How is the social world perceived and understood? Or, what is a human being?

Epistemology, on the other hand, refers to beliefs about the theory of knowledge and is concerned with the *nature of knowing*. This includes notions of the creation of knowledge, about the form knowledge takes, and how individuals assess and make sense of their world and then how they go on to communicate or express this. Epistemology is connected with the question of what should be viewed as acceptable knowledge in a discipline, that is, *how* do we know what we know.

Epistemological beliefs and ontological assumptions are directly related and both the qualitative and quantitative research paradigms embody a number of ontological and epistemological assumptions. If, for example, one considers reality to be external and obligatory, it then follows that epistemological assumptions will identify knowledge as concrete, quantifiable, 'real' and accessible (Annells 1996). These two concepts are inherently related to assumptions held about human nature and beliefs about the connection of people, their environment and personal control.

Qualitative and Quantitative Research Paradigms

Stake (1995, 37) compares qualitative and quantitative research. He notes that the assumptions of the qualitative and quantitative paradigms are based on specific ontological and epistemological approaches. Stake notes that in qualitative research, knowledge is inductive, subjective and constructed and the purpose of inquiry in quantitative research tends to be to provide explanation through measurement, objective and deductive means.

For the qualitative researcher, reality is considered subjective and is constructed by the individuals engaged in the research process. The qualitative researcher relies on the voices and interpretations of the respondents. The qualitative researcher interacts with those they research and both are involved in the knowing process. The researcher attempts to minimize the distance between the research participants and herself, so they can allow her to share in their understandings (Creswell 1994, 4-6; Berg 2001, 11). Moreover, the qualitative researcher recognises the impacts of the role of *values* in the study, the axiological issue, by recognising the value-laden nature of the study and actively reports her biases, as well as the nature of information gathered in the field (Guba and Lincoln 1994, 2004). Denzin and Lincoln (2005, 3) state that qualitative research is “a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible.”

For the quantitative researcher, an objective reality is recognised that is independent of the researcher, that is, reality is a concrete process or structure. The quantitative researcher relies on the use of measurement and statistics to gather data and has a goal of discerning statistical irregularities of behaviour. The quantitative researcher practices objective research where the researcher is separate from the respondent or object. The researcher attempts to maximise the distance between the research participants and herself, so she can objectively measure the phenomenon under study (Olsen 1999).

The manifestation of these two different sets of assumptions between qualitative and quantitative research “is the relation between the knowing subject and the studied object” (Olsen 1999, 3). Whilst there appear to be two clearly defined standpoints, critically viewed and already referred to earlier, considerable fluidity exists. According to Morgan and Smircich (1980) the methodology develops from the researcher’s ontological and epistemological position and this difference is critical. Morgan and Smircich (1980, 492) developed a spectrum (“Network of Basic Assumptions Characterizing the Subjective-Objective Debate within the Social Sciences) with subjectivist at one end and objectivist at the other. This spectrum reflects the acceptance of a world incorporating ontological stances of reality, varying from those that are socially constructed (human imagination) to realities as a

concrete process of structure. This spectrum implies “epistemic stances of knowledge for the purpose of revelation and for understanding social construction to knowledge for construction of a positivist science” (Olsen 1999, 3). According to the spectrum, the ontological and epistemological assumptions of a particular research project will clearly reflect the relation between the researcher (knowing object) and the respondent (the studied object).

The relationship (separation or integration) between the researcher and the respondent is an indicator of “the ontological and epistemological assumptions on which the given study is based” (Olsen 1999, 3). Based on the above, the present research argues that engaging with both paradigms and methods enhances and strengthens research in the social sciences (Creswell 2003; Creswell and Plano Clark 2007, 2008; Johnson and Onwuegbuzie 2004). The chosen **ontology** for this research project is defined as **pragmatic**, because it views reality as both external to individuals and constructed by and internal to individuals, and that this reality is also both independent and dependent of the researcher. That is, there are both multiple **and** singular realities. Both phases of the research rely more heavily on constructivist principles as discussed below. Furthermore, the **epistemology** is both **exploratory** and **explanatory**, as the research project sets out to investigate, explore, understand and explain the reality of prison life for health professionals, correctional staff and prisoner patients based on this pragmatic, or mixed, ontology. The **axiology** is also **mixed (multiple stances)** and both biased and positioned information is included in the process and findings. The **methodology** was a **sequential mixed methods** design and the **rhetoric** employed is both formal and informal throughout the research process and thesis writing.

Constructivism

Constructivists claim that there are multiple epistemologies or ways of knowing and that the researcher plays a central role in the construction of knowledge. The aim of constructivist research is to find a fuller and richer way of describing social life as it is experienced by people and research participants. Research activity may utilise a variety of methodologies but is best described as a subjective approach where the researcher is immersed in the research process. This allows the researcher the

opportunity to engage the participants in dialogue, in order to explore complex and unique settings (Campbell and Wasco 2000), such that, different people may apply diverse meanings to understanding certain events. As such, having participants explain their perceptions and experiences of events is central in the examining of discourse that is the result of experience and interactions and the perceived implications this has on the individual (Lincoln 2005). In order to achieve this most constructivist research uses a qualitative methodology as this seeks depth of inquiry. However, the constructivist philosophy is not restricted to qualitative methods and constructionist researchers are best thought of as “bricoleurs choosing and adapting methods which seem to show promise of eliciting the best data for the questions which must be answered” (Denzin and Lincoln 2000, 2). This is in keeping with much mixed methods methodology where “researchers should be concerned with applications, with what works, and with solutions to problems” (Plano Clark and Creswell 2008).

Mixed Methods Research

This research acknowledges the importance of both realist and relativist, critical and hermeneutic philosophical stances in the study of mental health and those who experience mental health related problems in the criminal justice system (Kaspersen 2000; Parker 1992). The research utilised pragmatist ideas in that it drew from both paradigms and aimed to take a holistic approach to understand the topic under study. The use of a mixed method approach helps to strengthen the construct and predictive validity of the research findings; it complements the constructivist and subjectivist nature of naturalistic inquiry.

In mixed methods studies, the combination of methods “reflects an attempt to secure in-depth understanding” and to synthesise results from different sources (Denzin and Lincoln 2005, 5). Denzin (1978) described four different types of triangulation, including data triangulation, investigator triangulation, theory triangulation and methodological triangulation (cited in Tashakkori and Teddlie 1998, 18). Mixed method research attempts to address the potential shortcomings of both qualitative and quantitative research by methodological triangulation and has been shown to be effective in research of a criminological nature, particularly prison based research

(Jupp, Davies and Francis 2000). Denzin and Lincoln (2000, 5) add that the “combination of multiple methodological practices, empirical materials, perspectives and observers in a single study is best understood...as a strategy that adds rigor, breadth, complexity, richness, and depth to any inquiry.” Creswell and Plano Clark (2007, 34) further state that the use of mixed methods research is appropriate when one needs to first explore the issue and to “aid in the identification of items and scales to help develop a quantitative instrument.”

The combination of qualitative and quantitative methodologies and theories in the present research project allowed for an enhanced scope, depth and exploration of findings creating both measurable and quantifiable data and data that gave priority to insight and reflection based on individual experiences. The design allowed for key informant interviews to be undertaken in order to explore the topic and key themes identified in the literature review, and to identify participant experiences and enhance the key themes. The literature review and these key themes were integrated in order to develop quantitative instruments and therefore further exploration of the topic across a larger number of prisons and staff groups. Dworkin (1992) has argued that mixed methods research is a particularly appropriate method when working with mentally ill prisoners. The chosen methodological framework engendered both constructive meaningful process allowing for depth and breadth and also quality of outcome.

The Researcher within the Mixed Methods Design

Although I came to this research with some grounding in the topic the participants were considered to be a key source of expertise with the most comprehensive and accurate knowledge of the research topic. They are the experts of the prison experience, not the researcher. The methods selected for the present research were chosen to give participants the opportunity to reflect on their subjective experiences in the prison context through qualitative semi-structured interviews, as well as to complete a quantitative survey reflecting on other participants' thoughts, attitudes and experiences.

This mixed methods design required me to wear two hats throughout the research process as I shifted from qualitative to quantitative research approaches, whilst still remaining central in the research inquiry and meaning-making process. As a qualitative researcher it was important to be absorbed in the research process and to recognise and explore the subjective experiences of myself and the participants and how these interacted with the objectives of the research. Working as a qualitative researcher required an open and flexible approach in order to allow the topic to evolve and for participants to share their perceptions, their experiences, their thoughts, and their hopes to the project and research aim. The interviews needed to be sensitive and I needed to be aware that the participants are essentially silenced by society due to their incarceration and I was now giving voice to many people who are disenfranchised and not often asked to share their stories. It was important to stay true to the constructivist approach by allowing space for people to make sense and meaning of events and situations and to remain central to the research, in the complex prison environment where the interviews took place.

The quantitative phase of the research required me to 'shift gear' in a sense and to utilise the results of the meaning making process in the qualitative research to design structured research instruments to gather data. The design of questionnaires allowed for a greater breadth of topics and research participants. It was important to take the perceptions and experiences, quantify them across a broader sample, and further add to the depth of information I was gathering on the topic. This was important as it allowed me to explore the experiences of staff and prisoners across a greater geographical area and would enhance the ability of the research to inform policy across Western Australia. During the survey design process I had to become more objective and slightly detached from the emotive subject matter in order to construct measurable questions. In keeping with the pragmatic stance and the mixed methods approach I remained flexible and adaptive, as I felt that a quantitative survey would elicit the best data and allow for further exploration (and testing for agreement/support) of the constructs. Using a survey would allow for the voices of additional participants' to be shared and supported.

The information obtained in Phase One provided the themes and quotes to be explored in Phase Two. The questionnaire was built around the emerging themes and

quotes of participants and during the survey design process I selected the words and voices of participants, and turned these direct quotes into survey questions to represent key constructs which I identified in Phase One and wanted to test for generalisability in Phase Two. Phase Two then asked participants if they would rate the quotes according to their views; strongly agreed, agreed, were undecided, disagreed or strongly disagreed. The data analysis also required a change in approach by moving away from inductive, subjective inquiry to closed, deductive mathematical analysis. I then had to sit with the results from both perspectives to integrate the findings into a cohesive whole in the discussion and results sections. Moreover, in some cases I related the findings in the discussion to my experience and history in the field.

The section below will briefly provide an overview of the mixed methods approach, research objective and aim, research parameters and a note on diagnosis and the sample. The section will then present the phase one and phase two methods separately. Within each phase the methods, participants, instruments, data collection and data analysis will be presented. The key ethical concerns and research limitations will then be highlighted.

Research Methodology

Utilising a mixed methods approach, applying both qualitative and quantitative methods to gather information and data, the research procedure can be viewed as what Creswell and Plano Clark (2007) refer to as a 'two phase sequential design'. The qualitative key informant interviews took place prior to the quantitative questionnaire. The phase one key informant interviews, and the key themes identified in the literature review, informed the development of the phase two quantitative questionnaire surveys. These phases acted as two different ways of exploring the research questions with the findings integrated in the discussion. It should be noted that equal weight was given to the phases and findings. This approach has been diagrammatically presented below and was adapted from Creswell and Plano Clark (2007).

The methods applied in this research are mainly exploratory and involved interviewing health professionals, correctional staff and prisoners to produce information amenable to qualitative content analytic techniques, and the administration of a staff questionnaire and a prisoner questionnaire that generated quantitative data that was statistically analysed. The **objective** is to investigate the experiences of prisoners, health professionals, and correctional staff in relation to mental illness and mental health service provision. The **aim** of this research is to gain a deeper understanding of a particular case, that is, the intrinsic nature of mental health services in prisons in Western Australia and to apply these lessons and experiences to formulating and improving policy; to provide insight for the instrumental application of these findings to correctional administrators and governments widely.

Significance of This Research

It is acknowledged that the cultural and local parameters in Western Australia are unique, and cannot be directly converged on other settings. However, uncovering perceptions and experiences among correctional staff, health professionals and prisoner patients may contribute to new approaches to care and service delivery and therefore mitigate the adversities of insufficient mental health care in prisons and the community, the high rate of incarceration of the mentally ill, the burnout and turnover of staff in corrections, and the possible human rights abuse of mentally disordered people in our communities. Throughout the research process I had discussions at conferences, both in Australia and internationally, with correctional staff and health professionals who stated the research findings resonated with their experiences.

A Note on the Research Parameters

It is important to declare that the scope of this research is the internal dynamics of eight prisons in Western Australia. The majority of the participants were employees of the Department or incarcerated in the Department's prisons, therefore the views of community health professionals or patients are not contained in this thesis. All prisoners in the sample were incarcerated in Western Australian prisons. The majority of the prisoners were sentenced and had not come under the insanity defence as

forensic patients. One prisoner interviewed at Hakea remand prison was awaiting a retrial. The key informant semi-structured interviews and the questionnaire surveys were designed to gather the perceptions, experiences and attitudes of participants. The semi-structured interview questions and themes were originally based on a review of the research literature. The findings and material gathered from participants in both phases was contextualised with current literature, government reports and inquires, and media reports regarding contemporary thought and debate across a number of fields (i.e., corrections, health, mental health, social work, nursing, medicine). The research instruments were intended to complement each other and enhance insight into a range of themes and issues rather than narrowly investigate singular aspects of the research objectives. The research was very broad, open and exploratory in this respect. The combination of findings from previous research and the key informant semi-structured interviews and the questionnaire surveys hence triangulates this research, which ideally enhances the strength and validity of the research (Berg 2004).

A Note on Diagnoses Confirmation

It should be noted that some data was also triangulated and verified with official records and case notes; I complemented and contrasted the information I received from participants with official file records (e.g., history of mental illness and diagnoses, and offence history) in both phases. This helped to improve the validity of the information I received and in most cases the information was confirmed. No prisoners misrepresented their circumstances as far as official records could discern, but a number of prisoners (n=5) were confused regarding their dual diagnosis status.

A Note on the Sample

It should be noted that only male prisoners were included in both Phase One and Phase Two as the Department of Corrective Services Research Application and Review Committee (RARC now known as REC) did not approve the inclusion of a female prisoner sample. I found this decision disappointing as research shows that women have higher rates of mental illness than male prisoner populations (Butler and Allnut 2003) and it was felt that women's views would have made an interesting contribution to the research and the understanding of women's mental health needs.

The Research Setting

As discussed earlier, the investigation took place in Western Australia. Eight prisons were identified for the research and all participants were selected from these sites (a brief overview of each prison is provided below along with a map of the locations). These prisons were selected in consultation with the Department. They were selected for the following reasons:

- ❖ they are the eight largest prisons in the state where the majority of prisoners with mental illness are housed;
- ❖ all of these prisons are operated by the Department (the private prison was not included in this research);
- ❖ they represented a good geographical distribution across Western Australia;
- ❖ they represented a mix of regional and metropolitan prisons;
- ❖ they represented a diverse range of prisoner ethnicity⁶;
- ❖ they provided a mix of security levels, although were predominantly medium and maximum security;
- ❖ they included a remand facility (Hakea Prison);
- ❖ they had a range of correctional staff and administrators and health professionals working at the site;
- ❖ they all had some form of mental health service provision; and
- ❖ they had capacity at the time to participate in the research.

⁶ Ethnicity and Indigenous status of participants was sought due to the over-representation of Aboriginal people in Western Australian prison populations and because of the documented health differences between Indigenous and non-Indigenous people (Kraemer, Gately and Kessell 2009).

Figure 4: Visual Diagram of the Research Procedures

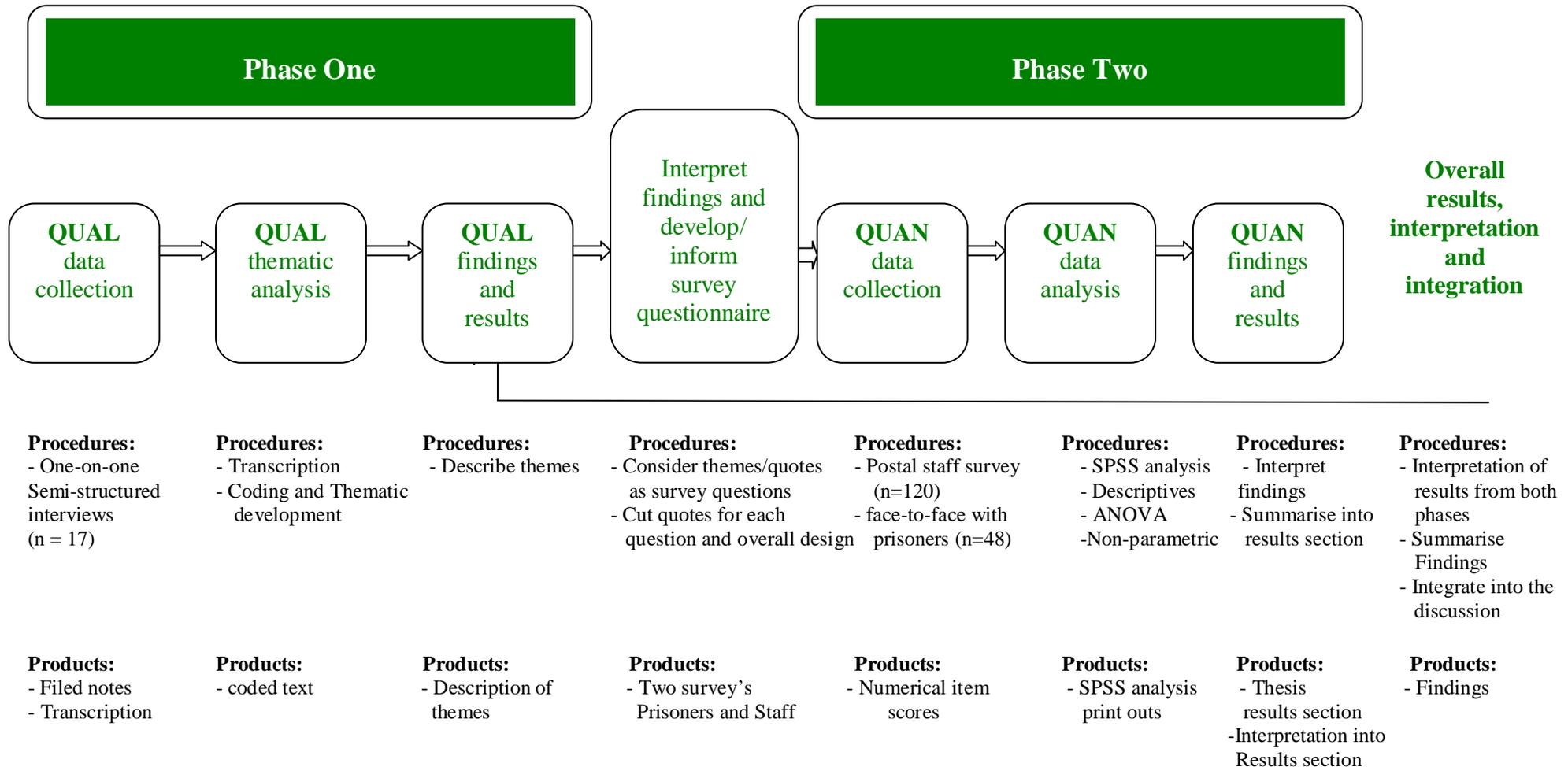


Diagram modified from Creswell and Clark (2007)

Phase One - Qualitative Component

The first phase of the research was a qualitative investigation designed to:

- ❖ Investigate, explore and describe the issues facing staff when working with prisoners who experience mental health problems;
- ❖ to investigate and gain insight into the attitudes of staff in relation to current services, treatment and facilities;
- ❖ to investigate, explore and develop an understanding of the issues, experiences and needs of prisoners with diagnosed mental illness;
- ❖ to investigate and identify any differences and similarities and gain a more focused understanding of experiences in urban and regional prisons in Western Australia; and
- ❖ to generate, flesh out and generate themes to be explored further in Phase Two.

The Selection of Phase One Participants

Generally, the sampling used in this research was non-probability. Of the four common types of non-probability sampling this research chose the purposive sampling technique. Purposive sampling was used in this inquiry as it allowed the research participants to be intentionally selected due to their relevance to the research topic. This recognised the participants as key informants who enriched and enhanced the key themes identified in the literature. A sample of 17 staff and prisoner patients were identified based on my knowledge in the field, from a review of the literature, were 'typical' examples in Western Australian prisons, and included a cross section of working role, gender, age, ethnicity, diagnosed mental illness, and professional experience.

There was a requirement that all prisoner patients were well enough at the time to participate in an interview. This was at the discretion of the mental health nursing staff and the prisoner patient's participant selection was a consultative process between me and the health professionals. I wanted to access a diverse sample of participants who had different experiences of mental health service provision and mental illness across a variety of prisons. It is argued here that this diverse sample

provided a rich and credible source of information to strengthen the findings and inform the questionnaire used in Phase Two.

As stated earlier, four prisons were selected to participate in phase one. Participants were selected from the following prisons: Hakea Remand Facility and Casuarina Prison in the metropolitan area, and Albany Regional Prison and Eastern Goldfields Regional Prison in remote areas. These prisons were included in phase one for three main reasons: 1) key correctional staff, health professionals, and prisoner patients were identified who worked or lived at these sites; 2) the prisons relative geographical proximity to Perth allowed the researcher to drive to these sites to undertake interviews (i.e., no site was more than an eight hour drive); and 3) the Department approved these prisons for inclusion in the research as they had capacity at the time.

The participants acted as key informants, helping me to explore and describe the phenomenon under study, and to also focus the issues for Phase Two. Two days of observation and a prison tour was also completed at Casuarina. Sixteen Interviews were conducted with 17 participants including 9 staff and 8 prisoner interviews. The interviews included 5 Aboriginal and 12 Non-Aboriginal participants. Prisoners had committed a range of offences including, Murder, Assault and Minor Assault, Driving Offences, Dangerous Driving Causing Death, Drug Offences, Robbery and Armed Robbery, Stealing, Break and Enter, Unlawful Wounding and Wilful Murder and had varying prison sentences - both short and long term. Moreover, prisoners had a range of disorders with the most frequently occurring being schizophrenia. Although the schizophrenia disorder is over-represented amongst prisoners it is proportionally small when compared with depression and anxiety disorders. The number of participants with major mental illness is therefore somewhat skewed in Phase One. The reasons for this are: 1) these were the participants selected as suitable by the nurses, and 2) of the participants who were asked to participate these were the ones who agreed. The majority of these prisoners had been transferred to the Frankland Unit at Graylands and spent both short and long term stints in prison. The nursing staff may have chosen these prisoners due to the prisoner's level of experience in prison and in utilising the correctional mental health services.

As good a cross section of key informant participants as possible was selected to participate in Phase One. Below is a breakdown of the participants:

Metropolitan Prisons Interviews

Prisoner Patients

- ❖ 1 x male Non-Aboriginal Prisoner diagnosed with Schizoaffective Disorder
- ❖ 1 x male Non-Aboriginal Prisoner diagnosed with Paranoid Schizophrenia
- ❖ 1 x male Aboriginal Prisoner diagnosed with Schizophrenia
- ❖ 1 x male Aboriginal Prisoner diagnosed with Drug Induced Schizophrenia

Staff

- ❖ 1 x female non-Aboriginal Psychologist
- ❖ 1 x male Aboriginal Prison Officer
- ❖ 1 x male non-Aboriginal Assistant Superintendent
- ❖ 2 x female non-Aboriginal Mental Health Nurse Specialists

Regional Prisons Interviews

Prisoner Patients

- ❖ 1 x male Non-Aboriginal Prisoner diagnosed with Schizophrenia
- ❖ 1 x male Non-Aboriginal Prisoner diagnosed with Anxiety Disorder/Obsessive Compulsive Disorder
- ❖ 1 x male Aboriginal Prisoner diagnosed with Schizophrenia
- ❖ 1 x male Aboriginal Prisoner diagnosed with Depression

Staff

- ❖ 1 x female non-Aboriginal Psychiatrist (this was a joint interview)
- ❖ 1 x female non-Aboriginal Nurse (this was a joint interview)
- ❖ 1x Female non-Aboriginal Nurse
- ❖ 1 x Female non-Aboriginal Prison Officer

Semi-Structured Interviews

Semi-structured interviews took place during site visits to the above four prisons from January 2006 to June 2008. As stated above, participants for semi-structured

interviews were selected purposely to act as key informants. These participants consisted of a cross section of correctional staff, health professionals and prisoner patients. This strategy to include and identify different traits among the interviewees, geographical location, correctional or health professional experience and backgrounds, diagnosed mental illness and offence history, and ensuring a mix of participants from both regional and metropolitan areas was essential to highlight and investigate key themes to be further developed and explored in phase two.

Gaining access to participants required a few levels of approval prior to starting the project and this is discussed in the ethics and approvals section below. Once these many and varied research, upper management, management and operational approvals were secured meetings were organised with key corrections and health staff to purposely select the phase one research participants. Once I had identified these correctional staff and health professional key informants they were contacted and asked to participate in an interview.

Access to interview prisoner patients involved visiting the prisons and discussing the required sample with mental health nursing and other nursing staff until we had identified a group of individuals. These nursing staff acted as liaison people to the prisoner patients or it would not have been possible to generate a purposive sample. The nursing staff knew the prisoners and had experience working with them, their history of mental illness, and their capacity to take part in an interview. When the nursing staff and I had identified individuals to participate they were contacted and asked if they would like to be involved in the research.

The interviews were conducted in various places where space was available in the prison; in unit offices, in the medical centre and even outside on the lawn. The interviews lasted from 30 minutes to 150 minutes and all interviews were tape recorded with consent. Prior to each interview, all participants were given and read aloud an information sheet and consent form. Once participants understood the background and purpose of the research and gave informed consent to participate, the interviews began in an informal manner. Participants were asked questions and were free to discuss what they wished in relation to the topic.

The semi-structured interviews were centred on the research questions and objectives, a document review of key topics from the literature review, and from my own understanding of mental illness in the prison context. The staff interviews covered a number of topics; the role staff play in diagnosing and treating mental health disorders, the process that takes place when a prisoner is diagnosed, their thoughts and perceptions of this process, the prison reception and orientation process, staff perceptions on treatment or various disorders, how staff feel/what are their attitudes to current levels and types of mental health treatment, what their perceptions and attitudes are to the incarceration of the mentally ill, any problems that staff experience working with prisoner patients, whether it is important to make time for prisoner who experience mental illness, if staff perceived that prisons with mental illness are treated differently, their experiences and attitudes to treatment and what additional services are required, what works well and what could be improved, the prevalence of mental illness and if, in their experience, mental illness was on the rise in prison populations, resourcing, staff attitudes about working with prisoners with mental illness and questions related to operational guidelines and training. A complete set of the prepared guiding questions for the semi-structured interviews with staff and the supporting material is attached in Appendix D. The information sheet and consent form for the interviews with staff is attached in Appendix E.

The semi-structured interviews with prisoner patients centred on their experiences of living in prison with a mental illness, what problems they have had in relation to their mental health, their stories, what it has meant for them living in prison with the illness, if they were diagnosed upon entry to the prison system, their attitudes, experiences and perceptions towards current mental health treatment, access to treatment, their attitudes or level of trust and comfort with their treatment and those treating them, questions relating to support, bullying, disciplinary action, and any topics they think are important for me to explore as part of this research. A copy of the research template is attached in Appendix F. The prisoner patient information sheet and consent form for the semi-structured interviews is attached in Appendix G.

The guiding questions were discussed with the Department's RARC committee, the research supervisors, the Research and Evaluation Team within the Department, the

Aboriginal Reference Committee, health staff from the Prison Counselling Service and Health Services, a group of prison officers from Casuarina Prison, and were discussed after the first prisoner patient interview to ensure their suitability, relevance and the question's interpretation and ease of understanding. These conversations and test interviews acted as a pilot to refine the questions. It should be noted that these questions acted as a template and guide only with participants free to go on tangents, answer questions in any order they wished, and generally discuss things of relevant to them within the realm of mental health services provision, mental illness, their offence, treatment, life in the community and lead up to arrest, and their personal experiences living or working in prisons. This is consistent with the proposition by Bryman (2004) that semi-structured interviews consist of guiding questions that are not fixed or rigid.

Data Analysis

I listened to the interview tape recordings a number of times and then transcribed them. When listening to the interviews I was paying attention to eliciting themes that related to the central research objectives. The interviews (n=16 with n=17 participants) were then thematically analysed. I looked for common themes and relationships and for any different or interesting information. It should be acknowledged that the themes I identified would be shaped and influenced by my position and experience working for the Western Australian Department of Corrective Services (refer back to the Researcher's Positioning on page 12 for further information) . The data was analysed using the following five steps:

1. Data was organised, cleaned up and reduced so that the information was accessible. In some cases this included removing 'umms' and 'arrrs' as it made the transcription clearer.
2. I then read through the transcripts a few times to get a general sense and feeling of the responses. I immersed myself in hardcopies of the transcriptions in order to develop themes and patterns across questions and participants. Themes were assigned colours and I began to form patterns in the material. The aim of these first two stages was to discover the main themes emerging from the research and to begin organising them loosely.

3. Some preliminary overarching headings were formed and then smaller headings and themes and supporting quotes were colour coded and inserted under each heading and theme. The process then moved from the paper transcripts to an electronic Excel spreadsheet where the themes and supporting material were entered. This stage was concerned with the process of assembling the information around certain themes and points.
4. The emergent understandings were analysed in the context of who the participant was and compared with the representations of mental health and institutionalisation in the literature review. The main aim of this fourth stage was to interpret and further analyse the information. This included identifying trends and explanations, interpreting the themes and writing them into text with supporting quotes.
5. The common themes, ideas and supporting quotes were then pulled out for the beginning of the phase two questionnaire survey design. These constructs were then examined in Phase Two.

Phase Two - Quantitative Component

The second phase of the research was a quantitative survey designed to:

- ❖ Investigate, explore further and quantify the issues facing staff when working with mental health prisoners;
- ❖ investigate and gain further insight into the attitudes of staff in relation to current services, treatment and facilities;
- ❖ to investigate, explore and quantify the issues, experiences and needs of mental health prisoners across a larger sample;
- ❖ to investigate and explore experiences in urban and regional prisons in Western Australia;
- ❖ to explore whether there was agreement about the constructs generated in Phase One and the pattern of that agreement/disagreement; and
- ❖ to gather survey data across a broader range of prisons and participants.

Phase Two used a survey questionnaire design. This phase allowed the researcher to increase the scope and breadth of the research by taking the findings from Phase One and investigating them across a wider range of participants and prisons by the use of a mail-out and staff distributed survey for staff and a focused face-to-face survey for prisoner patients. Phase Two provided an opportunity to build on the qualitative

findings, to look for similarities and differences in the findings across participants and to confirm or refute (test levels of agreement/convergence with the Phase One quotes) the Phase One results and identified constructs across a larger sample.

Samples and Sampling Method

Prisoner Patient Sample

The prisoner patient sample was selected using non-probability purposive sampling. The sampling method had to be approved by the Departments RARC. The RARC stipulated that non-probability sampling was to be used via conversations with mental health nursing personnel and that all questionnaire surveys with prisoner patients were to be completed face-to-face by the researcher, not via a mail out. This limited the sample size and the number of prison sites included in phase two. The researcher decided to survey prisoner patients at the same four prisons as Phase One and to select 15 participants from each of these four prisons.

Mental health nurses and general nurses helped to identify a list of possible participants who were well enough at the time of the visit to be interviewed. These prisoners were then asked if they would like to participate in the research and I visited each prison to complete the surveys face-to-face. The participants were chosen from two metropolitan prisons, Hakea and Casuarina, and two regional prisons, Albany and Eastern Goldfields. These four prisons were chosen as relationships had already been established with key health professionals in these prisons making the sample selection accessible, and the prisons represented a geographical cross section of prisons, nature of prison population, and differing availability of mental health services. These prisons were also selected due to their relative proximity to Perth.

Questionnaire survey completion was conducted with 48 prisoner patients across the four prisons. I had originally intended to undertake 60 prisoner surveys but this was not possible due to time constraints, prison access restrictions, and participants declining to participate. The sample (n=48) included a range of participants, who were of differing age, cultural background, history of mental illness, prison location, and term of imprisonment. Prisoners had committed a range of offences including,

Wilful Murder, Manslaughter, Assault, Dangerous Driving Causing Death, Drug Offences, Armed Robbery, Unlawful Wounding, Aggravated Burglary, Kidnapping and Sexual Assault. Prisoner patients were also diagnosed with a range of disorders including schizophrenia, obsessive-compulsive disorder, bi-polar disorder, depression, psychosis, personality disorders, Attention Deficit Hyperactivity Disorder (ADHD), and a combination of disorders (dual or multiple diagnoses). Many prisoners discussed being drug users before coming to prison and some discussed self-harming behaviours and attempting suicide.

When completing the survey with prisoner patients it was important to go through the information sheet and consent form addressing any questions the participant had. Informed consent was obtained from all prisoner patients. Completing the survey with prisoners lasted between 30 minutes and 150 minutes. In most cases I read the survey questions aloud and the participant and I completed the survey together. This was particularly necessary for prisoners who found reading and writing difficult (at the commencement of each interview I formulated with the participant the method of completion they were most comfortable with). In other instances, the prisoner preferred to complete the survey on their own.

The survey completion was conducted in various places where space was available in the prisons, in prison unit offices (both general and protection units), in medical centres, and Special Handling Unit (a supermax unit within the prison where prisoners are in single cells and kept in solitary confinement for most of the day. There have been calls that units such as these breach international human rights law due to their cruel treatment of individuals). It was appealing to complete the surveys in the Units as it gave me an opportunity to observe prison life and the interactions amongst staff, amongst prisoners and amongst staff and prisoners. The disparity between some of the events and conversations I witnessed in the units and the responses I recorded on the surveys was interesting.

Staff Participants

The staff sample was selected using a combination of key informants (prison liaison persons), convenience sampling, and snowballing techniques. Subjects were approached via liaison persons or directly by the researcher. Two or three staff

members (prison officers and/or health staff) were identified in each of the eight participating prisons and were asked to act as prison liaison persons. This required them to act as points of reference in each prison and to help distribute surveys to staff within the prison. In addition, an email was sent to all correctional staff and health professionals at the eight participating prisons. As stated earlier, the prisons were: Albany Regional Prison, Broome Regional Prison, Bunbury Regional Prison, Casuarina Metropolitan Prison, Eastern Goldfields Regional Prison, Greenough Regional Prison, Hakea Metropolitan Prison and Roebourne Regional Prison.

There were two ways in which people could take part in Phase Two -

1. Participants could either visit one of the liaison people in the prison they worked in, and collect a survey; or
2. They could contact me, and I would forwards surveys via the post, with an information sheet and consent form.

Participants could then -

1. Return the completed surveys directly to me via the post; or
2. Return the completed survey to the liaison person who then returned surveys to me in bulk packages.

These options were made available in order to make it easier for participants and with the hope of increasing the sample size. Many participants felt comfortable to speak with the liaison person about the research however, those wanting more confidentiality returned the questionnaires directly to me. In total, 120 staff questionnaires were completed.

As staff questionnaire participants were sought through convenience and snowballing techniques, it is not possible to give an accurate response rate, although these sampling techniques rely on established social networks and existing relationships which would be expected to enhance response rates. However, as the purpose of the questionnaire survey was to explore further the themes identified in phase one and to investigate perceptions and attitudes rather than map actual trends and epidemiological information, and participants were not sought through any form of probability sampling, participate response rate is not a major concern. Rather, the

representativeness of these participants, or who they represent, is the main interest when evaluating the information from this survey (Bryman 2004). A note on the research participants and the sampling method is discussed later in this section.

For interest in criminological response rates an approximate response rate can be provided. After discussions with the Department's RARC contact and my supervisors, a decision was made to forward sixty questionnaires to each of the eight prisons (a total of 480). A total of 120 surveys were completed, with the majority returned to the prison liaison people, and then forwarded to the researcher, thus producing a response rate of exactly 25%. However, the questionnaires could have been photocopied by staff and an identifying number was not placed on the documents.

Prisons are complex hybrid environments and it is often difficult to 'break into' this setting and gather information for research. Response rates have typically been low in this setting and the RARC anticipated the response would be low for this project. It should be noted that even though a small number of people chose not to participate (n=3), they took the time to write passionate emails, stating that they did not wish to participate because nothing would change and the research was a waste of time. In addition, my intentions were questioned in a number of these emails and a number were very harsh and cynical about me, the research and the 'system' in general. These emails show that prison staff are deeply affected by mental health and psychiatric challenges in their working environment and this often overflows into personal beliefs about the prison system, research or change in mental health services (or lack thereof) and government policy. I did not take these emails personally and felt somewhat pleased that the research was eliciting such strong emotions, discussion and debate. For confidentiality reasons (because the authors requested that the content of the emails not be discussed), the content of these emails is not discussed in this document, even though it could be deemed qualitative data.

Survey Questionnaire

The survey questionnaires were completed in Western Australia in 2007 and 2008. They were completed in one of two ways: they were distributed among key

correctional staff and health care professionals; or were completed face-to-face in an interview like setting with prisoner patients.

The Phase One interview information, themes/constructs and participant quotes were used to design two comprehensive questionnaires, one for staff and one for prisoner patients. I was conscious of allowing the participants' voices to be the defining aspect of the instrument in keeping with the epistemological underpinnings and origins of the project. Therefore a decision was made to use participant quotes to represent the construct as the questions and to then measure whether participants in phase two supported or disagreed with the experiences and thoughts of the phase one samples. This process allowed for in-depth exploration of the topic across both the qualitative and quantitative phases.

All participants participated in this research on a voluntary basis and no incentives were offered. All participants were presented with an information sheet, a consent form, and the questionnaire. The information sheet indicated that the return of a completed questionnaire would be interpreted as consent in cases where participants did not want to complete the consent form and remain completely anonymous. In the majority of cases the consent form was completed and returned to the researcher. The information sheet and consent form for prisoner patients is attached in Appendix H and the information sheet and consent form for staff participants is attached in Appendix J. An overview of both survey questionnaires is provided below.

Prisoner Patient Questionnaire

Question one asked for some demographic information including age, prison location, mental illness and if participants identify with a cultural or ethnic group. Question two related to current service provision, issues, attitudes and experiences. The question emanated from a series of quotes made in Phase One which ranged from 2A ("I find it hard living in prison with a mental illness") to 2Y ("I don't think prison officers should be looking after us as they are not qualified medical staff). Participants were asked to rate the quotes as to whether they Strongly Agreed, Agreed, were Undecided, Disagreed or Strongly Disagreed.

Questions three, four, five, six and seven related to participants' opinions on the level of care they are provided by prison officers, prison counselling staff, and nurses and whether they feel that staff should have additional training in mental health and whether prisoners could also have more access to information about mental health in prisons.

Question eight consisted of quotes from Phase One relating to education and training. The question was a series of quotes which ranged from 8A ("Training in mental health is vitally important") to 8O ("Officers who work in the Crisis Care Unit and places like that should be specially trained in mental health"). Participants were asked to rate the quotes as to whether they Strongly Agreed, Agreed, were Undecided, Disagreed or Strongly Disagreed.

Question nine consisted of quotes on what additional services prisoners would like to see established for treatment and on-going care of prisoners who experience mental illness. All quotes related to resources, funding and additional service provision. The quotes ranged from 9A ("I would like to have more regular visits by the mental health staff and greater access to staff") to 9Q ("It would be good to have mental health programs for mental health clients"). Participants were asked to rate the quotes as to whether they Strongly Agreed, Agreed, were Undecided, Disagreed or Strongly Disagreed.

Question ten asked participants to rate whether their experiences of living in prison with a mental disorder were generally positive or negative and questions 11 and 12 related to the numbers of prisoners with mental health issues and reasons why numbers are increasing if prisoners thought that was the case.

Questions 13 - 16 were optional free response questions if participants had any additional information to add about issues/problems of living in prison with a mental illness; attitudes and feelings to current levels of treatment and service provision; main experiences of living in prison with a mental illness and any short-term or long-term needs prisoners have in relation to their mental illness. In many cases participants raised additional thoughts, opinions and experiences throughout the

discussion and completion of the questionnaire and I wrote these responses in as the discussion took place.

The questionnaire was repetitive in some places and some questions/quotes were worded both positively and negatively in order to measure the reliability of responses. The prisoner patient survey is attached in Appendix I.

Staff Questionnaire

Question one asked for some demographic information - age, prison location, role within the prison, gender and if participants identify with a cultural or ethnic group. Question two asked participants to identify what they call prisoners from a list of options (e.g. clients, prisoners, inmates, patients).

Questions three and four related to current service provision - issues, attitudes and experiences. Question three consisted of a series of quotes/statements made in the Phase One interviews and were about issues staff may face in the prison, their attitudes or experiences and issues that may arise for them. Quotes ranged from 3A ("It is important to make time to listen to prisoners who experience mental illness") to 3W ("Prison is becoming the new kind of institution for people with mental illness"). Participants were asked to rate the quotes as to whether they Strongly Agreed, Agreed, were Undecided, Disagreed or Strongly Disagreed. Question four asked participants to rate a number of things that may work well for them in the service they provide (e.g. "we have great staff who work well as a team").

Questions five to nine related to education. Whether staff had received any training in mental health; feel that they have adequate access to training; that other staff have suitable levels of training and whether prisoners have adequate information and education about their own mental health.

Question nine consisted of a series of quotes from Phase One relating to training and education. Quotes ranged from 9A ("training is vitally important") to 9N ("Members of the Prison Counselling Service need additional specialist mental health training"). Participants were asked to rate the quotes as to whether they Strongly Agreed, Agreed, were Undecided, Disagreed or Strongly Disagreed.

Question ten consisted of a series of quotes from Phase One relating to management and consultation. The quotes/statements related to management, both prison and health, consultation and policy within prisons. Quotes ranged from 10A (“there is inadequate management support when faced with mental health crisis issues”) to 10O (“the interface between health and justice needs to be reviewed”). Participants were asked to rate the quotes as to whether they Strongly Agreed, Agreed, were Undecided, Disagreed or Strongly Disagreed.

Question eleven consisted of statements/quotes from Phase One that related to resources, funding and additional resources. The items sought staff views on what additional resources and services they would like to see established for the treatment and on-going care of prisoners who experience mental illness. Participants were required to circle whether they Strongly Agreed, Agreed, were Undecided, Disagreed or Strongly Disagreed. The quotes ranged from 11A (“the number of beds at the Frankland Unit extended) to 11T (“there needs to be a facility that accommodates mental health patients that can be managed according to their requirements and needs”). 11U asked if there were any other services they thought would be beneficial.

Questions 12, 13 and 14 asked staff to rate their experiences and if they thought the numbers of mental health clients was increasing and if so, why. Questions 15-18 were optional free response questions relating to key issues/problems that arise for staff; their attitudes and feelings about the placement of mental health patients in prison; any additional training they would like to undertake; their attitudes and feelings about the current level of service provision and their thoughts on services to metropolitan and regional prisons.

It should be recognised that the surveys were demanding and time consuming for me but more importantly for the research participants. This may have affected the quality of the responses, especially as participants became tired towards the end of the questionnaire. The staff questionnaire is attached in Appendix K.

Data Analysis

The results for both samples were analysed using SPSS 14.0, first in terms of frequency distributions, including means, medians and standard deviations, and then by One-Way Analysis of Variance (ANOVAS), Chi-Square Tests and T-Tests to determine any differences between groups. Normality tests were run showing that the data was not normally distributed. Therefore, the assumptions of the Chi-Square, T-tests and ANOVA tests were violated as the number of cases (expected frequencies not greater than 5) in each cell was not sufficient, the sample size (prisoner patients) was not large enough, and the data was skewed (not normally distributed). Due to this, complementary non-parametric tests were run in SPSS. This included both Kruskal-Wallis and Mann-Whitney Tests. Additional Phase Two analysis information is provided in the result chapter.

Participant Sampling for this Research⁷

As participants for neither the semi-structured interviews nor the questionnaires were based on any form of probability sampling, an account of the representativeness of the participants is warranted. Do the participants in this research reflect a reasonable sample of health professionals, correctional staff and prisoner patients? Although I cannot address this question with ultimate certainty, it is possible to argue that although the participants may not represent the whole spectrum of prison staff and prisoner patients, they represent significant sub-groups from a cross section of prison locations.

The prisoner patients who participated in both phases represent male prisoners from a diverse range of age groups, ethnicity - with approximately 35% of all participants recognising themselves as Aboriginal, offence history and diagnosed mental illness. All of the prisoners in the sample are in prison populations because they did not satisfy an insanity defence in Court. They were drawn from eight prisons, both remand and sentenced, minimum, medium and maximum security, and had various sentence lengths. Some had been previously diagnosed in the community and others were diagnosed with a mental illness in prison. Some had previous convictions and had spent time in jail and others had not. Some had spent time in psychiatric facilities

⁷ Additional information on participant characteristics is provided in the findings and results sections below.

prior to incarceration and others had spent time in psychiatric facilities during their prison stay. Moreover, some participants had drug and alcohol problems, had self-harmed or attempted suicide and others had not. What this information demonstrates is that these individuals were a diverse group who represent the range and type of individuals with mental illness in prisons populations. The common denominators are that these prisoners were incarcerated in Western Australian prisons at the time of this research, all had a diagnosed mental illness, all were male, had their individual experiences and stories of incarceration, and all were treated by, and had access to, mental health services.

The correctional staff and health professionals who participated in both phases represent male and female staff from a diverse range of age groups, ethnicity, working role, educational attainment, work and professional history, length of service, and prison location. More of the health professionals were female and more prison officers were male. However, this is not surprising as more females are nurses than males; it is common that 70 percent of all nurses are females, and 70 percent of all physicians are male across different health care systems (WHO 2006b). It was also anecdotally recorded (figures could not be provided) by Superintendents that the majority of prison officers are male. Every effort was made to ensure that participants were drawn from a range of prisons and represented a range of those involved in mental health service provision or correctional management.

These traits of the research participants are important as it is their views, experiences and attitudes that are reflected in this thesis. It could be argued that these findings are not generalisable as probability sampling was not utilised, however, the themes identified in this research by the participants clearly reflect and support the research literature in many instances. While the absence of probability sampling can be viewed as a limitation of this research, particularly from a naturalistic research methodological epistemology, the purpose of this research is to investigate and explore the mental health service provision experiences of staff and prisoner patients in Western Australia, as well as the challenges and issues they face in this context. As stated earlier, the vast majority of the research on mental illness in corrections comes from the epidemiological field; hence this research investigated experiences, perceptions and attitudes.

Ethics and Approvals for the Research

There is a fundamental requirement to conduct research which abides ethical etiquettes and standards. This is particularly necessary when undertaking research with prisoners and more particularly prisoners who experience psychiatric illness. This research was approved by the Curtin Human Research Ethics Committee and the Departments Research Application and Review Committee prior to any data collection. The phase two surveys were also additionally approved after the completion of phase one by the Curtin Human Research Ethics Committee (causing considerable delays to the project), and all interview schedules and survey questionnaires were provided to members of the Aboriginal Reference Committee for consultation. Consent and permissions were sought from all participants.

Once the formal permissions were received I then gained approvals for the research and data collection phases from a broad range of people within the Department. I identified all persons involved in the research from a management perspective and each person was contacted and asked for permission to undertake the research. This included all relevant people from Health Services and Prison Services within the Department, at an upper management, management and operational level. Meetings were held with key health staff and a list of initial staff contacts was referred by the Manager of Health Services.

In addition, all participants in this research were informed about the research objectives, the topic, significance, and the importance of their role, the limited likelihood of improved services during their sentence, confidentiality and the utilisation of the results in a language they could comprehend and understand. The researcher was available to answer questions or clarify information. The researcher provided a guarantee that no participant would be identified in the thesis and that privacy and confidentiality would be taken very seriously throughout the research process. This privacy extended to the written thesis and no participants are named or identified in any way in the results chapters; participants are not even given a number or pseudonym as this may have lead to the identification of participants at certain prisons. Prisoner patients were notified that the only time the researcher would break this confidentiality is if the prisoner divulged information that they were going to harm themselves or someone else, or told the researcher details of a crime

they had not told the police. Great care was taken to ensure rigorous ethical standards throughout the research process and to make sure that all participants thoroughly understood their rights and the voluntary nature of the research. It was important that no prisoner felt pressured to partake, or misunderstood that participation would lead to a reduction in their sentence (Grundzinskas 2003).

Moreover, the researcher organised for staff from the Prison Counselling Service and/or the Mental Health Team in each prison to be available should prisoners have any questions or experience adverse consequences from taking part in the research. The researcher was also available to revisit the prison at any stage should participants request. Additionally, the researcher feels that it is imperative to provide feedback to the people who took part in this study and she intends to follow up at each prison by providing a summary of the findings where possible.

Obstacles and Limitations

It should be recognised that this research was limited in a number of ways. These obstacles and limitations are discussed briefly here. Interviewing individuals in prisons can be difficult and time consuming, especially nursing staff that are very busy, prison officers who have strict routines, and prisoners who are frequently transferred to other locations or may be in work or education. The interviews and survey completion were a challenge to organise as I did not want to interrupt the flow of the prison or encroach on what staff already view as a hectic schedule. To counter this I made all appointments well ahead of time and the interview guides were well prepared and sent in advance. Even so, delays often occurred. For example, there were times when I would travel 600 kilometres and turn up to find that prisoners had been transferred elsewhere or staff were too busy to see me. There were also acts completely outside my control, such as a death in custody, which interrupted the surveys. This meant that I had to remain flexible and use my time as best as possible. I generally used this time to casually chat with staff to build rapport or look over case files. Such delays were also overcome by staying in town for a week or more so that I could interview or survey people at the time most convenient and suitable to them.

It was also imperative to be respectful and mindful of the prison 'code' or attitudes held by some staff that 'you do not talk out of school'. In some cases there was opposition or resistance to part-take in the research and my motives were openly questioned by people. In some instances it was additionally challenging to draw out the negatively held opinions of staff as they did not want to be seen to be 'trashing' their work, colleagues, or the prison they worked in. It was important to give people the time and space to vent their frustrations, even if a little off topic at times, to gain their trust, to do what I could to build their confidence in the research topic, and that I was there on their side to help try and make their lives easier in the long run. In retrospect I am unclear about whether my employment with the Department was a help or hindrance. I think in some cases it opened doors as 'I was one of them' and in other cases people were more suspicious. I always made it clear that I was undertaking this research as a student researcher and not as an employee of the Department.

When undertaking the interviews and surveys with prisoner patients I was conscious of the power imbalances between us. Some of the questions were quite confronting for people who are dependent on the people and services they were asked to assess and in many cases criticise. They did not know (beyond doubt) that their responses would be kept safe as all I could give them was my word and they didn't know me. I imagine that some respondents would have had suspicions and fear about repercussions from the information they gave me. This could have affected the way prisoners responded and may account for the high rate of undecided responses to some questions; they may have felt uncomfortable due to confidentiality reasons. I endeavoured to address this by talking openly with people about the aims and objectives of the research, that I would not share what they told me with prison authorities, that they would not be identified in the thesis, and I would take good care of the transcripts by keeping them in locked filing cabinets.

Another possible limitation is the reliance in this research on self-reports of an offender population. An often inevitable limitation of participant research is that it relies on the assumption that the person is correct in their information and is accurate in their reporting to the researcher. This can especially be the case in a prison interview setting where participants are particularly likely to talk about

themselves in a more favourable light. However, this research was not focused on offence history so this issue was already reduced due to the nature of the research topic. There was also the possibility that prisoners would be very unwell, be on high doses of medication and/or, have distorted memories or experiences. I combated this by trying to interview prisoners who were relatively stable at the time of interview, although some people were clearly acutely unwell and the need for open and sensitive interviewing was paramount, and through the triangulation of some information such as offence history, diagnoses and their contact with health services.

It is important to note that the survey questionnaires were demanding and time consuming for the researcher completing them with prisoner patients and also for both groups of research participants. This may have affected the quality of the responses, especially as participants became tired towards the end of the questionnaire/interview. In most cases this was combated by working through the questionnaire with participants and by the researcher having extensive experience interviewing in corrections. It should also be noted that no questionnaires were returned incomplete so staff who participated were dedicated to complete the survey.

Moreover, the exclusion of female participants was disappointing considering the research evidence of high rates of mental illness in women and the research cannot say anything about female prisoners in Western Australia. This again was outside of my control. The research was originally not approved to sample Aboriginal or female prisoners and I re-submitted to the RARC to have these overturned. They decided on the additional information I presented that Aboriginal people could be included but female prisoners could not.

Chapter Conclusion

This chapter has presented the research methodology utilised to explore mental health services and mental illness in prison settings, as outlined in the research questions and objectives. It has already been argued that the author does not perceive a conflict between qualitative and quantitative research instruments and methodologies, and this research utilises a pragmatist stance in that it draws from

the best of both paradigms in the research approach. However, this research arguably tilts more towards qualitative methodologies and ontology and draws on the constructivist framework; this does not exclude the research's subscription to the attributes of quantitative research and its axioms. This is reflected by the equal weighting of both phases of this research throughout the data collection and analysis and in the writing of the findings and discussion.

The research utilised a mixed methods approach; consisting of qualitative semi-structured interviews and a questionnaire survey. Research participants were correctional staff and health professionals who were employees of the Department of Corrective Services in Western Australia, and prisoner patients with a diagnosed mental illness who were incarcerated in prisons run by the Department. Despite participants not being selected through any form of probability sampling, the experiences, attitudes, feelings and needs of these participants will offer great insight into life and service provision in the prison environment. Moreover, great care was taken to ensure a diverse group of participants from a range of professional and work backgrounds, geographical locations and history of mental illness. Some of the characteristics of these participants may not be representative for all correctional staff, health care professionals, and prisoner patients in Western Australia, although these characteristics, such as age, ethnicity, professional role, prison officer ranking, administrative staff representation, physical prison location, offence history, and diagnosed mental illness are associated with a good mix of the typical subgroups of prisons staff, health professionals, and those males diagnosed with a mental illness incarcerated in prisons. These subgroups also reflect those identified in the mental health research literature. As such, attitudes and perceptions among these participants are valuable to the discussion regarding prison based mental health service provision and the services of the future.

The following five chapters will present, explore, and analyse the information thematically analysed from the semi-structured interviews and the data obtained from the questionnaires. The interview material and questionnaire data are presented in separate chapters according to their methodological traditions. The findings are then synthesised in to a coherent whole in the discussion chapter and the final chapter then concludes this research.

CHAPTER FIVE: PHASE ONE (QUAL) RESEARCH FINDINGS

Introduction

The purpose of this chapter is to present the qualitative Phase One findings. The findings will be presented excluding the analysis and interpretation which will be conducted in chapter Seven's discussion where the findings from both phases will be discussed. This separation of the findings and discussion follows Alston and Bowles (2003). They propose that research findings can either be integrated with the discussion (linked to theories and a literature review); or alternatively, that research findings and the discussion of these findings be presented in separate chapters. Moreover, I was mindful of Creswell and Plano Clark (2007), Creswell (2003) and the published mixed methods literature, where the findings are typically presented in sequence, with separate headings for each phase. The findings are then integrated and analysed in a discussion or conclusion chapter. For this research, the findings are presented with few comments, and the interpretation follows in the discussion chapter. This method is also applied to the Phase Two quantitative data in the following chapter.

In Phase One information was gathered through semi-structured in-depth interviews with staff (n=9) and prisoner patients (n=8). This chapter presents findings that were gathered from four prisons in Western Australia - Albany Regional Prison; Casuarina Prison; Eastern Goldfields Regional Prison and Hakea Prison.

Description of the research findings is divided into overarching themes followed by sub themes. The identification of these topics is based on the research objectives which are related to the research milieu, my background in the field and positioning as a researcher that is both internal and external to the Department, and to a literature review. The themes are illustrated by using quotes from staff and prisoner patients. The best way to convey the ideas, thoughts and intensity of participant feelings is to share these direct quotes. In some cases, the quotes are discussed in text but in other cases, the quotes are simply listed as they speak for themselves and help to give voice to the participants' experiences. There was a great deal of emotion expressed during these initial interviews with many discussions taking place over several hours. Because of the length of these

interviews, and the volume of significant material, direct quotes make up a large proportion of the chapter. It was imperative to me that participants' voices were clearly heard in this section of the thesis, because they so willingly gave their time and energy to participate; and they are so rarely heard.

Resources and Funding

According to the participants there were limited resources and insufficient infrastructure to provide the necessary care for people with psychiatric illness and mental health problems in prisons in Western Australia. Not surprisingly, the consequences of inadequate financial support were diverse and a variety of ideas were expressed about where best extra funding could be spent.

Prisoner Patient Quotes

Which Facility: Prison or Hospital Care?

Prisoners were not a homogenous group when it came to service provision and the kind of facility they would most like to be imprisoned in (based on the premise they are sentenced to be incarcerated as obviously they would rather their freedom). Most stated that prison was not an environment conducive to treating their illness and expressed a desire for special facilities to give attention to their needs. However, one young prisoner felt strongly that he would prefer to be housed in prison and under no circumstances would he be willing to be transferred to a medical facility.

Most participants commented that prison was a challenging environment, twenty four hours a day seven days a week, and they would like to be transferred to a medical based facility that provides similar services to those currently offered at the Graylands Psychiatric Hospital⁸. Prisoners spoke of their circumstances in prison and commented that it was not the right environment for them to get the care they require. One participant spoke strongly regarding this:

This is a hell hole and people like me don't belong here. It is very hard to live in here...the officers make life hard for you and you have to deal with funny characters, it is not a good place especially for someone with an illness...we need a medical place...it is a disgrace that people like me have ended up in prison.

⁸ Graylands is a State Psychiatric Facility in Perth. The Frankland Unit is a secure unit (locked ward) within this facility that accommodates clients from across the criminal justice system.

Prisoners were asked, if services were to change, where they should be treated and who they thought should provide them with this care. Some felt strongly that they should be treated by medical staff, not prison officers, and there was general dissatisfaction with the level of long-term care provided. One participant stated that prisoners are only sent to Graylands to be stabilised and then sent straight back to prison to begin the process of abating again:

I think they should build another thing like Graylands that can have more people because there is not enough room there for everyone. I think anything that is not prison but is similar to Graylands would be good for long-term stay for people like me. It is not good enough to send people off to be stabilised at Graylands and then send them back to this place to slowly deteriorate again. We should have a special unit where we can stay that is staffed by medical people. You definitely do not want officers or any of those sorts of people, I think it should be doctors, nurses, I am talking about psychiatric nurses, psychologists and social workers...there needs to be a place for people like us to go to. I mean, just throwing us in jail is a real cop out, they should not be doing that, it is inhumane and they should be ashamed of themselves for doing it to us.

For some, seemingly more acutely unwell prisoners, there was a perception that the Frankland Unit at Graylands Hospital was an appropriate facility. Many prisoners stated that the government was not committing adequate attention and funds to mental health treatment, both in the community and in prisons, and this was creating a desperate situation in prisoner health care. The statement below helps to illustrate the level of frustration prisoner patients experience and why one inmate chose to participate in the current research:

I believe that the Frankland Unit is an ideal situation and we need infrastructure much the same but on a much larger scale because there are many, many prisoners who are suffering mental illness, some worse than mine, some less than mine, and we need the money and the beds, and proper funding for these services. The mentally ill people are screaming out for help. Time and time again I read in the papers that people have gone to community mental health services for help and they end up killing themselves, now that is ridiculous. We are living in the 21st Century and we should not have things like that, it is a very sad situation where people are suffering you know. We should have more empathy, the people in power, the Ministers and politicians, should have much more empathy on the people with mental illness, it is a very sad situation...A lot of these prisoners need to be somewhere therapeutic and the Government has to do something constructive about it. They must provide the funding to adequately address illness. I know a lot of mentally ill people in this wing and they say that there is not enough being done in the system. I thought it would be a good opportunity to speak to someone like you who maybe has some power to make other people listen. I hope they listen to you, if not, they are fools as you are the only person

doing something about it and asking us what we need. They have to stand up and do something for the mentally ill not just talk about it.

However, other prisoners commented that they felt stable in prison and although mentally ill they criticised the idea of being transferred to a psychiatric facility:

In prison it is a bit more relaxed but it is not as thorough. It is very different but the idea of a psychiatric facility does not sit well with me.

I was stabilised at Graylands and then came to prison. Graylands is like a fish bowl. When you are unwell you want to be looked after but you also need to be able to walk around in open spaces.

The issue of where to be treated was not as evident at Albany Regional Prison where prisoners discussed positive experiences in a safe and secure environment. Not only did these prisoners not want to be transferred to other facilities but they suggested moving mentally ill prisoners to the prison. This appeared to be associated with positive staff relationships:

They need to get more people down to Albany from Perth who have got mental illness. It is a lot better atmosphere and is a more self maintaining kind of place. There are not many fights down here as everyone gets along. In other jails, it is more scary because there are more fights and that. I feel less paranoid here with the staff and others. The staff treat you like a human being. I would much rather be here than a mental hospital.

Inadequate Staffing and Access to Alternative Therapies

On a topic closely related to resources and funding, prisoner patients expressed concerns regarding their limited access to medical staff. Participants spoke of insufficient levels of nursing and clinical staff stating that the numbers affect the level and quality of care they were provided:

They need more staff to help us out. There are not enough and it means we do not get the proper care.

Other participants acknowledged the effect that a low staffing rate had on their treatment claiming they would like additional visits by medical staff and more input into their medication regime:

Well, more regular visits by the mental health staff, and more regular visits by the doctor, and particularly the psychiatrist, more say when it comes to what types of medication we take rather than just being plonked on any medication and we have to take it.

Prisoners expressed feelings of boredom due to an inability to participate in employment as a consequence of the effects of medication. Many felt that this segregated them further from prison life, and they would like additional services or programs if extra resources and staff were made available to run innovative programs. This was seen as a way to reduce their level of medication and do something more constructive with their time:

It would be good to have more counselling services, art therapy, and other forms of help rather than just only having to take drugs all of the time.

The effects of pharmaceuticals and a lack of input into medication regimes was an important topic raised by a number of participants. Prisoners stated that unsatisfactory staffing levels meant they had restricted access to nursing and psychiatric staff reducing their capacity for ongoing support and treatment beyond pharmaceutical medication rounds.

Health Professionals and Correctional Staff Participant Quotes

Limited Staffing and Staff Morale

The issue of derisory staffing levels was raised by all participants in Phase One. Staff expressed an urgent need for additional specialist mental health staff, particularly in regional prisons, and that these staff should be permanent employees of the Department rather than contracted agency staff:

...we need more mental health nurses and...occupational therapists would be good, I am aware when I say this it is like a wish list but to be honest it is impetrative.

There is a whole mix of things; mainly we need really need more trained and dedicated mental health nurses. It is important to be spending time with people to be able to treat them.

Health Professionals were very troubled by the lack of availability of psychiatrists and the implications this had for service provision. They experienced long waits for specialist consultations particularly in regional areas:

It was very hard when we only had the psychiatrist coming in once a month as so many people missed out. I feel sorry for the prisoners who still only have a psychiatrist once a month it is ridiculous...and seriously limits patient care...

Health professionals commented that regional and metropolitan prisons have similar needs but that variation in the prison populations, particularly prisons with a large Aboriginal demographic, is an important consideration. Moreover, the difficulty of attracting staff to work in regional areas was seen as an issue:

I don't think regional prisons have different needs but you always need to be aware of the demographics of the prison population and the availability of staff. Broome, Roebourne and Eastern Goldfields are mainly Indigenous populations, and we could be looking at quite a lot of organic brain damage and drug induced psychosis. I think the problem with the regional is we don't have enough PCS [Prison Counselling Service] staff and other services. I get concerned about this. It is hard to get staff in regional areas...

Health professionals and correctional staff articulated feelings of a disconnection between staff in Head Office, or management generally, and staff in prisons. A real 'us and them' attitude was apparent in some of the interviews. It was evident that there are contrasting philosophies and awareness at different ends of the system. One staff member described her experience in this way:

There are a whole lot of things especially in the health area that have been totally ignored and neglected. The morale of health staff and nurses is low. We have many agency nurses at present and to be totally honest a lot of nurses have left because of upper management. There is a disconnection...a huge divide between upper management up there and us on the ground. Many people - the staff, uniform staff, nurses, PCS...it is about saving money and cutting costs, we have lost some great and very dedicated staff. We lose people because they do not agree with the people up there. Field staff are not listened to. They need to find out what is going on and listen to the staff and find out what is needed. You have a person up there and then people down there with no connection. You must have a good relationship with the people on the ground. Good work with patients is not rewarded or validated by anyone...when you are removed several times you have no conception of what happens on the ground. The layers are difficult to get through and people are not always honest about the success or failure of projects or ideas. Agency staff come in and out and this is not the best solution. You need regular staff that are aware of the issues. You always need staff who are prepared to fight the battles.

In addition to this 'us and them' attitude staff expressed that working in prisons can be negative particularly when the financial and human support mentioned above is not provided:

When there is a lack of resources people on the ground are frustrated and may become punitive. It is very easy to get sucked into the negative environment. People need supervision and support; for nurses and officers who are working in mental health. Prisons do not usually provide a supportive working environment.

The 'Wish List' for Improving Services: What we could do...

Health professionals and correctional staff had what they saw as a 'wish list' of additional services they would like to provide ranging from art therapy, additional staff, time, to new therapeutic psychiatric facilities. Each of the prisoner patients also expressed a desire for similar services and there is a discernible congruence of the findings across participant groups.

Staff reflected on their current experience and provided suggestions for improving services. Some quotes were very practical:

There is a lack of appropriate office space for visiting psychiatrists.

And, others were far broader:

Without improving the current facilities the human rights of many prisoners are in question.

The staff interviewed stated that they experience many challenges providing psychiatric and mental health services to prisoners. Moreover, they expressed a need for a range of mental health services and additional facilities to accommodate mentally ill clients. The following points and quotes draw attention to their views.

- ❖ There are challenges managing clients with personality disorders in the prison. However, the PD unit was not viewed positively or as a service that would be of assistance. An attitude towards PD clients emerged in the subtext of the interviews and there was a perception of a need for different accommodations for differing disorders:

I think the Personality Disorder Unit is very political. That unit is not going to assist us on the ground.

There needs to be a facility that accommodates mental health patients that can be managed according to their requirements and needs. When I say this, this is not a unit for Personality Disorders. Personality disorders do not cover the mentally ill, they are a different category all together. We need to focus on managing mental illness, people with personality disorders are problematic for us but we cannot only focus on one group and we need to deal with the current level of mental health prisoners. We need different units for different people.

- ❖ Staff experienced difficulties transferring clients to the Frankland Unit and suggested an increase in bed numbers as a way to improve current service provision:

Sometimes we have had highly psychotic people in the prison that can't get to Frankland because it is very restrictive...we need to increase the beds to treat people properly.

- ❖ For some staff building a state facility at Casuarina Prison and transferring all mentally ill prisoners to this site upon return from Graylands will help alleviate the problems. Alternatively, placing all mentally ill prisoners in one unit that is staffed by trained correctional officers may help:

Where there is an identified need by the professional staff that a prisoner needs to go to Graylands, they should go to Graylands. Then they need to come back here, as is current practice, to a psychiatric unit, that is, a State facility...there needs to be a ward area attached to the infirmary where people can be looked after by a medical officer. I would see this being staffed on the same basis as the infirmary and the Crisis Care Unit, that is medical staff and uniformed staff..

Mentally ill prisoners are dotted all over the prison in the protection unit, in the disturbed and vulnerable unit, in mainstream, and in the crisis care units. It would be much better to have them in one place and to train the custodial staff to be able to work in the unit. At the end of the day the custodial staff are the care people and they need proper training.

- ❖ Health professionals stated they struggle with the limited appointment times and believe that an increase in treatment time would improve patient services by allowing for health promotion and prevention to be undertaken:

We get people case managed and we get them seen but all we are doing is crisis managing people...we have a captive audience here, we can pick things up quickly. If we have more resources we could do a lot more strategic stuff, a lot more health education stuff. We are just seeing people adhoc, there is not the time to spend with people. It would be better to have the time to spend with people. It would be great to do group work.

- ❖ Other staff placed emphasis on the importance of additional consideration for the re-entry of mentally ill prisoners when they are released into the community and the possibility of providing them with supported accommodation:

They need supported accommodation in the community. Many of these people will never be able to make it in the real world and will need constant care which is currently not provided hence they are in prison.

- ❖ Correctional officers stated that a refocus of the current court based referral system and services is required:

Any changes need to focus attention on the interaction between courts and prisons and a defendant who may or may not be mentally ill. The Judiciary are putting a lot of work on prisons and mental health services and they do not know the difference between Mad and Bad. They put a lot of people down for psychiatric reports who do not really have a mental illness. There is a lack of understanding from the courts about mental illness and they wind up in prison. In addition, courts should have their own specialist mental health facility.

The experience of one officer and a suggestion of what is needed to improve services, including new facilities to be built as a priority and additional staff and programs to cater for clients, was expressed by one correctional staff member:

We are struggling and need a psychiatric ward. We need something that has a two-fold approach. First of all there needs to be more beds at Frankland because there are certainly times here when we need to get prisoners there and we cannot because there are not enough beds. Frankland is short-term...the second component is the need for a long-term unit where we can place quite a large percentage, lets say that figure I spoke of before, that is 70-80 people in this prison only, not including future projections, and of that 70-80 about 25-30 people would qualify for placement in a long-term facility. Because of the nature of their illness they are not unwell enough to be placed in Graylands but they are not well enough for us to have them out in mainstream. You cannot have them in a mainstream unit with all of the other prisoners as it is just problematic. It is not fair on the prisoner, the staff and the other prisoners. There is a considerable lack of knowledge and understanding about mental illness amongst both staff and prisoners, they just don't know what it is about, what is involved, and what to do with them. Invariably you end up with a core group of people who are on a merry go round through the safe cells, in the CCU [crisis care units] and the other units. We even have to have some of the prisoners in the protection unit as they would not survive in mainstream as they are too vulnerable...they should be in a psych unit.

All staff discussed the significant contribution that could be made and the importance of targeting prison programs, such as anger management or life skills (i.e., budgeting and cooking) programs, to the needs of mentally ill prisoners. At present staff stated there are limited programs offered to all prisoners and mentally unwell prisoners miss out all together:

Programs for mental health clients would be great! Programs are important because often people have to do particular things in order to be able to come up for parole and mentally ill people are disadvantaged here as they may not be able to concentrate as well due to the medication. There are no tailored programs for psychiatrically ill persons in Western Australia and this is a real pitfall. People need education regardless of whether or not they have a mental illness.

Some of the staff members described the importance of involvement in creative pursuits and in particular the potentially positive influence of art therapy. One staff member stated that art therapy services, which were provided in the past, were very beneficial, and reflected that it would reduce prisoner boredom, provide a sense of accomplishment for prisoners with mental illness, and give prisoners another way to explore their illness:

That is a hard question. There are so many things that could make such a big difference. Drawing and painting...we used to have a lady who came in once a week but she doesn't come any more. It really soothed people and made them calmer and happier. They used to hang their work up outside and they felt proud of something they had done. It was a real shame that it stopped. The guys get really bored and they are unwell...they need things to keep them busy or they fall in a hole.

It can be seen from the comments above that prisoners and staff had similar ideas regarding the need for additional staff and found common ground on the subject of facilities and psychiatric service provision. Staff participants had varying views on what was required to adequately provide services to prisoners who experience mental illness. On one level staff reported having insufficient funds to provide appropriate services and that this generated struggles in their everyday work life. Specifically, this related to: inadequate staffing, facilities and infrastructure, appointment lengths and treatment options, and a need for programs, alternative therapies, and enhanced community re-entry services. On another level this related to differences in philosophical ideas of how to treat, what works and what is evidence based practice, and what staff were trying to achieve through treatment. Overall, the inability to access funding and resources to support treatment options is deplored by health professionals, correctional staff and prisoner patients alike.

Education and Training

Strong views were embedded within the notion of education and training and its relationship to psychiatric illness and treatment. The topic of education was discussed passionately by all staff and most prisoners with a view that everyone, including the community, needs information and education to breakdown the mystery of mental illness in our society. Prisoner patients discussed levels of knowledge and understanding of mental illness by the people who are supposed to be caring for them, their own level of knowledge, and the understanding of mental illness and mental health by the rest of the prison population. Both health professionals and correctional staff experienced many varied challenges when providing services to mentally ill prisoners and expressed a desire for improved knowledge and access to training.

Prisoner Patient Quotes

Prison Officer Care

It was evident from the outset that prisoners felt strongly about the ability, or perhaps inability, of correctional staff to provide them with mental health services and care. As one prisoner commented:

The officers have no idea of what mental health is and are not properly trained to help us.

Other Prisoners and Support Networks

Prisoners articulated that knowledge of mental illness was important if other people were to empathise with them and that at present there was a lack of education provided to staff, themselves and other prisoners:

Most prisoners have no idea of what I am going through and what is wrong with me, they just think I am kooky. There should be pamphlets and information available in the medical centre and mental health education for staff and prisoners so people understand better.

Another participant discussed the support networks that were available in prison and stated that it would be useful for those support people, mainly the Peer Support Teams⁹, to have mental health training:

⁹ Peer Support Teams is where older prisoners, or prisoners who take an interest in helping others, provide support to vulnerable or younger prisoners.

Peer support is really good; prisoners often feel comfortable talking to another prisoner. There should be a specialist mental health peer support team who are properly trained.

Health Professional and Correctional Officer Participant Quotes

Correctional Officer Training

Correctional officer training was identified as one of the most pertinent issues in relation to mental illness and service provision in prisons. All staff spoke on the subject of the role of prison officers when providing care and support to prisoners with mental health problems. Health professionals commented that prison officers lack the necessary training and skills and that limited training options were available to them. Prison officers experienced role conflict and confusion due to the lack of training opportunity.

The initial correctional staff training was viewed as seriously flawed and in some cases prison officers were only provided with the bare minimum due to staffing shortages:

The initial prison officer training is seriously lacking and needs to be revised. It should be a comprehensive 8-10 weeks training course. Quite often they are so desperate for staff that the training is nothing. It needs to be completely revised as a matter of urgency. The content is not adequate. There then needs to be ongoing updating.

Prison officers shared this sentiment and most had not participated in any form of mental health training despite expressing that it would be beneficial:

I have never done training on mental health. There was none in the initial training I did. It would be good to have some level of understanding of the different mental illnesses, the symptoms, what people are going through and how to manage them and to recognise what is going on. I have no idea and it is worrying.

In addition, staff expressed a desire to learn specialist knowledge in order to improve their ability to manage prisoners:

The need is in At Risk Management System [a system to case manage prisoners at risk of suicide], suicide, risk prevention, self harm and also personality disorders and how to manage difficult behaviours. It is about how to manage someone when they are angry and upset.

In contrast, some officers stated that despite prisoners with mental illness being difficult to manage, and an explosion in numbers, they did not want additional training. These officers were of the view that it was not their responsibility to care for prisoner patients:

It really concerns me the mental health problem...after more than two decades in the service I have just seen an explosion of numbers, and it is very difficult for uniform staff in the prison environment to manage these people. Generally uniform staff receive no training whatsoever in the management and care of mental health patients and rightly so as it is not their job.

Health Professionals Training

Health professionals stated that training opportunities were limited in the prisons they worked in and they would like access to additional training and professional development. Staff articulated that training was not valued by the prison administration they worked in, and that even though the prison may pay for them to undertake a limited amount of training, they had to do this training in their own time (i.e., holidays). The following quote embodies these views:

That is a hard one. We can put in for relevant training and they will pay but you have to do it in your own time. So you can do anything you want but you have to use your own time. The reason I don't want to do it in my own time is that we work in a very stressful environment, the most stressful area to work in the nursing profession is mental health and also in the prison so you need your holidays and time off for yourself to recharge your batteries not to do extra training. Training is important in this field and you should be allowed to improve your skills on work time. I don't want to use all of my holidays doing training or I would end up stressed out to the max. However, people need to do training and be continually educated about mental health.

Concerns regarding the training of mental health nurses were also discussed:

No one has any training other than the nurses and they are not trained mental health nurses.

Prisoner Education

Limited opportunities to provide education to prisoners on topics relating to general and mental health was identified by some participants as a concern:

We really push drug issues and self-harm but mental health is forgotten. They need more information and education, education is the key but at the moment there is no time or funding for education.

Staff expressed concern that due to resourcing issues education was not provided. Staff stated that this had implications for clients understanding of their illness and overall treatment:

They need education but this is about time and resources. It is very common for clients to have little insight into their illness and the effect of medication or other drugs with their medication.

As was noted in the additional services section above most staff had a desire to provide programs to clients:

Programs for mental health clients would be great.

A dominant theme to emerge from these interviews was that there were limited training options provided to correctional staff and health professionals on the subject of working with and managing prisoners with mental illness. Moreover, the induction training provided to prison officers was seen as woeful in relation to mental illness, creating a situation where many officers were unclear of their role and where they worry about their treatment of people who experience mental illness. There were limited professional development options for nurses and health staff. This is concerning given the number of individuals with mental illness in prison populations. Education and programs for prisoners were also viewed as inadequate limiting the level of insight prisoners have into their illness and the potential for improved healing.

Management, Consultation and Context

Health professionals and correctional staff were upset and disillusioned with management and the organisational style provided by the Department. Many of the participants spoke of their concerns regarding a lack of consultation at the grass roots, that is, with those who actually directly provide services to offenders. This was touched on above in relation to the 'us and them' attitudes that emerged, however this was expressed more concretely here. There was an 'ivory tower' perception that policy and management staff at head office make decisions and are out of touch with the 'coal face' of service provision. This theme specifically related to staff experiences but ultimately impacted on the level of service provided to clients.

Policy and Operational Guidelines

Reflecting on the more formal side of prison services raised concerns for staff. They stated that there are limited policies and guidelines for them when managing mental health patients and those that were available were seen to be outdated and impractical:

The policy and guidelines need revising and updating as we go along and things change.

The health management policies need reviewing in relation to the role of mental health and what actually happens on the ground.

In some cases, staff had never seen or heard of any policies relating to providing mental health services. This raises questions of accountability and leaves staff feeling concerned about prison protocols and practices:

[I've] never seen or heard of any that relate to mental health. There should be some definitely because what happens when we don't know what to do in a particular situation.

One staff member provided a suggestion that the relationship and connections between health and justice be reviewed:

Someone needs to look at the interface between health and justice and the module of care we provide.

Meaningful Staff Consultation

For some of the staff participants, there were concerns about the level of consultation with staff regarding policies that affect their everyday working environment. Again, a real 'us and them' attitude emerged from the interviews with health professionals and correctional staff feeling as though their knowledge, management skills and opinions were overridden by people further up the chain of management. Staff indicated that they felt powerless to manage clients, and the overall prison environment for which they were responsible and accountable. The following quotes reflect the disillusionment in staff voices as they struggle to be heard:

We are never asked what we need and why we need, people just make decisions that affect us with no consultation. I will tell you how it is. You start with the Minister, and he says this is what I want done, then it comes down to policy and planning, and everybody else gets their finger in the pie, then it comes down to the populations, and then by the time it comes down

to the people on the ground floor it doesn't reflect in any way what it started as or what is really useful. There are too many bureaucrats who are social engineers who are getting their hands on the policy and planning. The issues of not consulting, not looking at the detail on the ground, it is quite often that people tell us what we need or what to do but they never ask us or consult with us. It is very simple but we don't live in a simple world, everybody thinks that they know best. It is hard to overcome the egos and ambitions of bureaucrats who like to have glossy CV's and be able to show that they have achieved something but not necessarily done anything. You get callous working in prisons because everybody who is outside of the prison thinks that they know how to do the job better. All too often we see it a lot with the planning and policy areas, they don't consult with us.

The reality is that it is about people trying to impose things from the top down when it should be managed from the bottom up. If there is going to be consultation, the consultation must be meaningful...

In addition to feeling isolated at the ground level, health professionals described having a lack of support from within the prison and health management, feeling invisible, and one staff member shared the desperation of her position:

There is a total lack of health management and prison management support for mental health.

Management support from upper levels of health is very poor and totally inadequate. We are never listened to by people up there; it is very difficult to be invisible.

I have no support from [management] for mental health. It is verging on work place bullying. I feel like I am fighting for the mental health of the prisoners at the moment and the other nursing staff do not care. I have no support from anyone other than the community psychiatrist and she is treated appallingly by the other staff in this prison.

The lack of influence of staff external to the Department weighed heavily on health professionals and they expressed distress about the employment of psychiatrists in the system and the chain of command for nursing staff:

Custodial management system - yes you generally get support however our recommendations are sometimes overturned. It is difficult; as the psychiatrists do not work for Department of Corrective Services they are guests in the prison and work for health [the Health Department] so they do not have authority to get treatment done. They make recommendations and we try to carry them out but sometimes the prison system gets in the way of this. It would be much better to have the psychiatrists working for Department of Corrective Services and the mental health nurses responsible to them. There is a total lack of management direction from Department of Corrective Services and health. Clinically if the psychiatrist wants things done they happen but they are not here to make it happen and nurses are not

listened too as much...people have no idea of what is happening at the coal face if you like.

Another central issue discussed by most staff concerned the prison environment itself and the difficulties of providing health services in this context. Staff experienced challenges as security is the first consideration in this setting and staff stated that health is often not given the priority it deserves:

You have to factor in the security aspect because working in a prison people have to understand that top of the list is people's safety, clients and staff. Life threatening situations are top of the list, then it is security, and then it is health underneath that. Therefore, nurses working in the custodial environment have to get used to that. The security coming above everything is different from the community because in a hospital the health of clients comes first...this impacts on the service we provide. It is all to do with time management. If we had freer access to the prisoners our time would be used more effectively, and we would be able to see more people. Obviously you have to learn to deal with this and work around that. It is still frustrating...

Health professionals and correctional staff expressed concerns regarding the Department's culture of care and they would like to see the interface and philosophical underpinnings between health and justice reviewed with a specific focus on improving current policies and procedures. In addition, they have a desire/need to be meaningfully consulted regarding practices, and to improve accountability through enhanced management systems and structures.

Current Service Provision, Prisoner's Experiences and Institutionalisation

Prisoner Patient Quotes

Prisoner's perceptions of current service provision varied as were their experiences of these services and their incarcerated lives. Prisoners reported having good days and bad days with some prisoners experiencing adequate access to mental health care and others where access was not timely or consistent. Relationships with staff also varied as did levels of support, bullying and perceptions of confidentiality. Prisoner patients' experiences are shared below.

First Encounter with Health Services

When prisoners first arrive in prison they have an initial health assessment that is designed to establish any prior history of mental and psychiatric illness. Across the interviews participants' experiences of first services provision varied.

Some prisoners stated they received immediate treatment and were provided with support from friends and family in the community who supplied the prison with information regarding the prisoner's history of mental illness:

My family rang and let the prison know that I was unwell and I told them that I had schizophrenia. My doctor also phoned and told them as he was concerned and worried about me coming to prison.

Other prisoners experienced a long wait for help, and although now stable (at the time of interview), many felt that adequate support was not provided in the early stages of their imprisonment. Issues relating to inadequate psychiatric services were discussed by all participants. The following two quotes illustrate prisoners' experiences:

I was suffering for about 10-11 months before anything happened. I then saw the psychiatrist and was put on anti depressants. My disorder was not initially picked up by the system.

I saw the psychiatrist eventually. I had tried to get help for about 13-15 months before anything actually happened and that was very distressing. The nurse manager would not help me. I was put on anti depressants by the psychiatrist and now I don't worry as much. I am pretty happy with this treatment but I should have been listened to earlier when no-one would help me, they just thought I wanted medication, but I would rather that I didn't have to take it...but I need it.

Another participant stated that he found it difficult to access services and shared the view that most prisoners were not good at asking for help. He also stated that when they do pluck up the courage they are often met by staff who do not believe they are unwell:

I went to see the psychiatrist and they kept me on my medication. I am good at asking for help but lots of people are not and even when they do people don't believe that they are sick...but you can see they are. Not everyone here just wants to take medication, some people really need help and they don't get it. Even when I say that I am having difficult day's no-one really cares or tries to support and help me.

Prisoners who were interviewed in regional prisons said they experienced challenges accessing the treatment they required due to the limited availability of the psychiatrist:

I was transferred to see the doctor and he prescribed me some medication. I have only seen a psychiatrist twice, they never come here,

it makes it difficult for the doctors as they have to prescribe the medication and they don't really know about this stuff, you know.

Access to Services: is the system failing people with mental illness?

Current and ongoing service provision was seen to be inadequate by some prisoners and 'great' by others. These attitudes were very dependent on prison location and centred on the staff and facilities available. The quotes below illustrate the negative and positive experiences prisoners face and begin to identify where the system is both failing and succeeding.

Prisoners discussed many issues relating to service provision and as stated above there was a general sentiment that they would like to be transferred to a psychiatric facility. One prisoner shared his opinions of current services and his need for increased compassion and understanding from the people around him; and another expressed a need for additional activities and people to chat with:

I do not feel that I have adequate access to care, services and treatment. I am happy with my treatment in the sense that at least we have mental health staff. I mean, if we were living in a third world country, I would have something seriously to worry about. I know the way they treat people over there. I still believe that I should be in the Frankland Unit or a mental hospital as prison is not the right place to put people who are mentally ill. A mentally ill patient needs a little bit more understanding and I am not saying that we deserve a better service than anybody else but what I am saying is that we deserve a different level of understanding in a legal and human sense.

They need to have more activities and games and people to talk to so that you understand your illness and yourself better and to help build your spirit.

Another participant expressed his belief that the system is failing those with mental illness:

For people who are unwell the system is failing. People have to wait too long to get care and many are placed in the CCU [crisis care units] which is not an ideal place for them to be. It takes a long time for people to get stable on medication and even then, many people should not be placed back in prison, as they cannot handle it. They should go to a special medical ward or something.

Moreover, another prisoner shared his views of the conditions in the observation cells used in some prisons:

The facilities here could be better and the observation cell is terrible. It is a bare concrete room that makes you more aggro or sad or what ever you are feeling, it makes it worse, it is inhumane to put people in there.

There was a sense amongst participants that over time prisons had taken the place of the psychiatric hospital. Prisoners stated that the number of mentally unwell people is increasing in prison populations:

Prison is becoming the new kind of institution for people with mental illness. It should not be like this.

In contrast, other prisoners were content with the existing services and reflected positively about staff and their environment. The quotes below encapsulate these views, however, it should be noted that all of these views were expressed by prisoners at Albany Regional Prison:

I am pretty happy with the treatment I am getting and I no longer hear voices. All of the staff are really helpful.

Most of the staff here are really helpful and supportive, when you want an appointment or someone to talk to, you can.

The services here are wonderful, the staff are all very nice and understanding and caring. They are beautiful people. The prison staff here are all very caring, it is not like this at all of the prisons but it is here, it is a country thing. There is no-way to describe it.

The best is in Albany. It is a home away from home but still not many visitors but I don't like visits. The staff are really up to standard and treat you like a human being, they call you by your first name. All of the staff are great. Whenever you want to see the health staff you just put your name down and they see you pretty much straight away.

Nothing at Albany cause it is great. At other prisons, it is terrible. I have been to Casuarina, Acacia and Canning Vale and most of the staff don't give a shit and you do not have easy access to anything or nurses to talk to, you just have to bite your teeth and grin, it was really hard at Casuarina. When you put your name down you have to wait a week or more to be seen, they are understaffed to deal with it, and by the time you get to see someone you are all right you have dealt with it, kinda, on your own or you are too scared to ask because they don't have the time to talk to you.

Good Days and Bad Days

One of the objectives of this research was to gain a sense of what it was like for mentally ill individuals to live in prison. It is difficult to really understand the

experiences of prisoners, and without being a part of the environment, we may never fully understand. However, the quotes below in some way provide an insight into the lives and everyday experiences of prisoners.

Prisoners' experiences of incarceration varied greatly, and ranged from awful; *"It is awful...simply awful, I am sick and do not belong here"*; to being a helping hand:

I find that sometimes being in prison is a help, it is a helping hand because on the outside no-one looks after you. I can honestly say that out of the prison system I would be in more trouble...I am happy to be here as I get help. Sometimes prison is scary and you get abused but I just try to stay away from them, I try to not take any notice of them even when they take their anger out on me...I would be in even more trouble if I was out there in the community. I don't take my anger out on other people.

The officers do not care and prison is about discipline not treatment. Treatment should come first.

Despite prison being a 'helping hand' this prisoner is evidently frightened of both the wider community and others in prison. He is the target of abuse and other prisoners' anger within the prison and although the structure of the environment may help in one hand the environment is also definitely taking away with the other.

Prisoner patients shared their experiences of the challenges of taking medication and the lack of understanding they receive from the 'screws' and employment staff about the effects of the medication on their minds and bodies. One prisoner shared his experience this way:

It is hard to explain. Sometimes I have a good day and sometimes I have a bad day. It's like sometimes when I go to work I am real drowsy from the medication, and I feel unwell and groggy. The screws [prison officers] come along and coach you out of bed, and when you get out of bed and to work the boss is on your back trying to get you to work when you don't want to work, and you just want and need to be in bed. I work in upholstery, I used to be a cabinet maker on the outside but drugs got the better of me. No-one understands. I feel groggy in the mornings from the medication. Sometimes I wake up real early in the morning and I stay up because if I go back to bed then I will wake up really groggy, so it is better to stay up and watch TV. I have been in jail a lot now so I have gotten used to it. It is really hard to describe this place and the effect it has on you. It is different for each person but it is never simple.

The prisoners interviewed also identified with feelings of loneliness and seclusion and shared that they are isolated in prison. They said they try to keep out-of-the-way and to themselves most of the time as they get 'fed up' with other prisoners or because their illness takes over their ability to interact with others:

I find it hard most of the time, I get fed up and I just want to be isolated and be on my own.

When you have your good days it is easy to mix with people but when you have mental illness they [the other prisoners] are looking out for someone to pick on and they take you for a ride. It is hard to find people who understand you and that you can talk to. There is never anyone to talk to. It is like there is no-one to get support from that does not have other motives. These are very hard times.

An Aboriginal prisoner discussed feeling particularly isolated from other Aboriginal people. He said that closer ties would provide him with additional support networks:

I feel very isolated and alone. It is very negative here and that makes it very hard to build the spirit back up. When you have an illness those bad days are really bad, I want to close down and my spirit is affected by other prisoners and they take it away from me. I don't understand why they treat me bad and hurt my spirit. I want to be near the older Aboriginal people. I want to have their support and talk to them. They have had spiritual experiences and they understand, no-one else understands and even if they do feel empathetic the system stops them from really being able to help you. I just want to sit down and talk to someone. You cannot put your guard down at all; I just find it really hard.

Other prisoners shared their feelings of paranoia and that the prison environment is not a place where they ever feel safe, they feel pressure from other inmates to stop taking their medication:

They [medical staff] let me go after a week and they put me on drugs. I get real paranoid in prison all of the time. It is not easy as you are around a lot of people and when you get paranoid you think that they don't want to talk to you or something like that, and so you go into your room and lock yourself away...my voices have gone away since taking the injection...my friends in here keep telling me to get off the medication but I tell them that I can't because if I do I will go hay wire again...they don't like the medication they reckon you don't need it, it is all in your head.

Other prisoners felt their moods fluctuated and stated they had good days and bad days. A few prisoners discussed their mental illness in relation to spiritual or

religious beliefs and acknowledged that each day was a battle with themselves, their mind, and the system. One prisoners quote illustrates this:

Some days are good and some days are bad. It is a spiritual thing for me. You see, when you use drugs you damage your spirit and that is how you fall into a mental illness because your mind becomes weak. I am living with people who don't care about spiritual things, and that makes it more difficult. For a person with mental illness they are getting punished twice when they get sent to prison because they are fighting a battle everyday and then they have to deal with the system. Lots of people just shut down.

In contrast, one prisoner articulated that although being isolated in prison he didn't mind as he felt he had adjusted well to prison life. However, he also stated that he felt safer at Graylands Hospital than in prison. He shared his experience in this way:

I am mainly on my own I don't speak to many people. I keep to myself a lot but I feel like I have adjusted very well. I am a sort of independent person. I like my own company. I don't like to talk rubbish which is what a lot of the guys do. I found that in Graylands they leave you more to yourself, they give you space, you have more space, the food is much better and I take a lot of notice of people who take medication and it slows them down and I do not want to get like that. If you cannot help yourself, no one else can help you. I really enjoyed my time in Graylands and think that it is a much better place for people like me. I feel safer there.

Another prisoner responded that he felt happier in prison because he is away from the drugs he used in the community and that he now had a structured routine which helped him to cope:

I think I have felt better in prison as I have a structured routine and am away from the drugs.

Confidentiality, Trust, Surveillance and Control

Some negative and concerning information emerged in the interviews regarding prisoner's personal medical information. Prisoner patients expressed anxiety that their personal information was available to staff as staff share this information with other people and that staff cannot be trusted as the information may later be used in a way that is detrimental to the prisoner. Participants felt strongly that their medical information should only be available to qualified medical/clinical staff:

I don't think that the prison system should have access to our personal information. I believe that the only person who should be privy to that information should be doctors, psychiatric doctors, and nurses, and maybe on the odd occasion psychologists.

You cannot confide in people here, officers, health staff or prisoners as they share the information with other people which is difficult.

No, I don't think they should have access to any information...there are some good officers, there are some very good officers but some of them can be very sarcastic, they can be very blunt, and they...I think they don't really fully understand, some of them can be very mean about a persons mental capabilities and they don't really understand the obstacles that a mentally ill person has to overcome, especially being in an environment like this...they use your own personal medical information against you.

One prisoner pointed out that any support provided in prison came with a number of caveats. That is, he felt when he did confide in someone he knew that this information may then be passed on and used against him:

The mental health staff are very good, they are very helpful, supportive and understanding. However, sometimes I believe that they talk to the officers about us, and give them a bit of information they shouldn't be given; they all talk about us. If I was in an asylum the guards would not talk about me. After I talk to someone here, they go straight in the officer's office and talk about me. That should not happen unless of course I am endangering someone else's life, or my life, or something like that, but sometimes I think they talk a bit much and are free with their lips. And then everyone knows about you and they are sarcastic and say nasty things to your face. This harassment makes me lose confidence and makes me think 'are they really here to help me or are they out to get me and stab me in the back'? I don't know who to trust most of the time.

Trust and confidentiality are difficult issues in a place like a prison; on the one hand it is important for prisoners to feel they have people who they can trust and confide in, however on the other hand it is also important that officers be given adequate information to provide prisoners with care. It is concerning that prisoners feel officers may use this information against them, however it also needs to be remembered that many of these prisoners report feeling paranoid, and this may impact in their perception that people are talking about them.

Different Treatment/Bullying

Bullying is in many ways related to the confidentiality and trust issues presented above and also with the way service provision is conducted in prisons. Most prisoners, at some point in their sentence, reported they had been bullied,

harassed or abused by staff and/or other prisoners. The seriousness of this bullying varied, as did the way it affected the manner in which the person spoke of their prison experience. From my reading of the literature, and the impression I got from the interviews, violence and brutality are things that occur frequently in prisons and are inherent to the very nature of the environment, however it seems to be rarely spoken of or openly acknowledged. A few prisoners discussed this topic loosely and with caution. Regardless, bullying is inappropriate and needs to be taken into serious consideration when talking about any service provision to the mentally ill, who are often a vulnerable demographic in prison and in the community. The quotes below illustrate the experiences of prisoners in relation to certain subthemes:

❖ Medication, bullying and punishment:

I get the feeling that other prisoners think you should not be on all of the medication and they be strange towards you, they think you are taking advantage of the situation and can get free medications, they don't understand that you have serious medical issues and have to take the medications. Another thing I have found is that when I want to stop taking my medication they [staff] punish me by putting me down the back for days until I start taking it again...there is no TV or anything down there...you have a mattress on the ground that you are not allowed to lie on during the day, they order you around...it is like third world activity which should not even go on in a prison, it is a disgusting way to treat people who are mentally ill. They should not have the right to do that. The only person who should be able to deal with me regarding my medication is a qualified psychiatrist and he should have the right to sign a form 1 and place me in a medical facility. I am sick of officers who don't understand me, picking on me and blackmailing me and punishing me to take my medication.

❖ Etiquette and distancing:

I noticed that I get treated very well as I have a lot of manners and I am not afraid to use my manners. Some of the prisoners are very rude and have no manners and they get in trouble. I am treated very well. Sometimes the other prisoners think I am a bit funny, tease me, and keep away from me...but I guess I keep away from them.

❖ Peer-pressure, bitching and name-calling:

Nah, not really picked on, just by my mates who keep telling me to get off it. They don't understand and they would have to go through what I am going through to understand it. They reckon I am full of shit and that I need to be a man they keep saying, they reckon it is all in my head, it's real hard that no-one understands. They don't have any pamphlets on schizophrenia or nothing so no-one even knows about it. The prison staff

here are all really nice; it is a country bumpkin town, they like what they are doing and their job. At Casuarina I was treated differently because people don't like their job. The officers sort of make fun of you, they are real rude, you go and ask them something and they just say go away to you and then you would hear them say stuff under their breath about you like you are nuts or something, calling you a nutter and names, it was the worst.

Not me because I am stable but the treatment of other people disgusts me. Some of the officers are great but many of them do not understand or care and treat people differently, they talk about people behind their back and say horrible things to their face.

❖ Prisoner to Prisoner bullying:

Many of the prisoners are vulnerable and are easily taken advantage of...especially the guys with mental illness. They give their stuff away and people take their smokes and use them to do things. So many people should not be here.

❖ Fear of accessing services due to retaliation, reactions and on-going bullying from other prisoners:

Sometimes they pick on you and you feel their energy and they hang off you and hold you back and say things about you. They ask questions like - why do they call you to the medic, and they don't understand, they think you just want the drugs or that you are strange because you have a mental illness. People see schizophrenia and they don't understand. I don't know what it is myself. The officers are okay. Some will help you and ring the medic and that to get you help but others are real bad. Some of them see you struggling [and] try to help but you have to be able to ask them. It depends on the person. Some days I feel like going to crisis care but I would not go there, I have never seen it and the other people would pick on me more for going even though I may need to, it would make it worse.

Disciplinary Action and Punishment

Again, there is common ground here with the theme above and in some cases the use of discipline within prisons could be seen as a form of bullying. Discipline and obedience are a part of everyday prison life and prisons administrators must walk a fine line between keeping order and being over punitive. Prisoners are being punished for the crime they have committed by having their freedom taken away for the duration of their sentence. Additionally, disciplinary action is taken against those prisoners who abuse the prison rules or do not comply with prison standards. Prisoners spoke about the use of discipline to force them to take their medication:

I have been ordered by a psychiatric nurse to go into crisis care because she said to me, I won't mention her name, that "no-one in their right mind would take you off your medication", and then she said, "you will be going immediately to crisis care or MPU [Multi Purpose Unit] and staying there until you take your medication." MPU is where they send you when you have done something wrong. I don't think I should be put in there and treated like a bad person. It makes me feel horrible and sad...sometimes this place gets way over my head and gets too much for me...it is simply too much for a mentally ill person.

Another prisoner shared how he felt, when to his mind, he was punished for feeling particularly unwell and paranoid:

Yeah, I had my injection and the pills and I got into a paranoid state and I could not breathe. They restrained me and stripped all of my clothes off and put me in the IOU [Intensive Observation Unit]. It was terrible! They strip all of your clothes off and cut your jocks off because you won't let them take them off, it is terrible to be man handled like that when you are paranoid and freaking out anyway. I was having a panic attack, and they put me observation and you have to wear a special gown. This was at Canning Vale - it was terrible. They have real strict rules there and they don't seem to understand that you are unwell; it is like you are getting raped. They missed my medication one night, my night time medication and I went into a state of paranoia, I could not sleep and I stayed up all night. I was a nervous wreck the next morning. I guess that is one of the bad things down here there are no nursing staff or anyone on in the nights. The medication helps me to sleep as well because I cannot sleep. On the outside the doctors had me on sleeping tablets as well but they won't give them to me in here. I feel doubly punished in prison.

Health Professional and Correctional Staff Participant Quotes

The issues, attitudes and experiences of health professionals and correctional staff, with regards to current service provision, working in prisons and institutionalisation, related to a number of sub-themes. Staff were very candid in the interviews and within the discussions many themes emerged. Some of these overlap with the themes above and with the prisoner patient findings around these themes. The quotes below demonstrate their views.

The Challenge of Therapeutic Intervention in a Total Institution

A key feature of the staff interviews was that they faced numerous challenges in the attempt to provide therapeutic services in the structured and heavily controlled prison environment. Staff reported they found it difficult to cope with the limited services they are able to provide prisoners. Staffing levels, the number of beds at the Frankland Unit, limited access to the psychiatrist, prisoner

boredom, overcrowding, time constraints, and training were amongst the issues raised. The quotes below provide valuable insights into the thoughts, experiences and attitudes of staff.

Increasing Numbers of the Mentally III

All staff reported that, in their experience, there are increasing numbers of prisoners with mental health problems in prison populations putting additional pressure on already struggling services:

There are increasing numbers of people with mental illnesses and unfortunately many of them end up in prison. They should extend Frankland or set up a secure hospital unit for mental illnesses not personality disorders as currently planned.

These participants reported that in their opinion prisons had become a virtual 'dumping ground' for individuals with mental illness:

Prisons have become the dumping ground for a deregulated mental health system. We have steadily seen an increase in people coming into the prison system who have mental health problems. It is not any secret and there is a large body of research on it however, having done all of that clearly people are not doing much about it. I am not sure that people fully understand or appreciate the significance, or what the impact of trying to manage these people is within a prison environment.

Furthermore, staff viewed prisons as the dumping ground for mental health clients due to:

❖ Deinstitutionalisation, drug use and societal attitudes:

It relates to deinstitutionalisation and the increase in drug use. There have been big increases in drug induced psychosis and there are many on-going issues related to drug use. It is hard to work out whether after people remove themselves from a drug they will not have symptoms of mental illness and psychosis or whether they have done permanent damage and go on to have long-term schizophrenia.

Drugs are the number one factor. It does not cause mental illness but triggers it. Changes in society and access of people to material wealth and work prospects, lack of supported accommodation and violence factors - zero tolerance by hospitals and mental hospitals has seen more people come to prison.

❖ trans-institutionalisation:

It is just trans-institutionalisation [moving people from one institution to another]. Society says let's close the mental hospitals and move people into the community but the reality is we have just moved them into prison.

❖ inadequate community service provision:

Sometimes you feel like people are sent to prison as they will get some treatment whereas they will get nothing in the community.

Why Prison?

There was a struggle in many correctional officer and health professional minds and they expressed limited understanding as to how and why mental health clients were in mainstream prison populations and not in psychiatric facilities. Staff were genuinely baffled and many were not sure how to cope:

My overall experience is one of just managing day by day but not really knowing what to do with people with mental illness and wondering why they are here. This is a prison.

They are very vulnerable and I just don't understand why they are here.

Assessment

Generally, the initial mental health assessment was perceived to be effective. However, this was dependent on the staff member administering the assessment: *Assessment is only as good as the nurse administering it;* and the patient's history of mental illness:

This tool does not pick up all of them it's very dependent on whether the client has a previous history that we know of or they tell you. It is not always picked up because they may deny it and we are none the wiser to it. It is only as effective as the information you are told or the staff member who is doing the assessment.

One health professional noted the importance of the tool being sensitive to mental health issues:

Yes, definitely the assessment needs to be sensitive to mental health issues. Most of the guys need time and understanding.

Whether or not mental health issues were identified depended on a number of factors. This included the amount of information provided to staff:

Not everyone is picked up in the initial assessment; it depends what they tell the nursing staff and how good the staff member is at extracting information.

And, whether the prisoner was new to the system or not:

If he is a 'clean skin' and new to us then it is more difficult to assess.

Prisoner Boredom

Prisoner boredom, the inability of mentally ill prisoner patients to work, due to levels of medication, and prison overcrowding were discussed as central concerns for staff:

The problem is when they are on medication and they want to work and they cannot, I see the problem as boredom...

The big problem is overcrowding. It makes it hard to give everyone jobs and something to do. It also makes it hard for guys in the units. If you are mentally ill it is even more difficult, it is very full-on.

Bullying and Punitive Action

As with the prisoner patients, staff shared attitudes and experiences of the bullying of prisoner patients by staff members and prisoners. Mental health clients were seen to be particularly vulnerable and there was a perception that prisons are overly strict and do not provide the kind of therapeutic environment many prisoner patients require:

They are vulnerable and they get picked on by other prisoners for their cigarettes. They are used all of the time.

Many people in the prison are very strict and disciplinary not therapeutic like the kind of care clients need. Officers do not care; it is not their job to care.

Staff also implied that prisoners with mental illness are over-represented in incidents of sexual assault:

They are so vulnerable in the prison. Other inmates try it on the vulnerable to get cigarettes, sexual favours whatever.

I have no idea of the statistics but for them to sexually assault others is not prevalent but for them to be sexually abused it is quite high as they are in the vulnerable category. They are vulnerable to be sexually assaulted by other prisoners' just as much as young, naive inmates who come into the prison for the first time. We don't get reported many of these incidents. Men

do not come forward to talk about their health. There is a huge sense of shame attached to it but it happens more than you think.

One staff member spoke of a kind of reverse bullying, that is, avoidance which was also apparent in the comments above made prisoners themselves:

... they are in prison when they should be in Frankland or another special unit. Some of these people have been here for ages. It is like out of sight out of mind. People have tried to do things and are often beaten down by the system. Their energy gets lost and sometimes people [staff] avoid, withdraw and have to remove themselves as they get too depressed themselves. With the mentally ill patients...we sometimes get punitive because we are frustrated and there is nothing we can do about it. We have the danger of being too punitive rather than therapeutic. Sometimes it is even not punitive and not therapeutic it is just avoidant. People get forgotten in prison.

In a similar vein, another staff member discussed staff becoming worn down by difficult prisoners which resulted in staff frustration. He shared his experience in this way:

Prison staff often don't listen to people and don't understand. This permeates through the prison. After a time people get worn down, we had a guy who constantly lit fires and eventually staff had done everything possible and then they get frustrated because they don't know how to help or what to do any more. Many people are very demanding and staff get quite traumatised. They are not trained to deal with mental health cases. It is difficult for them to watch someone who is actively psychotic.

How to Manage Difficult Behaviours and Role Conflict?

Closely related to the concept of bullying and victimisation was the management style adopted by prison officers when managing and liaising with prisoner patients. Participants stated that some staff, in some cases, made special allowances for prisoners whilst others were overly punitive:

Some prison officers make allowances for prisoners who struggle but there is always the prison officer who...doesn't make allowances. It really depends on how vulnerable they are.

Definitely but that is no different from in the community. When it comes to prison officers some of them are fantastic, they have a good understanding and are caring people. We then have other prison officers, who are indifferent, then there are those who treat them differently, and it really upsets me. Yesterday I sat and listened to an officer in a meeting say it is a pity that we don't have a nut unit in the prison and also called them Nuff Nuff's. This is a term used by prison officers. There are these attitudes amongst the officers and they victimise the clients in little ways. Some of them find it amusing to pick on them and wind them up. I hope that this is a

small minority. People pick on the most vulnerable people which is the most fun to them.

Other staff shared experiences of 'bending the rules' but also conveyed this created role conflicts in their daily work:

In terms of other prisoners - yeah they get stood over all of the time for all sorts of things. I feel sorry for them and we try to help sometimes but you can't be seen to be favouring anyone in a place like this.

Some of us are more accommodating and we bend the rules to give them what they want and we let them get away with more but it upsets the flow and order of things. However, this is a prison not a psychiatric facility and I am a prison officer not a psychiatrist or a nurse. I can bend the rules only so much and then it creates conflicts for my role with other prisoners and staff.

The Frankland Unit and Courts

Limited access to the Frankland Unit at Graylands Hospital was of concern to staff and health professionals stated they battled with this every week:

Beds at Frankland are often taken up with people from the courts - some of them are ill and others are drug induced. These people take up a lot of beds that should be used for [prison] mental health clients as we don't have another mental health ward...we have no-where else to send them. Every week we experience the problem of not being able to get people to a bed at Frankland and these are people who really need it. I mean we prioritise so much if there were more beds there would be others who also need them but we cannot even get the acute ones in. People still get sent back to us who are very unwell, they get sent back to the prison and we have no mental health ward to look after them. We automatically send people to the CCU when they get back from Frankland and we do the best we can to look after them but they should be in a proper facility.

Crisis Care and Observation Cells

Crisis care was seen as a valuable tool at two metropolitan prisons. However, crisis care was not actually designed for use with prisoners unless they are at risk of suicide. The use of the facility outside this scope creates additional problems for staff:

Originally the CCU was for self harm clients but I think it has evolved away from that. Unfortunately, we don't have a specialist mental health unit within the prison system and Frankland only have 30 beds for the whole state. At least if we get people into CCU we can give them some treatment. Although it is not the intention of the CCU that is what it is being used for. We have to put all of the clients on the At Risk Management System when they go into the CCU which is problematic as many of them are not suicidal

but unfortunately that is the way it has to be even though it inflates the ARMS and self harm figures.

Furthermore, participants stated that crisis care has becoming a pseudo-psychiatric ward within the prison. The following quotes below embody these views:

Now crisis care is like a pseudo psychiatric wing...

The crisis care unit is for prisoners who are at high risk of self-harm activity or attempted suicide, but we regularly find that at least, I would say, 70-75% of our clients going into the crisis care facilities are mental health patients. This is because of medication issues and non compliance and general destabilisation...the crisis care unit has become a defacto psych ward.

Staff also had concerns that prisoners may be bullied when asking for assistance to spend time in CCU:

We only get people down here in dribs and drabs. I think that people get worried to ask and they worry about what other prisoners are going to say and think of them. They don't want to get singled out by other prisons and picked on for taking time out in crisis care. It makes them seem weak and then the other prisoners know that they are mentally impaired and they bully them and pick on them...

Correctional staff from the CCU shared what they believe are 'the special skills' required to work with prisoners who experience mental illness:

I have chosen to work in this Crisis Care Unit. Your attitude with them is very important, not every prison officer can work down here because they have the wrong attitude, you need to be patient and listen a lot, you don't need to be shouting at them, they really don't need that, you can snap them in some way. You need to be quiet and calm. The way I behave and what I say affects them and I try to help them as much as possible.

Staffing Shortages

As was raised in the Resources and Funding section above a main point of discontent was the observation that the Department, well prisons anyway, was seriously understaffed resulting in a belief that prisons are merely crisis managing prisoners. Staff raised this issue again as a main challenge they face:

There are not enough mental health nurses to adequately deal with the numbers [of mentally ill prisoners] we have. They [the mental health nurses] have a high case load especially when you consider the other functions that the mental health nurses have to perform. There are many things that pull

out of their time. All too often it means them having to prioritise their work load and that quite clearly reflects on how many cases they can deal with in a day, and how much time they can give people. Therefore, it is the most urgent cases that are dealt with. The mental health nurses are doing a very good job and we try to give them as much support as possible but there are clearly limitations all around for everybody.

You have to see the most serious first and unfortunately many people miss out on adequate services as you're crisis managing people much of the time.

Limited access to psychiatrists and specialist mental health staff was raised by all staff as a considerable challenge and limitation of current services:

We have very limited access to a psychiatrist and this is problematic. They do not come frequently enough and are here for half a day when they arrive. It is also generally a different person each time so clients cannot establish rapport with the psychiatrist and the psychiatrist does not know our clients or their history of illness.

There is a lack of psychiatric support especially if someone needs to look at medication. Once a month is not enough! We need someone once a fortnight for a whole day and it needs to be the same psychiatrist every time. It is very important to have some consistency in treatment not just catching up when they come but actually spending some decent time with the fellows.

Limited access to a qualified General Practitioner who has experience dealing with mental illness was also a limitation of:

The GP we have is limited and is not specifically trained in mental health.

Excess Workload and Staff Roles

Interrelated with participants experiences of staffing shortages were concerns regarding time constraints and the excess workload of managing prisoners with mental illness:

There are problems everyday. We work in a confined space and they are very high maintenance. It is draining on the staff as they are in your face all day and take up a lot of your time. They have no proper treatment or things to help them in here. It is a joke.

There are so many issues and complications attached to managing people with mental illness in prisons, there are so many variables...prison officers are not carers, dieticians, and mental health nurses, they are prison officers and they have to look after people because there is no-one else to do it. It affects the staff and their level of morale as they are under huge stress and pressure.

People with mental illness can dominate the officers' time and this becomes problematic, you can lose days trying to manage one situation with one prisoner to get him back on track and stabilise him. One prisoner can draw in the prison officers, the unit manager, the mental health nurses, PCS and other staff. There can also be disciplinary action taken until it is sorted out so it may involve the recovery team and the prisoner may find himself in circumstances that make things worse and exacerbate the problem. It is rewarding when you get people on track but there is not a lot of that.

Furthermore, another staff member commented that prison officers do not have the time or the training "to deal with them":

Officers don't have the time or training to deal with them and we should not have to. Sometimes I think this place is a funny farm and it is very hard to manage.

Time Constraints and Service Provision Limitations

Within the context of the two sub-themes above is the concept of time. Staff felt that they needed additional time in order to provide appropriate services. This was raised in some of the quotes above but the quotes below also present thoughts regarding the empowerment of mental health clients and including them in treatment decision making:

We need to empower people. Half the time they are treated like small children or they have the expert telling them what to do. They are told what to do rather than asked or engaged. You are constantly thinking these are adult people who need to be empowered and treated with respect...we just need the time to engage people...

For others, it was important to explain the reasoning behind decisions to people with mental illness:

You really have to take the time and explain the reasons for decisions and talk to people but we often do not have the time in here as there are so many people to see.

It is very difficult to listen to people when we are made to have 20 min appointment times.

Regional Specific Comments

Additional comments were made by staff in regional prisons, which were not directly raised in other interviews. Regional prisons were seen as having much the same needs as other prisons (*regional prisons have much the same needs as other prisons*), however, at present service provision was seen as limited due to

inadequate resources and facilities (*the regional prisons need additional resources*).

Access to qualified mental health staff and psychiatrists was problematic (*we have very limited access to the psychiatrist which is difficult; having a qualified mental health nurse would really help and more hours for mental health*), as was a lack of management support (*there is a total lack of management support at this prison. The nurse manager and other staff do not care about mental health and they are so rude to the community psychiatrist...it amazes me they would speak to a doctor like that*).

In addition, the demographics of regional prisons was perceived as different with many Aboriginal prisoners. This created a special set of issues related to spirituality and family networks:

Aboriginal people have some different needs to the rest of the prison population. They like to be with their own people and some have other spiritual issues and needs.

Yes, the regional prisons have lots of Aboriginal crim's and they prefer to be with their friends and family. They rely on each other and help each other. Family members often come in and talk to them and they feel heaps better. They should always be near their family.

What Works?

Initially, many staff struggled to provide positive responses about mental health service provision. However, with further prompting they reflected on the dedicated staff in their teams and their ability to provide clients with a certain level of care:

The Prison Counselling Service, Mental Health Nurses and Peer support work well. Often the Indigenous families support and look after each other. Therefore, you would not always want to remove a person from their family and put them in crisis care. The family will often notice changes in people and say they are worried. Illegal drugs in prison are a problem and when the guys are on medication it can tip them right over the edge into crisis.

We have a good team and that works really well. The staff really make it

Well, there are some services. We do the best with what we have got.

One staff member stated that she believed prison was the best place for those with mental illness because at least this way they would receive some treatment:

In some ways, although it is very sad to say, it is the best environment as it supports and allows people to receive medication and treatment that they would not get in the community.

Transition and Community Care

Community care was seen to be inadequate by most staff interviewed: This also related to re-entry and transition back into the community services.

Transition into the community is difficult. It is very difficult to appropriately link them into services, as there is just a huge void in service provision.

One staff member stated that prisoners could not be reintegrated into the community due to some prisoners becoming institutionalised:

It is very hard [to reintegrate people] as many people have become institutionalised. Sometimes the Frankland unit will do pre-release for people. The transition from a max prison to the community is very hard.

Other staff had solutions and suggested that supported accommodation be provided upon release to get people back on their feet:

There needs to be supported services and accommodation for when people get released outside of prison...prison is almost the only supported accommodation/institution type of facility which is ridiculous. It is not good enough to link people into community services, even if the services are efficient, many of these people need to live in supported accommodation.

Chapter Conclusion

This chapter has illustrated the multi-dimensional nature of staff and prisoner patient attitudes and the variation but also consistency of experience in relation to mental illness and mental health service provision in Western Australian prisons. There are many commonalities in the findings within and across participates and prison locations. Phase One was designed to explore the issues staff experience when working with mentally ill prisoners, to gain insight into their views on current services, treatment and facilities, to develop a greater understanding of the issues, experiences and needs of mentally ill prisoners, to identify any differences and experiences across rural and metropolitan prisons, and to generate key topics and constructs that would be further explored in Phase Two via a survey questionnaire.

There are many important points that can be drawn out from this chapter. In particular, it highlights the multiple and complex challenges health professionals, correctional staff and prisoners experience in the face of limited funding and due to the very nature of incarceration and the prison environment.

It shows that there are inherent difficulties staff face: staffing shortages; management issues; inappropriate facilities and infrastructure or facilities that are pushed beyond their initial intended usage; limited treatment options beyond medication which creates its own problems in this context; in many cases no training for prison officers and/or insufficient training, education and professional development opportunities in an environment that does not regard the value of furthering staff knowledge; nonexistent and/or ineffective policies and procedures resulting in reduced accountability; bullying; stress, distress, role confusion and a feeling of been 'worn down' by the system staff operate in; a feeling that staff are merely 'crisis managing' clients with mental illness due to insufficient treatment times; and a struggle with striking a balance between therapy and security. Moreover, staff suggested a number of solutions depending on their philosophical ideas regarding how best to treat, and where to treat, prisoners with mental illness.

In addition, the chapter demonstrates the complexity and frightening situation prisoner patients experience living in prisons, not only with a mental illness, but with people who generally do not understand them and with limited services to adequately address their needs. It illustrates the difficulties mentally ill prisoners face: isolation and seclusion including cultural isolation; bullying and victimisation; limited access to psychiatrists, mental health nurses, alternative therapies, programs, prison employment, and counselling; an overreliance on pharmaceutical medication as a cure-all and little voice, choice, or input regarding medicating; anxiety at their predicament of imprisonment and in some cases desperation to be transferred to medically based facilities; insufficient education and access to information resulting in some prisoners having little insight into or understanding of their illness; long waits to initially access services for some prisoners; angst over the confidentiality of personal medical information; trust issues; and prison regimes that are often difficult to negotiate resulting in punishment and segregation.

However, despite these challenges health professionals and correctional staff stated in some cases they have great teams who work well together to achieve positive outcomes. That prisons provide a captive audience where there is an opportunity to provide medical treatment to disenfranchised populations, that some prison officers are skilled at working with and understanding mentally ill prisoners, and under certain conditions make allowances to work with prisoners. Prisoner patients also reported that prison can be a helping hand providing them with access to some services, to get them away from drug abuse and into a structured environment. They also reported positive relationships with some staff and when there is time for these relationships to be fostered prisoners are generally happier, more relaxed and feel better. If prisoners have supports in the community access to initial mental health services in prison can also be improved.

The key constructs identified in this chapter were used to design two survey questionnaires for Phase Two (please refer to the methodology section for the design content and of these questionnaires). The use of a survey in Phase Two allowed the researcher to increase the scope and breadth of the research by exploring and investigating the identified themes/constructs across a wider geographical area and number of prisons and range of participants. Phase Two provided an opportunity to build on Phase One and look for similarities and differences in the findings and data. This allowed the researcher to test levels of agreement and/or divergence amongst participants and confirm or refute the Phase One findings. This process allowed for an in-depth exploration of the topic across both the qualitative and quantitative phases and is in keeping with pragmatic and constructivist philosophies employed in this research.

CHAPTER SIX: PHASE TWO (QUAN) DATA

Introduction

The purpose of this chapter is to present the quantitative Phase Two data. As stated in the previous chapter, the results will be presented excluding the interpretation which will be conducted in chapter Seven's discussion. In Phase Two data was gathered through a survey questionnaire completed face-to-face with prisoner patients (n=48), and via a mail out with health professionals and correctional staff (n=120). This chapter presents findings that were gathered from prisoner patients at four prisons in Western Australia - Albany Regional Prison; Casuarina Prison; Eastern Goldfields Regional Prison and Hakea Prison. An extra four prisons were included for staff due to the ease of postage: Broome Regional Prison; Bunbury Regional Prison; Greenough Regional Prison and Roebourne Regional Prison.

Firstly, this chapter outlines some relevant data analysis and significance testing information. It then presents the research results. Data looking at both parametric and non-parametric tests are outlined in the chapter below. Due to the sheer volume of data collected and analysed only a small quantity is presented here. Particular attention is paid to the findings that showed strong agreement or disagreement and for patterns in the data. Other results are presented in the appendices as supporting material. The data is presented in relation to the overarching themes/constructs that were identified in Phase One and further explored in Phase Two: Resources and funding; education and training; current service provision; and management, consultation and context. The chapter is broken down into six sections as follows:

- ❖ Section One presents the general demographic information;
- ❖ Section Two presents prisoner patient and staff results that relate to the resources and funding construct;
- ❖ Section Three presents the prisoner patient and staff results that relate to the education and training construct;
- ❖ Section Four presents the prisoner patient and staff results that relate to the current service provision construct;
- ❖ Section Five presents the prisoner patient and staff results that relate to the management, consultation and context construct; and

- ❖ Section Six presents the qualitative findings from the free response questions at the end of the survey questionnaire.

Data Analysis

Assumption Testing

Data was analysed using SPSS 14.0 first in terms of frequency distributions and then using One-way Analysis of Variance (ANOVAS), Chi-Square Tests and T-Tests. In keeping with recommendations given by several statistical tests (Field 2005; Howell 2002), and by the SPSS guide menu, the descriptive statistics of all items were examined in order to establish their normality. A Shapiro-Wilk test was employed for the prisoner patient data as this is the most appropriate test with small size samples (less than 50 cases), and a Kolmogorov-Smirnov test for the staff data. The null hypothesis is that there is no difference between the distribution of the data and a normal distribution. The null hypothesis was rejected on almost all counts indicating that the data has significant skewness or kurtosis and is therefore not normally distributed.

The assumptions of the Chi-Square, T-tests and ANOVA tests were violated as the number of cases (expected frequencies not greater than 5) in each cell was not sufficient, the sample size (prisoner patients) was not large enough, and the data was skewed. A Bonferroni multi comparison test was undertaken with all ANOVAS and the 'Exact' method was used when doing crosstabs and chi-square tests as this helps compensate for the small sample sizes. Due to the data distribution I decided to additionally run non-parametric tests in SPSS. This included both Kruskal-Wallis and Mann-Whitney Tests. The findings of these parametric and non-parametric tests were complementary and are therefore presented together. Due to the complementary nature of findings, I made a decision to present the significant ANOVA results in most cases. There was a mass of data printouts, and the ANOVA result SPSS print outs were broken down as they appeared in the questionnaires; they are therefore user-friendly and straightforward to interpret. Due to the volume of data and findings non-significant results are not reported in this thesis and supplementary data is presented in the appendices as supporting material.

Significance

There is much debate over what level of significance to use (and in some cases whether significance testing is reliable at all) but instead of embarking on a debate of this issue I will instead outline the method used for the research.

A significance criterion is a statement of how unlikely a result must be, if the null hypothesis is true, to be considered. According to Field (2005) and Howell (2002), social scientists use a cut-off point of 0.05 as this criterion forms the basis of modern statistics and is the value most widely employed in social research. This significance level was set by Ronald Fisher in the early 1920's and means that if there is only a 5% probability of something occurring by chance then we can accept it as a true finding, or alternatively when we are 95% certain that the result is genuine we say that it is statistically significant (Field 2005, 25). This criterion of 95% confidence is somewhat arbitrary, however this is the arbitrary convention that has been established over the years (Howell 2002, 103). After discussion with the research supervisor a decision was made that a p-value of 0.05 (5%, 1 in 20) would be used to determine significance in this research.

Section One: Participant Demographics

Prisoner Patient Demographics

Age Ranges

Table 4: Prisoner Patient Age Ranges

Age Range	Number of Participants	Percentage of Participants
18-29	15	31.3%
30-39	22	45.8%
40-49	10	20.8%
50-59	1	2.1%
60-69	0	0.0%
70+	0	0.0%
Total	48	100%*¹⁰

Table 4 shows the prisoner sample consisted of a total of 48 prisoners ranging in age from 18 to 59. Twenty-two (45.8% of the sample) participants fell within the 30-39 age category.

¹⁰ * some rounding errors in percentages

*Prison Location***Table 5: Prison/Incarceration Location**

Prison Location	Number of Participants	Percentage of Participants
Albany Regional Prison	11	22.9%
Casuarina Prison	16	33.3%
Eastern Goldfields Regional Prison	7	14.6%
Hakea Prison	14	29.2%
Total	48	100%*

Table 5 shows the distribution of participants surveyed at each prison. In total 30 prisoners (62.6% of the sample) were located in metropolitan prisons, and 18 prisoners (37.5% of the sample) were from regional prisons.

*Mental Illness/disorder***Table 6: Prisoner Patient**

Diagnosis	Number of Participants	Percentage of Participants
Schizophrenia	19	39.5%
Bi-Polar Disorder	4	8.3%;
Personality Disorder	1	2.1%
Depression	4	8.3%
Psychosis	3	6.3%
ADHD	1	2.1%
Obsessive Compulsive Disorder	1	2.1%
Post Traumatic Stress Disorder	1	2.1%;
Anxiety Disorder	2	4.2%
Multiple Diagnosis	12	25.0%
Total	48	100%*

Prisoners were asked about their psychiatric history/illness and any diagnoses they had received from a doctor/psychiatrist. I then checked their health records and prison health staff to check the accuracy of the information I received. In all cases, the disorder the prisoner responded they were diagnosed with was the same as the 'on file' diagnosis. However, a number (n=5) of prisoners who responded that they had one diagnosis, were recorded as having a multiple

diagnosis on file. Table 6 above shows (for single diagnosis) the largest number of participants identified themselves as having a diagnosis of Schizophrenia (n=19 or 39.6%), followed by Bi-Polar Disorder (n=4 or 8.3%), and Depression (n=4 or 8.3%). Again, it needs to be recognised that participants with schizophrenia are over-represented in this sample. For information on participant selection please refer back to the methodology chapter.

A number of prisoners (n=12 or 25%) were diagnosed with multiple disorders. They were as follows: Schizophrenia, bi-polar and anti-social personality disorder (n=1); Bi-polar, depression and anxiety disorder (n=1); Schizophrenia, bi-polar, depression and anxiety disorder (n=2); Schizophrenia and bi-polar (n=1); Depression, psychotic disorder and organic brain disorder (n=1); Depression and anxiety disorder (n=1); Bi-polar and depression (n=1); Schizophrenia, personality disorder and social phobia (n=1); Bi-polar, personality disorder, depression and anxiety disorder (n=1); Personality disorder, depression and anxiety disorder (n=1); and Schizophrenia, bi-polar, personality disorder, depression and organic brain disorder (n=1). These findings illustrate that many people who experience mental illness do not have a clear diagnosis and may be diagnosed with more than one mental illness.

Ethnicity

The majority of the sample did not identify with an ethnic or racial group (n=30, 62.5%). The remaining participants identified themselves as Aboriginal or Torres Strait Islander (n=15, 31.3%); Italian (n=2, 4.2%), and Asian (n=1, 2.1%). The number of Aboriginal prisoners in this research is not quite representative of the total prison population. Figures could not be obtained to ascertain if the sample was representative of the total number of Aboriginal prisoners diagnosed with a mental illness. Every effort was made to include Aboriginal participants at all prisons

Staff Demographics

Age Ranges

Table 7: Staff Age Ranges

Age Range	Number of Participants	Percentage of Participants
18-29	3	2.5%
30-39	23	19.2%
40-49	53	44.2%
50-59	37	30.8%
60-69	4	3.3%
70+	0	0.0%
Total	120	100%*

Table 7 shows the staff sample consisted of 120 participants ranging in age from 18 to 69. The majority of the sample were in the 40-49 category (n=53 or 44.2%), followed by the 50-59 range (n=37 or 30.8%).

Prison Location

Table 8: Prison Work Location

Prison Location	Number of Participants	Percentage of Participants
Albany Regional Prison	14	11.7%
Broome Regional Prison	11	9.2%
Bunbury Regional Prison	9	7.5%
Casuarina Prison	27	22.5%
Eastern Goldfields Regional Prison	12	10.0%
Greenough Regional Prison	19	15.8%
Hakea Prison	16	13.3%
Roebourne Regional Prison	10	8.3%
Both Albany and Greenough	1	0.8%
All Prisons	1	0.8%
Total	120	100%*

Table 8 shows the distribution of participants at each prison. One staff member worked at all of the prisons and one staff member worked at Albany and Greenough prisons. In total metropolitan prisons participants totalled n=43 (35.8% of the sample), and regional prisons participants totalled n=77 (64.2% of the sample).

Position/Role

Table 9: Staff Occupation

Staff Group	Position/Job Title	Number of Participants	Percentage of Participants
Health and Clinical Professionals	Mental Health Nurse	4	3.3%
	Nurse	10	8.3%
	Psychologist	12	10.0%
	Psychiatrist	1	0.8%
	Social Worker	3	2.5%
	Counsellor and Addictions Specialist/Drug and Alcohol	2	1.7%
	Total	32	26.6%
Prison Officers and Senior Officers	Prison Officer	72	60%
	Senior Officer	2	1.7%
	Total	74	61.7%
Education and Programs	Education Services Officer	1	0.8%
	Education Officer	1	0.8%
	Clinical Coordinator Programs	1	0.8%
	Total	3	2.4%
Other Staff	Prison Support Officer	3	2.5%
	Work Support Officer	1	0.8%
	Assistant Superintendent Prison Management	1	0.8%
	Operational Manager	1	0.8%
	Assistant Superintendent	2	1.7%
	Administration Assistant Crisis Care Unit	1	0.8%
	Superintendent	1	0.8%
	Prison Manager	1	0.8%
Total	11	9.0%	
	Total	120	100%*

Table 9 shows the role distribution of staff participants. The largest group of participants consisted of Prison Officers/Senior Officers (n=74 or 61.7%), followed by Health Professionals and Clinical staff (n=32 or 26.6%). This was not surprising as prison officers comprise the largest staff group in Western Australian prisons.

Gender

The sample consisted of both male and female staff participants. Male participants totalled n= 84 (70% of the sample), and female participants totalled n=36 (30% of the sample).

Ethnicity

The majority of the sample did not identify with an ethnic or racial group (n=103, 85.5%). The remaining participants identified themselves as Aboriginal (n=8, 6.7%); Torres Strait Islander (n=1, 0.8%), Italian (n=1, 0.8%); Dutch (n=1, 0.8%); Maori (n=2, 1.7%); and other (n=4, 3.3%).

Language

Question Two on the Staff Questionnaire asked participants: 'I call prisoners with mental health problems'?

Table 10: Language Staff Utilise when Referring to People with Mental Illness

Name Used	Frequency	Percentage
Prisoners	77	64.2%
Inmates	4	3.3%
Clients	18	15.0%
Patients	8	6.7%
Prisoners and Students	1	0.8%
Offenders	2	1.7%
Other Terms: Loopy, Crazy, Nuff Nuffs, Nutters	10	8.3%
Total	120	100%

The researcher asked staff the principal name (how they refer to individuals in prison) they use when referring to prisoners with mental illness. Table 10 shows the frequency and percentages for all staff groups combined. 'Prisoners' was the term utilised most frequently (n=77 or 64.2%) by participants in the research. A further breakdown showed that prison officers used this term more frequently than other staff groups. All staff groups used the term 'clients' (n=18 or 15%) with the health/clinical grouping responding they made use of this term more frequently than other staff groups. The term 'patients' was used exclusively by participants who identified with the health/clinical staff grouping, and the terms 'inmates', 'prisoners and students', and 'offenders' were used by some staff groups (students was an Education staff expression). Ten participants (8.3%) reported calling prisoners other words, such as 'loopy', 'crazy', 'nuff nuffs', and 'nutters'. It was surprising that anyone openly responded they use these derogatory terms. Nevertheless, after conducting the Phase One interviews and particularly the Phase Two prisoner patient surveys, the researcher can confirm

firsthand that these terms are indeed used openly and regularly by some prison officers. Therefore, it is likely there was a significant underreporting by staff of their use of these terms.

Section Two: Resources, Funding and Additional Services

The purpose of this section is to present the prisoner patient and staff results for questions in the surveys that related to resources, funding and additional service provision. Some general frequencies are presented and then the findings are broken down as per the analyses. That is, looking at the findings for regional and metropolitan prison groups and in some cases, the findings are analysed in terms of staff position group, and age. Not all of the significant findings for the parametric and non-parametric tests are presented here. Rather, those findings that stood out as strongly supportive (i.e., similarities and convergence) or strongly opposing (i.e., differences and divergence) are presented below. The findings not presented in this section are available as supportive material in Appendix N.

Prisoner Patient Results

Question Nine: Resources, Funding and Additional Service (9A to 9C Statements)

Table 25 presents each statement with the mean and standard deviation. In addition, it presents the percentages and frequency for each response.

Table 11: Question Nine Prisoner Frequencies

Statement Question Nine	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
9a) I would like to have more regular visits by the mental health staff and greater access to staff	2.17	.859	16.7% (n=8)	62.5% (n=30)	8.3% (n=4)	12.5% (n=6)	0.0%
9b) There needs to be a greater range of staff	2.44	.965	10.4% (n=5)	56.3% (n=27)	14.6% (n=7)	16.7% (n=8)	2.1% (n=1)
9c) I would like more input into my treatment and	2.06	.976	29.2% (n=14)	50.0% (n=24)	6.3% (n=3)	14.6% (n=7)	0.0%

Statement Question Nine	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
medication							
9d) It would be good to have more counselling services and art therapy rather than just having to take drugs all of the time	1.90	.857	35.4% (n=17)	45.8% (n=22)	12.5% (n=6)	6.3% (n=3)	0.0%
9e) We need more services in regional areas	1.81	.734	35.4% (n=17)	50.0% (n=24)	12.5% (n=6)	2.1% (n=1)	0.0%
9f) They need more staff to help us out. There are not enough and it means we do not get proper care	2.29	1.07	22.9% (n=11)	45.8% (n=22)	12.5% (n=6)	16.7% (n=8)	2.1% (n=1)
9g) They should build a special unit for people with Personality Disorders	2.21	1.03	27.1% (n=13)	39.6% (n=19)	20.8% (n=10)	10.4% (n=5)	2.1% (n=1)
9h) I would like to have greater access to the psychiatrists	2.21	1.09	25.0% (n=12)	50.0% (n=24)	8.3% (n=4)	12.5% (n=6)	4.2% (n=2)
9i) Prison is a hell hole and mental health people do not belong here. We need a medical place	2.73	1.46	29.2% (n=14)	20.8% (n=10)	12.5% (n=6)	22.9% (n=11)	14.6% (n=7)
9j) We need to be in a medical environment and a special unit that is staffed by medical people where we will get looked after properly	2.15	1.07	29.2% (n=14)	45.8% (n=22)	8.3% (n=4)	14.6% (n=7)	2.1% (n=1)
9k) I think they should build another place like Graylands that can have way more people	2.02	.934	29.2% (n=14)	50.0% (n=24)	12.5% (n=6)	6.3% (n=3)	2.1% (n=1)
9l) When you are unwell you want to be looked after but you need to be able to be outside and walk around in	1.90	.857	33.3% (n=16)	52.1% (n=25)	6.3% (n=3)	8.3% (n=4)	0.0%

Statement Question Nine	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
open spaces							
9m) People need to be somewhere therapeutic and the government has to do something about it	2.04	.874	27.1% (n=13)	50.0% (n=24)	14.6% (n=7)	8.3% (n=4)	0.0%
9n) I am happy to stay in prison and receive treatment from the medical staff	3.21	1.36	6.3% (n=3)	35.4% (n=17)	18.8% (n=9)	10.4% (n=5)	29.2% (n=14)
9o) I would not want to go to a Psychiatric hospital. I have a mental illness but I am stable and able to manage in prison	2.77	1.27	14.6% (n=7)	35.4% (n=17)	22.9% (n=11)	12.5% (n=6)	14.6% (n=7)
9p) It is a disgrace that people with mental illness have ended up in prison we really need care and support	2.00	1.09	39.6% (n=19)	37.5% (n=18)	8.3% (n=4)	12.5% (n=6)	2.1% (n=1)
9q) It would be good to have mental health programs for mental health clients	1.90	.778	25.0% (n=12)	68.8% (n=33)	0.0%	4.2% (n=2)	2.1% (n=1)

This table clearly shows there was agreement from prisoners in relation to more assistance and support from mental health staff. In particular, there were strong responses and agreement for a greater range of staff, more psychiatrists and mental health programs (9a, 9b, 9e, 9f, 9h, 9q), alternative therapies rather than a heavy reliance on medications, and for more involvement of the service user in treatment (9c, 9d). There were some interesting results related to the environment (9g, 9i, 9j, 9k, 9l, 9n, 9o). Here, the findings show prisoners are evenly spread regarding their attitudes towards prison (9i) with some agreeing (n=24) that prison is a 'hell hole', others undecided (n=6), and the rest in disagreement (n=18). The majority of prisoners agreed that they need to be in a medical environment staffed by medical people (9j, n=36) and that they want to be somewhere looked after and to be in open spaces (9l, n=41). However, the scores were evenly spread regarding staying in prison or being transferred (9n),

and a number (n=13) of prisoners would not want to be transferred or were undecided (n=11) if they would want to be transferred to a psychiatric hospital (9o). There was a perception that people need to be somewhere therapeutic and that it is for the government or society to consider the current situation of having people with mental illness being kept in prisons (9m). This is an interesting finding as it is potentially reminiscent of the dark ages of the lunatic asylum. The Participants also agreed with the statement that it is a disgrace people with mental illness are in prison populations (9p, n=37).

Metropolitan/Regional

The results that revealed a significant relationship for the Mann-Whitney tests are presented in Appendix N. Overall, the data highlighted the differences between metropolitan and regional prisons. The data shows that prisoner patients in metropolitan prisons would like additional access and visits from staff; more input into their treatment and medication; that the government has a responsibility to look after those with mental illness and people need to be somewhere therapeutic; and that they are happy to stay in prison and receive treatment from the medical staff. These findings are interesting and somewhat contradictory; on the one hand metropolitan participants are stating a need for additional input into their treatment, access to staff and a desire to be somewhere therapeutic, however, they want this treatment in prison; an environment they have clearly stated is not therapeutic. By comparison regional participants who have limited access to services and staff are generally happier than metropolitan participants with their level of access to staff but would rather be treated outside of prison.

Question Ten: My experiences of living in prison with a mental illness are generally?

Table 12: Question Ten Prisoner Frequencies

Question Ten	Mean	Std. Dev	Very Positive	Positive	Neutral	Negative	Very Negative
My experiences of living in prison with a mental illness are generally?	3.25	1.29	8.3% (n=4)	22.9% (n=11)	29.2% (n=14)	14.6% (n=7)	25.0% (n=12)

Table 26 above shows that prisoners' experiences of prison life vary. The frequencies show that 31.2% (n=15) of the sample reported very positive and positive experiences in prison, 29.2% (n=14) are neutral and 39.6% (n=19) report very negative and negative experiences.

Question Eleven: From your experience do you think the numbers of prisoners with mental health issues is increasing/has increased in the time you have lived in prison?

Table 13: Question Eleven Prisoner Frequencies

Question Eleven	Increased	Decreased	Stayed the same
From your experience, do you think the numbers of prisoners with mental health issues is increasing/has increased in the time you have lived in prison?	91.7% (n=44)	0.0%	8.3% (n=4)

The frequencies in Table 27 above show that 91.7% (n=44) of the sample reported the numbers of prisoners with mental health problems has increased during their incarceration.

If yes, why do you think this is the case?

Table 14: Question Twelve Prisoner Frequencies

Question Twelve - If increased, why do you think this is the case?	Percentage/Frequency
Improved screening and awareness	8.3% (n=4)
Increases in illegal drug use	31.3% (n=15)
De-institutionalisation	4.2% (n=2)
Larger prison populations	2.1% (n=1)
Lack of understanding from Courts - mental health people going to prison instead of elsewhere	8.3% (n=4)
Prisoners become institutionalised and rely on prison to deal with mental health as there are no services in the community	2.1% (n=1)
Social issues and family breakdown	22.9% (n=11)
Alcohol abuse	2.1% (n=1)
All of the above	10.4% (n=5)
No need to answer as has decreased or stayed the same	8.3% (n=4)

The frequencies in Table 28 show that 31.3% (n=15) of the sample report increases in illegal drug use, and 22.9% (n=11) of the sample report social issues and family breakdown, as the top two reasons behind perceived increases in the number of mentally ill patients in Western Australian Prisons. It is unclear whether family breakdown has led to mental illness or to the mentally ill ending up in prison? What role drug taking has played both in prison and in the community (i.e., is this increase in drug uses in prison or lead to imprisonment)? And, what are the social issues and role of family breakdown leading and contributing to mental illness and imprisonment?

Staff Results

Question Eleven: Resources, Funding and Additional Service (11A to 11U Statements)

Table 29 presents each statement with the mean and standard deviation. In addition, it presents the percentages and frequencies for each response.

Table 15: Question Eleven Staff Frequencies

Statement Question Eleven	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
I would most like to see:							
11a) The number of beds at the Frankland Unit extended	1.74	.855	49.2% (n=59)	30.0% (n=36)	19.2% (n=23)	0.8% (n=1)	0.8% (n=1)
11b) A special facility set up at each prison for mental health clients	2.12	1.17	35.8% (n=43)	38.3% (n=46)	10.0% (n=12)	10.0% (n=12)	5.8% (n=7)
11c) A special facility built off the grounds of the prisons for mental health prisoners	2.48	1.18	26.7% (n=32)	27.5% (n=33)	20.0% (n=24)	23.3% (n=28)	2.5% (n=3)
11d) Group and art therapy for prisoners	2.27	.959	23.3% (n=28)	38.3% (n=46)	27.5% (n=33)	10.0% (n=12)	0.8% (n=1)
11e) The extension of regional services	1.80	.784	37.5% (n=45)	50.0% (n=60)	7.5% (n=9)	5.0% (n=6)	0.0%
11f) A state facility for mental health at Casuarina	2.23	1.16	34.2% (n=41)	26.7% (n=32)	28.3% (n=34)	4.2% (n=5)	6.7% (n=8)
11g) A state facility for mental health at Hakea	2.40	1.17	26.7% (n=32)	28.3% (n=34)	30.8% (n=37)	6.7% (n=8)	7.5% (n=9)

Statement Question Eleven	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
I would most like to see:							
11h) A special mental health service for courts clients so they are not transferred to Frankland	2.36	.933	19.2% (n=23)	35.8% (n=43)	37.5% (n=45)	5.0% (n=6)	2.5% (n=3)
11i) A unit for people with personality disorders	2.52	1.14	19.2% (n=23)	36.7% (n=44)	24.2% (n=29)	13.3% (n=16)	6.7% (n=8)
11j) A psychiatric hospital for prisoners	1.89	.906	37.5% (n=45)	43.3% (n=52)	13.3% (n=16)	4.2% (n=5)	1.7% (n=2)
11k) Closer linkages with community services	2.11	.924	26.7% (n=32)	45.0% (n=54)	20.8% (n=25)	5.8% (n=7)	1.7% (n=2)
11l) Supported accommodation and services in the community	2.13	1.00	29.2% (n=35)	40.0% (n=48)	22.5% (n=27)	5.0% (n=6)	3.3% (n=4)
11m) Extension of crisis care facilities to cater for mental health clients	2.28	1.15	25.8% (n=31)	43.3% (n=52)	14.2% (n=17)	10.0% (n=12)	6.7% (n=8)
11n) Additional mental health nurses	1.67	.726	43.3% (n=52)	50.8% (n=61)	2.5% (n=3)	2.5% (n=3)	0.8% (n=1)
11o) Additional psychiatrists	1.72	.735	40.8% (n=49)	50.0% (n=60)	6.7% (n=8)	1.7% (n=2)	0.8% (n=1)
11p) Additional Psychologists	2.01	.966	33.3% (n=40)	43.3% (n=52)	14.2% (n=17)	7.5% (n=9)	1.7% (n=2)
11q) Additional Social Workers	2.32	1.13	29.2% (n=35)	31.7% (n=38)	20.0% (n=24)	16.7% (n=20)	2.5% (n=3)
11r) Specialist people in the prison to work with mental health prisoners	1.77	.877	41.7% (n=50)	48.3% (n=58)	4.2% (n=5)	3.3% (n=16)	2.5% (n=3)
11s) Programs for mental health clients	1.89	.818	33.3% (n=40)	49.2% (n=59)	13.3% (n=16)	3.3% (n=4)	0.8% (n=1)
11t) There needs to be a facility that accommodates mental health patients that can be managed according to their requirements and needs	1.58	.740	53.3% (n=64)	37.5% (n=45)	7.5% (n=9)	0.8% (n=1)	0.8% (n=1)

As with the prisoner sample, there was significant convergence across the staff sample for some statements (11e, 11j, 11n, 11o, 11p, 11r, 11t). There was

agreement for the need to extend regional services (n=105), to build a psychiatric hospital for prisoners (n=97), for additional mental health nurses (n=113), psychiatrists (n=109), psychologists (n=102) and specialist people to work with mentally ill prisoners (n=108). There was also agreement of the need to have a facility to accommodate the needs and requirements of the mentally ill (n=109). However, the table also shows that a number of staff were undecided regarding other ways to make things better (11a, 11d, 11f, 11g, 11h, 11i, 11k, 11l, 11m, 11q, 11s). Although some staff agreed that it is important to extend bed numbers at the Frankland Unit (n=95) others were unsure (n=23), the same was the case for group and art therapy (SA/A¹¹ n=74, U n=33), having a State facility built at either Casuarina (SA/A n=73, U n=34) or Hakea prisons (SA/A n=66, U n=37), special facilities for Courts clients¹² (SA/A n=66, U n=45), a unit for those with PD (SA/A n=66, U n=29, D n=16), closer linkages with community services (SA/A n=86, U n=25), supported accommodation in the community (SA/A n=83, U n=48), and the need for additional social workers (SA/A n=73, U n=24). The findings are relatively evenly spread regarding the need to build a special facility off prison grounds (SA n=32, A, n=33, U n=24, D n=28). These findings may be accounted for by differences in staff occupation? It may be that health professionals are more supportive or certain types of treatment in comparison to correctional staff (prison offices) who are uncertain?

Metropolitan/Regional

Parametric and nonparametric tests were chosen to analyse the interaction between prison location broken down into regional (*Eastern Goldfields and Albany*) and metropolitan (*Hakea and Casuarina*) prisons and the results that revealed a significant relationship are presented in Appendix N and a summary is presented below. Overall, regional participants reported a stronger level of agreement with the following statements: 1) a special facility be set up off the grounds of the prisons for mental health clients; 2) the extension of regional services; 3) additional mental health nurses; 4) additional psychiatrists; 5) additional psychologists; 6) additional social workers; 7) specialist people in the prison to work with mentally ill prisoners; and 8) programs for mental health clients. On average regional participants reported a stronger agreement with

¹¹ S/A = Strongly Agree, A = Agree, U = Undecided, D = Disagree

¹² Courts Clients - those referred straight from Court to the Frankland Unit for a mental health assessment and observation. Some argue a need for separate services for those referred directly from Court and those transferred from prisons.

proposed increases in all forms of mental health service provision. This is not surprising given the staff and service shortages in remote areas in Western Australian prisons.

Prison Staff Group/Occupation

The significant ANOVA results across occupation are presented in Appendix N. Overall, the findings show that on average Health Professionals/Clinical staff supported increasing services in prisons and the extension of psychiatric services than do Prison/Senior Officer staff groups. Specifically, the significant results show that Health Professionals/Clinical Staff agree more strongly than prison staff in the following statements: 1) group and art therapy; 2) extension of regional services; 3) closer linkages with community services; 4) supported accommodation and services in the community; 5) extension of crisis care facilities to cater for mentally ill clients; and, 6) programs for mental health clients. This is somewhat surprising given prison officers reported that they struggle when providing care to mentally ill prisoners. It may be that they do not want an increase in services as this would ensure these prisoners remain in prison populations.

Question Twelve: My experiences with mental health prisoners are generally?

Table 16: Question Twelve Staff Frequencies

Question Ten	Very Positive	Positive	Undecided	Negative	Very Negative
My experiences with mental health prisoners are generally?	9.2% (n=11)	44.2% (n=53)	25.8% (n=31)	16.7% (n=20)	4.2% (n=5)

Table 30 shows that the majority of participants report very positive (9.2%, n=11) or positive (44.2%, n=53) experiences when working with mentally ill prisoners. However, 25.8% (n=31) are undecided, 16.7% (n=20) report negative experiences and 4.2% (n=5) report very negative experiences. No significant differences were found across metropolitan and regional prisons or staff groups for the results in question twelve.

Question Thirteen: From your experience do you think the numbers of prisoners with mental health issues is increasing/has increased in the time you have worked in prisons?

The majority of staff participants responded that in their experience/opinion the numbers of mentally ill prisoners has increased in the time they have worked in Western Australian prisons (95.0%, n=114). This finding supports the prisoner patient data.

If yes, why do you think this is the case?

Table 17: Question Thirteen Staff Frequencies

Question Twelve - If increased, why do you think this is the case?	Percentage
Improved screening and awareness	4.2% (n=5)
Increases in illegal drug use	43.3% (n=52)
De-institutionalisation	9.2% (n=11)
Larger prison populations	5.0% (n=6)
Lack of therapeutic community services	3.3% (n=4)
Lack of dedicated and appropriate facility	1.7% (n=2)
Social attitudes, welfare and money problems	0.8% (n=1)
Social problems	2.5% (n=3)
Lack of funding for mental health services to help people before the problems escalate	0.8% (n=1)
All of the above	26.7% (n=32)
No need to answer as responded - decreased or stayed the same	2.5% (n=3)

The frequencies in Table 31 show that 43.3% (n=52) of the sample report increases in illegal drug use, 9.2% (n=11) report de-institutionalisation, and 26.7% (n=32) report all of the above as the top three responses/reasons for increases in the number of mentally ill patients in Western Australian Prisons.

Summary

Prisoner Patients

The findings here indicate that prisoners agree with the statements relating to a need for greater access to staff, increased services in regional prisons and

additional accommodation to provide a more therapeutic environment. Specifically, prisoner patients agree with the statements that they would like: increased access to health staff, and to be treated by a greater range of staff, including access to art therapy and counselling; further input into their treatment and medication; an increase in mental health services in regional prisons, more mental health staff in all prisons and greater access to the psychiatrist; a large proportion of the sample would like a special unit to be built for prisoners with personality disorders; over half of the sample report that they would not want to be transferred to a psychiatric facility; Metropolitan prisoners agreed more strongly that they would like greater access to staff, further input into treatment, that they need therapeutic services and that they would like to stay in prison and receive treatment than regional prisoner patients. Moreover, the majority of prisoners believe that the number of prisoners with mental health problems is increasing. This increase is attributed to illegal drug use, social issues and family breakdown.

Staff

Staff supported the majority of the statements presented in question eleven and would like to see: an additional special facility built for mental health clients; group and art therapy; the extension of regional services; a mental health facility specifically for Courts; a unit for clients with personality disorders; closer linkages with community services and supported accommodation; additional mental health nurses, psychiatrists, psychologists, social workers and other specialist staff; and prison programs for mental health clients. However, some staff were undecided regarding what might make things better. The findings show that health professionals are more supportive than correctional staff of the need for additional services. Moreover, over half of the staff participants report mainly positive experiences with mental health clients; and the majority of staff report that in their experience the number of mental health clients is increasing in the prison. This increase is attributed to illegal drug use and deinstitutionalisation.

Section Three: Education and Training

This section presents prisoner patient and staff results for questions in the surveys that related to education and training. Some general frequencies are presented and then the findings are broken down as per the analyses. That is, looking at the

findings by regional and metropolitan prison groups and in some cases, the findings are analysed in terms of staff position group, and age.

Prisoner Patient Results

Question Three: Do you feel that the Uniform Staff (Prison Officers) Adequately Care for you?

The frequency data illustrates that a large proportion of the sample were undecided about this statement. 37.5% (n=18) of the sample strongly agreed or agreed with the sample, 29.2% (n=14) were undecided and 33.3% (n=16) of the sample strongly disagreed or disagreed (M 3.06 and SD 1.29). The survey then asked participants why they felt that prison officers did not adequately care for them. Most respondents (60.4%, n=29) did not feel the need to answer this question, which is interesting as 29.2% of the sample were undecided about the question above. Some participants may have felt uncomfortable answering these questions due to confidentiality reasons. Other responses included are presented in table 15 below:

Table 18: Question 3A Prisoner Frequencies

Question Three A - Why?	Percentage/Frequency
Because they do not have enough training	2.1% (n=1)
Because of the personality of the officers	6.3% (n=3)
Because of the low awareness of mental health	2.1% (n=1)
All of the above	25.0% (n=12)
Feel no need to respond	60.4% (n=29)
All of the above and officers use too much violence to make you submit and no-one will help you. They joke with you and threaten you	4.2% (n=2)

Question Four: Do you feel that the Prison Counselling Staff provides you with adequate care and services?

The frequencies show that a large proportion of the sample were undecided about this statement (39.6%, n=19). This could be due to the fact that clients had no or little contact with PCS and therefore could not comment on the service. 47.9% (n=23) of the sample strongly agreed or agreed with the statement, 2.1% (n=1) disagreed, and 10.4% (n=5) strongly disagreed (M 2.63 and SD 1.08).

Question Five: Do you feel that the nurses adequately care for you?

The frequencies demonstrate that a significant proportion of the sample strongly agreed or agreed with this statement (75.0%, n=36). 18.8% (n=9) of participants were undecided, 2.1% (n=1) disagreed and 4.2% (n=2) strongly disagreed (M 2.06 and SD .976).

Question Six: Do you think that all the prison staff need more training in mental health?

The frequency data shows that the majority of the sample (83.3%, n=40) strongly agreed or agreed that prison staff need additional mental health training; 10.4% (n=5) were undecided, 4.2% (n=2) disagreed and 2.1% (n=1) strongly disagreed (M 1.90 and SD .905).

Question Seven: Do you feel that prisoners have adequate information and education about mental illness, medication, how to manage their own illness, how to ask for help and how to understand the behaviours of other prisoners?

The frequency distributions illustrate that a large proportion of the sample scores were evenly spread from strongly agreed to strongly disagreed. 16.7% (n=8) of the sample strongly agreed, 20.8% (n=10) agreed, 22.9% (n=11) were undecided, 18.8% (n=9) disagreed, and 20.8% (n=10) strongly disagreed (M 3.06 and SD 1.39).

No significant differences were found across prisons for questions 3 to 7.

Question Eight: Education and Training (8A to 8O Statements)

Again, there were an overwhelming number of participants who strongly agreed or agreed with the statements/quotes in Table 20 below. The table presents each statement/quote with the mean and standard deviation. In addition, it presents the percentages and frequency for each response.

Table 19: Question Eight Prisoner Frequencies

Statement Question Eight	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
8a) Training in mental health is vitally important	1.58	.498	41.7% (n=20)	58.3% (n=28)	0.0%	0.0%	0.0%
8b) All prison staff need more training in mental health	1.85	.714	29.2% (n=14)	60.4% (n=29)	6.3% (n=3)	4.2% (n=2)	0.0%
8c) Most other prisoners have no idea what a mental illness/disorder is and it would good for people to have a better understanding	2.02	.758	16.7% (n=8)	72.9% (n=35)	4.2% (n=2)	4.2% (n=2)	2.1% (n=1)
8d) Only trained medical staff should be allowed to work with people who have mental illness/disorder	2.29	1.05	25.0% (n=12)	39.6% (n=19)	16.7% (n=8)	18.8% (n=9)	0.0%
8e) ARMS, risk prevention and self harm training are really important	1.67	.595	37.5% (n=18)	60.4% (n=29)	0.0%	2.1% (n=1)	0.0%
8f) The officers have no idea what mental health is and are not properly trained to help us	2.48	1.16	18.8% (n=9)	45.8% (n=22)	8.3% (n=4)	22.9% (n=11)	4.2% (n=2)
8g) There should be pamphlets and information available at the medical centre so people understand better	1.94	.633	18.8% (n=9)	72.9% (n=35)	4.2% (n=2)	4.2% (n=2)	0.0%
8h) Staff need to be very well trained to care for prisoners with mental illness/disorders	1.94	.633	18.8% (n=9)	72.9% (n=35)	4.2% (n=2)	4.2% (n=2)	0.0%
8i) People need to be educated about mental health	1.79	.544	25.0% (n=12)	72.9% (n=35)	0.0%	2.1% (n=1)	0.0%
8j) Prisoners need to be educated about their own mental health	1.69	.624	37.5% (n=18)	58.3% (n=28)	2.1% (n=1)	2.1% (n=1)	0.0%
8k) Prisons should have special programs for mental health clients	1.96	.898	21.3% (n=15)	50.0% (n=24)	12.5% (n=6)	4.2% (n=2)	2.1% (n=1)

Statement Question Eight	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
8l) There is plenty of information available on mental health in the prison	3.75	.957	0.0%	14.6% (n=7)	16.7% (n=8)	47.9% (n=23)	20.8% (n=10)
8m) Peer support is really good. They should get extra training and have a specialist mental health peer support team	2.33	1.22	27.1% (n=13)	39.6% (n=19)	14.6% (n=7)	10.4% (n=5)	8.3% (n=4)
8n) Members of the Prison Counselling Service need additional specialist mental health training	2.27	.893	14.6% (n=7)	56.3% (n=27)	18.8% (n=9)	8.3% (n=4)	2.1% (n=1)
8o) Officers who work in the CCU and places like that should be specially trained in mental health	1.54	.544	47.9% (n=23)	50.00% (n=24)	2.1% (n=1)	0.0%	0.0%

A significant majority of the prisoner patient sample strongly agreed or agreed with the statements/quotes in question eight showing they consider training is important. In particular, there was agreement that training in mental health is vitally important and of the value of suicide and at risk training (8a and 8e). Prisoners also felt strongly about the current level of training and education provided to staff but also for themselves and other prisoners. Specifically, they agreed that staff need to be well trained, that all prison staff need additional training, that most other prisoners have no idea about mental illness, that pamphlets are required, that prisoners need information and education about their own health, and that there is a need for special programs for those with mental disorders (8h, 8i, 8b, 8c, 8g, 8j, 8k). There were some interesting results relating to who should provide services to prisoners with mental illness. The majority of prisoners agreed (8d, SA/A n=31) that only trained medical staff should work with the mentally ill, however others were not so sure (U n=8). In addition, some participants (n=13) disagreed or strongly disagreed with the statement 'the officers have no idea what mental health is and are not properly trained to help us' (8f). These findings show that there may be some officers who are capable, and good at working, with mentally ill prisoners. However, the

majority of the participants (over 60% in both cases) have a perception that prison officers are not properly trained to help them.

Metropolitan/Regional

The results that revealed a significant relationship between metropolitan and regional prisons are presented in Appendix O. Overall, the data shows that on average metropolitan prisoners support the following statements more strongly than regional participants: 1) all prison staff need more training in mental health; 2) there should be pamphlets and information available in the medical centre so people understand better; and that 3) staff need to be very well trained to care for prisoners with a mental illness/disorder.

Staff Results

Question Five: Have you received any training to have people with mental illness under your care?

The frequencies data highlights that over half (66.7%, n=80) of prison staff reported never having had any form of mental health training compared to only 32.5% (n=39) that have (M 3.78 and SD 1.26).

Metropolitan/Regional

A chi-square test was performed for question five and the assumptions were not violated due to only four categories or cells of response (no cells had an expected count of less than 5). The finding shows a significant result ($X^2 (1) = 4.172, p < .05$). Regional participants are more likely to report having received no training than metropolitan participants.

Question Six: Do you feel that you have adequate training or access to training to have persons with mental illness under your care?

The results found that 66.7% (n=80) of the sample responded they do not have enough training to care for people with mental illness. 8.3% (n=10) strongly agreed, 9.2% (n=11) agreed and 15.8% (n=19) were undecided. The ANOVA showed a significant difference across staff/occupation groups for q six: [$F (3, 116) = 16.541, p < .05$]. Health/clinical participants had a mean score of (M=2.78, SD1.408), prison/senior officers had a mean score of (M=4.28, SD.868),

education/programs staff had a mean score of ($M=2.33$, $SD1.528$), and other staff had a mean score of ($M=3.64$, $SD1.120$).

Multiple comparisons revealed a significant difference ($p < .05$) between health/clinical staff and prison/senior officers and between education/programs staff and prison/senior officers. Health/clinical staff and education/programs staff agreed more strongly with the statement than prison/senior officer staff.

Question Seven: Do you feel that uniform staff have a suitable level of training to be managing persons with mental illness?

The frequency percentages show that 81.6% ($n=98$) of the sample do not feel that uniform staff have a suitable level of training to be managing and caring for persons with a mental illness ($M 4.23$ and $SD .847$).

Question Eight: Do you feel that prisoners have adequate information and education about mental health, illness, medication, how to manage their own illness, how to ask for help and how to understand the behaviours of other prisoners?

The frequency results demonstrate that 58.3% ($n=70$) of the sample reported that there are inadequate quantities of information and education available for prisoners. 27.5% ($n=33$) were undecided and 14.2% ($n=17$) strongly agreed or agreed with the above statement ($M 3.70$ and $SD 1.08$).

Question Nine: Education and Training (9A to 9N Statements)

Table 24 presents each statement/quote with the mean and standard deviation. In addition, it presents the percentages and frequencies for each response.

Table 20: Question Nine Staff Frequencies

Statement Question Nine	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
9a) Training is vitally important	1.43	.617	62.5% ($n=75$)	34.2% ($n=41$)	1.7% ($n=2$)	1.7% ($n=2$)	0.0%
9b) All staff need more training in mental health	1.57	.764	55.0% ($n=66$)	37.5% ($n=45$)	4.2% ($n=5$)	2.5% ($n=3$)	0.8% ($n=1$)
9c) I have adequate	3.78	1.15	5.8%	11.7%	9.2%	45.0%	28.3%

Statement Question Nine	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
training in mental health			(n=7)	(n=14)	(n=11)	(n=54)	(n=34)
9d) There is a lack of training for uniform staff in prisons	2.18	.993	25.8% (n=31)	45.0% (n=54)	16.7% (n=20)	10.8% (n=13)	1.7% (n=2)
9e) ARMS, risk prevention and self harm training are really important	1.66	.825	49.2% (n=59)	41.7% (n=50)	5.0% (n=6)	2.5% (n=3)	1.7% (n=1.7)
9f) I have never done any training in mental health	2.88	1.13	21.7% (n=26)	31.7% (n=38)	3.3% (n=4)	24.2% (n=29)	19.2% (n=23)
9g) Time off work is never given for mental health training	2.28	1.13	29.2% (n=35)	31.7% (n=38)	26.7% (n=32)	6.7% (n=8)	5.8% (n=7)
9h) Staff need to be very well trained to care for prisoners with mental illness	1.93	.954	35.8% (n=43)	47.5% (n=57)	6.7% (n=8)	8.3% (n=10)	1.7% (n=2)
9i) People need to be educated about mental health	1.65	.752	45.8% (n=55)	47.5% (n=57)	4.2% (n=5)	0.8% (n=1)	1.7% (n=2)
9j) Prisoners need to be educated about their own mental health	1.60	.653	45.8% (n=55)	50.8% (n=61)	1.7% (n=2)	0.8% (n=1)	0.8% (n=1)
9k) Prisons should have special programs for mental health clients	1.93	.817	29.2% (n=35)	54.2% (n=65)	12.5% (n=15)	2.5% (n=3)	1.7% (n=2)
9l) There is plenty of information available on mental health	3.67	.964	1.7% (n=2)	12.5% (n=15)	20.8% (n=25)	47.5% (n=57)	17.5% (n=21)
9m) Training and education are valued in the prison I work in	2.56	.968	10.8% (n=13)	41.7% (n=50)	32.5% (n=39)	10.8% (n=13)	4.2% (n=5)
9n) Members of the Prison Counselling Service need additional specialist mental health training	2.43	.932	20.0% (n=24)	25.8% (n=31)	46.7% (n=56)	5.8% (n=7)	1.7% (n=2)

This table clearly shows there was agreement that training is important, that staff need to be well trained to care for mentally ill prisoners, that ARMS and suicide training are important, and that prisoners need to be educated about their own mental health (9a, 9e, 9h, 9i, 9j). The majority of staff agreed that all staff need more training (9b, SA/A n=111). However, when asked if they have adequate training (9c), if there is training available for prison officers (9d), if they had ever attended training related to mental health (9f), and whether PCS require additional training (9n) the staff scores are more evenly spread and in some cases were undecided. This diversity may be accounted for by the fact that health professionals have more training and experience than correctional staff or due to metropolitan staff having greater access to training than staff in the regions? There were some interesting findings in relation to the value of training and whether time off work was granted to undertake training (9g, 9m). Specifically, the data shows participants have a perception that time off work is rarely given to undertake training (9g, SA/A 73, U n=32), and a proportion of participants are undecided (n=39) or disagree (SD/D n=18) that training is valued in the prison they work in.

Metropolitan/Regional

The significant findings between metropolitan and regional prisons are presented in appendix O. Overall, the data demonstrates that on average regional participants agree with the following statements more strongly than metropolitan participants: 1) training in mental health is vitally important; 2) all staff need more training in mental health; 3) ARMS, risk prevention and self-harm training are really important; and 4) time off work is never given for mental health training.

Prison Staff/Occupation Group

The ANOVA results that revealed a significant relationship between occupational groups are presented in Appendix O. On average, uniformed staff reported that they do not have adequate training, have never done any mental health training, and that time of work is rarely given to undertake training.

Summary

The findings demonstrate that prisoners report mixed/undecided attitudes to service provision and in some cases related this to a lack of training opportunities for staff, in particular prison officers. Increased and on-going education and training were reported to be very important for both staff and prisoners.

Prisoner Patients

Prisoners are divided as to the level of care they experience from prison officers. Some prisoners report that they are not adequately cared for due the personality of prison officers, due to inadequate training, low levels of awareness towards mental illness and because of bullying. Almost half of the prisoners agreed that they are adequately cared for by PCS with regional participants more likely to agree than metropolitan participants and the majority of prisoners agreed that they are adequately cared for by nurses. The data shows that prisoners agree that all staff need additional training and that in their view more information needs to be made available in the prisons about psychiatric illness.

Staff

The findings show staff believe that training and education are vitally important especially in relation to working with vulnerable prisoners. This is concerning given the large percentage of staff who have never received training in managing psychiatric illness (67.5%) and the percentage that do not feel they have adequate training to have persons with mental illness under their care (66.7%). Prison officers have less training than other staff and agreed more strongly that time of work is rarely given for mental health training. Moreover, the majority of the sample do not feel that uniform staff have adequate training in mental health/illness (81.6%) and staff report that at present there is a lack of training for uniform staff. The data shows that participants in Phase Two agree with the staff in Phase One that it is very important for people to be educated about mental health and psychiatric illness.

Section Four: Current Mental Health/Psychiatric Service Provision

Prisoner Patient Findings

Question Two: Issues, Attitudes and Experiences in relation to Current Service Provision (2A to 2Y Statements)

The overall frequency distributions were again very interesting showing a high degree of convergence across the phases and amongst participants. Table 11 below presents each statement and the corresponding mean and standard deviation. In addition, it presents the percentages and frequency for each response.

Table 21: Question Two Prisoner Frequencies

Statement Question Two	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
2a) I find it hard living in prison with a mental illness	2.15	1.238	39.6% (n=19)	33.3% (n=16)	2.1% (n=1)	22.9% (n=11)	2.1% (n=1)
2b) No-one understands what I am going through	2.90	1.242	14.6% (n=7)	31.3% (n=15)	10.4% (n=5)	37.5% (n=18)	6.3% (n=3)
2c) Some days are good and other days are bad	1.56	.580	47.9% (n=23)	47.9% (n=23)	4.2% (n=2)	0.0%	0.0%
2d) My mental health is a very spiritual thing for me	2.94	1.465	20.8% (n=10)	25.0% (n=12)	14.6% (n=7)	18.8% (n=9)	20.8% (n=10)
2e) I got seen by the medical staff right away when I came to prison	2.40	1.395	29.2% (n=14)	41.7% (n=20)	4.2% (n=2)	10.4% (n=5)	14.6% (n=7)
2f) (reversed mean) I do not feel that I have adequate access to care, services and treatment	3.10	1.292	16.7% (n=8)	14.6% (n=7)	22.9% (n=11)	33.3% (n=16)	12.5% (n=6)
2g) I think that the mental health service and treatment is really good	2.65	1.211	16.7% (n=8)	39.6% (n=19)	12.5% (n=6)	25.0% (n=12)	6.3% (n=3)
2h) For people who are unwell the system is failing. People have to wait too long to get care and many are placed in CCU which is not ideal. It takes a	2.06	.998	33.3% (n=16)	39.6% (n=19)	14.6% (n=7)	12.5% (n=6)	0.0%

Statement Question Two	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
long time to get people stable on medication and even then lots of people should not be in prison. They should go to a special ward or something							
2i) Prison is becoming the new kind of institution for people with mental illness	1.94	.885	31.3% (n=15)	52.1% (n=25)	10.4% (n=5)	4.2% (n=2)	2.1% (n=1)
2j) (reversed mean) I feel very isolated and alone	2.75	1.194	14.6% (n=7)	35.4% (n=17)	16.7% (n=8)	27.1% (n=13)	6.3% (n=3)
2k) You cannot confide in people here. Officers, health staff or prisoners as they share the information with other people	2.63	1.196	20.8% (n=10)	29.2% (n=14)	20.8% (n=10)	25.0% (n=12)	4.2% (n=2)
2l) My health information should be private and only available to medical staff	1.88	1.064	43.8% (n=21)	39.6% (n=19)	6.3% (n=3)	6.3% (n=3)	4.2% (n=2)
2m) The mental health staff are good, helpful and understanding	2.08	.895	25.0% (n=12)	52.1% (n=25)	12.5% (n=6)	10.4% (n=5)	0.0%
2n) The officers treat you differently because you have a mental illness. They talk behind your back and call you names.	3.02	1.376	22.9% (n=11)	10.4% (n=5)	20.8% (n=10)	33.3% (n=16)	12.5% (n=6)
2o) Many of the prisoners are vulnerable, especially the guys with mental illness	1.81	.816	39.6% (n=19)	43.8% (n=21)	12.5% (n=6)	4.2% (n=2)	0.0%
2p) The officers don't care and prison is about discipline not treatment	2.58	1.164	18.8% (n=9)	33.3% (n=16)	25.0% (n=12)	16.7% (n=8)	6.3% (n=3)
2q) The other prisoners treat you differently and think you should not be taking all the medication	2.60	1.106	14.6% (n=7)	41.7% (n=20)	14.6% (n=7)	27.1% (n=13)	2.1% (n=1)
2r) I find that sometimes being in prison is a help as you get	3.25	1.345	12.5% (n=6)	22.9% (n=11)	10.4% (n=5)	35.4% (n=17)	18.8% (n=9)

Statement Question Two	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
looked after and have better treatment than you would in the community							
2s) The prison should not use disciplinary action to force us to take our medication	2.35	1.158	25.0% (n=12)	37.5% (n=18)	20.8% (n=10)	10.4% (n=5)	6.3% (n=3)
2t) The psychiatrists are very helpful and I have enough access to see them	2.90	1.096	6.3% (n=3)	37.5% (n=18)	25.0% (n=12)	22.9% (n=11)	8.3% (n=4)
2u) I feel that the staff listen to me and that I have people who I can talk too	2.71	1.110	8.3% (n=4)	45.8% (n=22)	20.8% (n=10)	16.7% (n=8)	8.3% (n=4)
2v) It is very negative in prison and it makes it hard to build the spirit back up	2.25	1.139	29.2% (n=14)	41.7% (n=20)	4.2% (n=2)	25.0% (n=12)	0.00%
2w) The peer support team is a real help	2.90	1.309	10.4% (n=5)	37.5% (n=18)	25.0% (n=12)	6.3% (n=3)	20.8% (n=10)
2x) The prison counselling service is very helpful	2.65	1.041	8.3% (n=4)	41.7% (n=20)	37.5% (n=18)	2.1% (n=1)	10.4% (N=5)
2Y) I don't think that prison officers should be looking after us as they are not qualified medical staff	2.75	1.158	12.5% (n=6)	39.6% (n=19)	12.5% (n=6)	31.3% (n=15)	4.2% (n=2)

The findings in Table 11 demonstrate prisoner's have varied experiences of current service provision with the scores far more spread than for the other themes. However, in the majority of cases at least half of the sample strongly agreed or agreed with the statements made in the questionnaires. There was general agreement from prisoners that they find it difficult living in prison with a mental illness, they experience good days and bad days, that the system is failing, that prison is the new kind of institution for people with mental illness, that their health information should be private, that prisoners with mental illness are vulnerable, and that they find it very negative living in prison (2a, 2c, 2h, 2i, 2l, 2o, 2v). However, in the case of 2a and 2v approximately 20% of the sample disagreed with these statements perhaps showing some prisoners are better able

to cope than others? Unexpectedly, the data shows a proportion of the prisoners (n=26) agreed that prison is proving them with a helping hand in comparison to the services they received in the community (2r). Perhaps this demonstrates that prisoners want to be looked after in a supported accommodation type setting, or that prison provides them with the structure and order they desire? It could also make a rather dismal remark about community mental health services?

The findings illustrate that prisoners in the sample had mixed perceptions regarding staff and other prisoner's ability to understand them, whether they felt they had people they could confide in, and the level of bullying/segregation that occurs (2b, 2j, 2k, 2q, 2u). Interestingly, 20.8% (n=10) were undecided (perhaps due to concerns about the confidentiality of the survey?), and 25.0% (n=12) disagreed with statement 2K claiming they can confide in people. Participants had varied attitudes about the behaviour of other prisoners towards them (2q), and in relation to peer support teams (2w). There was agreement that prison administrators should not use disciplinary action to force prisoners to take medication (2s, SA/A n=30), however a number of prisoners were undecided (n=10).

Table 11 shows a fairly even spread of scores for statements relating to staff and current services. Three quarters (n=34) of the sample were promptly seen by medical staff (2e), however one quarter (n=12) strongly disagreed or disagreed with this statement. A further 56.3% (n=27) strongly agreed or agreed that the current service provision and treatment is good (2g), compared to 31.3% (n=15) who strongly disagreed or disagreed. The majority of prisoners agreed that mental health staff are helpful and understanding (2m), however they were less sure regarding prison officers (2y, 2n), and over half of the sample agreed that the officers do not care and prison is about discipline not treatment (2p). A large percentage of prisoners were undecided regarding the helpfulness of the PCS (2x), although half of the sample agreed they were helpful. There was a varied response in attitudes towards psychiatrists (2t). These findings show that prisoners have marked differences in attitude, perception and in their experiences of current mental health services across prisons in Western Australia. These findings may be accounted for by a variation in staff and services across prisons, or that some prisoners are more acutely unwell and thus require a greater depth and range of services?

Metropolitan/Regional

The interaction between prison location - regional (*Eastern Goldfields and Albany*) and metropolitan (*Hakea and Casuarina*) prisons and the statements in Q2 were analysed using both parametric and nonparametric tests; the significant t-test results are presented in Appendix P. A summary is provided here: On average metropolitan participants agreed more strongly with the following statements/quotes than regional participants 1) I do not feel that I have adequate access to care, services and treatment; 2) you cannot confide in people here, officers, health staff or prisoners as they share the information with other people; 3) the officers treat you differently because you have a mental illness. They talk behind your back and call you names; 5) it is very negative in prison and it makes it hard to build the spirit back up. On average, regional participants agreed more strongly than metropolitan prisoners that the peer support team is a real help.

The data shows that participants in metropolitan prisons reported poorer experiences of service provision, increased rates of bullying and feelings of being treated differently by officers, than did participants in regional prisons. Although metropolitan prisoners should have better access to services there is more likely to be overcrowding at these sites thus putting pressure on the services available and reducing prisoner access and satisfaction. It is also possible that prisoners incarcerated at Casuarina and Hakea prisons are actually unwell in comparison to prisoners in the regions who may be more stable and therefore metropolitan prisoners do not feel that the services are adequate.

Staff Findings

Question Three: Issues, Attitudes and Experiences in relation to Current Service Provision (3A to 3W Statements)

Yet again, an overwhelming number of Phase Two staff participants strongly agreed or agreed with the statements/quotes of the Phase One participants. The table below presents each statement with the mean and standard deviation. In addition, it presents the percentages and frequency for each response.

Table 22: Question Three Staff Frequencies

Statement Question Three	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
3a) It is important to make time to listen to prisoners who experience mental illness	1.63	.649	46.7% (n=56)	44.2% (n=53)	9.2% (n=11)	0.0%	0.0%
3b) It is important that the initial assessment is sensitive to mental health issues	1.62	.611	44.2% (n=53)	50.8% (n=61)	4.2% (n=5)	0.8% (n=1)	0.0%
3c) Crisis care has become like a pseudo psychiatric wing	2.42	.940	19.2% (n=23)	31.7% (n=38)	38.3% (n=46)	10.0% (n=12)	0.8% (n=1)
3d) My overall experience is one of just managing day to day but not really knowing what to do with people with mental illness and wondering why they are here. This is a prison	2.85	1.24	17.5% (n=21)	26.7% (n=32)	15.8% (n=19)	33.3% (n=40)	6.7% (n=8)
3e) There are not enough mental health nurses to adequately deal with the numbers of mental health clients	1.97	.888	34.2% (n=41)	40.8% (n=49)	20.0% (n=24)	4.2% (n=5)	0.8% (n=1)
3f) We do not have the appropriate facilities to manage people with mental illness	1.62	.735	50.0% (n=60)	41.7% (n=50)	5.0% (n=6)	3.3% (n=4)	0.0%
3g) The initial assessment is only as good as the nurse administering it	2.33	.947	20.8% (n=25)	37.5% (n=45)	29.2% (n=35)	12.5% (n=15)	0.0%
3h) Officers don't have the time or the training to deal with them and they should not have to. Sometimes I think this place is a funny farm and it is very hard to manage	2.88	1.10	10.8% (n=13)	30.0% (n=36)	25.0% (n=30)	29.2% (n=35)	5.0% (n=6)
3i) We have very limited access to the psychiatrist and this is problematic for us	2.08	.931	30.8% (n=37)	38.3% (n=46)	22.5% (n=27)	8.3% (n=10)	0.0%
3j) The GP we have is limited	2.54	.777	12.5%	25.8%	56.7%	5.0%	0.0%

Statement Question Three	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
and not trained in mental health			(n=15)	(n=31)	(n=68)	(n=6)	
3k) Mental health prisoners are very vulnerable and I just don't understand why they are here	2.63	1.11	16.7% (n=20)	35.0% (n=42)	20.0% (n=24)	25.8% (n=31)	2.5% (n=3)
3l) It is important to take the time to explain reasons for decisions to prisoners	1.81	.759	35.0% (n=42)	53.3% (n=64)	8.3% (n=10)	2.5% (n=3)	0.8% (n=1)
3m) Prisoners with mental illness have different needs to the rest of the prison population	1.94	.882	31.7% (n=38)	51.7% (n=62)	8.3% (n=10)	7.5% (n=9)	0.8% (n=1)
3n) I don't feel comfortable working with prisoners who experience mental health issues	3.80	1.05	3.3% (n=4)	12.5% (n=15)	10.0% (n=12)	49.2% (n=59)	25.0% (n=30)
3o) Prisons are very punitive and mental health clients need to be in a more therapeutic environment	2.28	.925	17.5% (n=21)	51.7% (n=62)	17.5% (n=21)	12.5% (n=15)	0.8% (n=1)
3p) Mental health prisoners are very vulnerable	2.10	.814	20.0% (n=24)	58.3% (n=70)	13.3% (n=16)	8.3% (n=10)	0.0%
3q) Aboriginal prisoners have different needs to other prisoners	2.61	1.14	15.8% (n=19)	39.2% (n=47)	19.2% (n=23)	20.0% (n=24)	5.8% (n=7)
3r) Regional Prisons have much the same needs as other prisons	2.98	1.16	8.3% (n=10)	33.3% (n=40)	20.0% (n=24)	28.3% (n=34)	10.0% (n=12)
3s) Mental health prisoners have committed a crime like anyone else and should be in prison	2.81	.863	6.7% (n=8)	27.5% (n=33)	45.0% (n=54)	20.0% (n=24)	0.8% (n=1)
3t) The human rights of many mental health prisoners is in question	2.92	1.06	10.0% (n=12)	23.3% (n=28)	35.0% (n=42)	28.3% (n=24)	3.3% (n=4)
3u) You just do the best with what you have	2.10	.782	15.8% (n=19)	68.3% (n=82)	5.8% (n=7)	10.0% (n=12)	0.0%
3v) It is not prison officer's job to care for prisoners	3.99	1.05	4.2% (n=5)	7.5% (n=9)	8.3% (n=10)	45.0% (n=54)	35.0% (n=42)
3w) Prison is becoming the new	2.02	.917	28.3% (n=35)	53.3% (n=67)	7.5% (n=9)	10.0% (n=12)	0.8% (n=1)

Statement Question Three	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
kind of institution for people with mental illness			(n=34)	(n=64)	(n=9)	(n=12)	(n=1)

As with the prisoner patient data, this table clearly shows staff were divided and somewhat more uncertain when it came to rating the statements in relation to their perceptions and experiences of current service provision. There was agreement that prisoners need to be listened to, that it is important for time to be taken to explain decisions, for the initial assessment to be sensitive to mental illness, that prisoners with mental illness have different needs to the rest of the population (3a, 3l, 3b, 3m). The results show staff were sure regarding the needs of Aboriginal prisoners (3q) and patients in regional prisons (3r). Participants agreed that mentally ill persons are vulnerable (3p) and need to be in a more therapeutic environment (3o), however they were less sure about their understanding of why the mentally ill are in prisons (3k). The results show participants were evenly spread between agree and disagree for statement 3s, however a large percentage were undecided. The results are similar for statement 3t regarding an abuse of human rights with a number of participants undecided. The majority of participants agreed that prison is becoming the new kind of institution for people with mental illness (3w).

Over 90% of the sample agreed that they do not have the appropriate facilities to care for mentally ill prisoners (3f, SA/A n=110), and although half of the sample believed that crisis care has become a defacto psychiatric ward, the other half were either undecided or disagreed with this statement (3c). These findings may be accounted for by the differences in service availability across prisons? There is only one crisis care facility at Casuarina prison so staff in the other prisons may not have the knowledge of what is occurring at this prison site? The majority of staff agreed that they are doing the best they can with the service available to them (3u), however, the data is varied in relation to whether they manage day to day and do not know what to do with the mentally ill (3d). It is likely these findings will differ according to occupational group with health professionals more confident than correctional staff? There was agreement that it is prison officers' job to care for prisoners (3v), however there were mixed attitudes regarding

officers time and training to 'deal with them' (3h). A large number of participants were undecided (25%, n=30) about this statement. There were some interesting results related to health staff with a large percentage of undecided responses for three statements (3e, 3i, 3j). The majority of staff agreed there are not enough mental health nurses (3e, SA/A n=90), and that they have limited access to psychiatrists (3i, SA/A n=63), however approximately 20% of the sample were undecided about these statements. Almost 60% of the sample were undecided about access to and training of GP's (3j). These findings may be accounted for by variation across staff groups as correctional staff would have less contact with health professionals and be more unclear regarding their attitudes towards the incarceration of the mentally ill and human rights issues? It is interesting that both the prisoner patient and staff results show variation for statements around these themes.

Metropolitan/Regional

The interaction between prison location - regional (*Eastern Goldfields and Albany*) and metropolitan (*Hakea and Casuarina*) prisons and the statements in Q3 were analysed using both parametric and nonparametric tests and the significant t-test results are presented in Appendix P. A summary is provided here. On average, regional staff agreed with the following statements more strongly than metropolitan participants: 1) there are not enough mental health nurses to adequately deal with the numbers of mental health clients; 2) we do not have the appropriate facilities to manage people with mental illness; 3) we have very limited access to the psychiatrist and this is problematic for us; and 4) it is important to take time to explain reasons for decisions to prisoners. Regional staff disagreed more strongly than metropolitan participants that it is not officer's job to care for prisoners. The data here helps to support, provide context and possible reasons for the variation in prisoner's experiences in regional and metropolitan prisons. Despite reporting limited access to facilities staff in regional prisons take a positive attitude, feel that it is their job to care for prisoners, and take the time to listen and explain reasons for decisions. This is reflected in the prisoner attitudes. It may be that staff working in regional prisons have more time due to smaller populations or that prisoners are less acute and therefore easier to manage?

Prison Staff Group

A one-way Analysis of Variance, Pearson Chi-Square Test and Kruskal-Wallis Test were chosen to analyse the interaction across staff groups (*health/clinical, prison/senior officer, education/programs and other*) and the statements in Q3. The results that did not violate assumptions and revealed significant relationships are presented in Appendix P. A summary is provided here. On average, health/clinical staff and education staff agreed more strongly than prison officers that it is important to make time to listen to prisoners. Prison officers reported more strongly than Health staff that they find it difficult, and are operating on a day-to-day basis when working with prisoners who experience mental illness. Furthermore, a therapeutic/treatment attitude is evident in relation to Health/Clinical staff responses in comparison to the management/security stream of prison officers. This is not unexpected given the differing roles and expectations of these staff.

Age

A significant difference between age groups was noted for statement Q3a only: "it is important to make time to listen to prisoners who experience mental illness" [$F(4,115) = 2.666, p < .05$]. The difference was between those in the 30-39 age bracket ($M = 1.91, SD = .733$), who agreed less strongly than those in the 50-59 age bracket ($M = 1.43, SD = .603$).

Question Four: From your experience what currently works well in the service you provide? (4A to 4G)

Frequencies

The table below presents each statement/quote from the survey questionnaire with the mean and standard deviation. In addition, it presents the percentages and frequency of each response.

Table 23: Question Four Staff Frequencies

Question Four	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
4a) We have great staff who work well as a team	2.10	1.01	30.0% (n=36)	44.2% (n=53)	14.2% (n=17)	9.2% (n=11)	2.5% (n=3)

4b) In prison you have a captive audience so clients get some treatment	2.75	.964	6.7% (n=8)	38.3% (n=46)	31.7% (n=38)	20.0% (n=24)	3.3% (n=4)
4c) We get to know the clients and their needs really well which creates a positive environment	2.67	.947	5.0% (n=6)	46.7% (n=56)	30.0% (n=36)	13.3% (n=16)	5.0% (n=6)
4d) We have enough time to manage people well rather than just crisis managing people	3.54	.995	1.7% (n=2)	14.2% (n=17)	30.0% (n=36)	36.7% (n=44)	17.5% (n=21)
4e) We have a good relationship with Prison Counselling Service	2.32	1.05	26.7% (n=32)	30.0% (n=36)	30.8% (n=37)	10.0% (n=12)	2.5% (n=3)
4f) Peer support is a real benefit	2.53	1.20	21.7% (n=26)	33.3% (n=40)	23.3% (n=28)	13.3% (n=16)	8.3% (n=10)

The data shows that 74.2% (n=89) of staff participants report they work well as a team (4a); 56.7% (n=68) agree they have a good working relationship with PCS (4e), and 55.1% (n=66) strongly agree or agree that the peer support program is a real benefit (4f). The data shows that staff are unsure about the benefits of having a captive audience in prison (4b) and they felt they were only crisis managing prisoners due to pressures on their time (4d).

Metropolitan/Regional

On average, regional participants reported a stronger level of agreement with the statement "we get to know clients and their needs really well which creates a positive environment" ($M = 2.49$, $SD = .821$), than metropolitan participants ($M = 2.98$, $SD = 1.080$). This was significant [$t(118) = 2.754$, $p < .05$] at the .05 level.

Prison Staff Group

There was a significant difference between staff groups for Q4f only: "peer support is a real benefit" [$F(3,116) = 10.384$, $p < .05$]. Health/clinical participants had a mean score of ($M=1.97$, $SD1.031$), prison/senior officers had a mean score of ($M=2.96$, $SD1.164$), education/programs staff had a mean score of ($M=1.33$, $SD.577$), and other staff had a mean score of ($M=1.64$, $SD.674$). Multiple Comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers, between prison/senior officers and other staff, and between other staff and education and programs staff.

Summary

Prisoner Patients

Generally, prisoners reported that living in prison with a mental health issue can be challenging for a number of reasons. The prisoner patient findings suggest:

- ❖ It is hard living in prison with a mental illness.
- ❖ The majority of prisoners were seen by medical staff promptly when arriving in prison and over half are happy with the treatment they received. However, prisoners also reported that the system is failing for those who are unwell and that prison has become the new kind of institution for people with mental illness.
- ❖ Medical information should be private and only available to medical staff.
- ❖ Half of the sample reported feeling isolated and alone, and that they could not confide in people in prison.
- ❖ Prisoners reported that the mental health staff are helpful and understanding.
- ❖ A third of the sample reported being treated differently by prison officers.
- ❖ Individuals with mental health problems are seen as vulnerable.
- ❖ Over half of the sample feels that they are treated differently by other prisoners because they have a mental illness.
- ❖ Over half of the sample were unsure or did not feel that they have adequate access to psychiatrists.
- ❖ Over half of the sample reported that prison officers should not be looking after them, as they are not qualified medical staff.
- ❖ On average, prisoners at metropolitan prisons are less satisfied with service provision and prison life generally than participants at regional prisons.
- ❖ The findings seem to support that prisoner patients were more cautious of service provision at the larger metropolitan prisons in the sample.

Staff

The findings here are interesting and reveal that staff have a wide range of views and experiences when it comes to current psychiatric service provision. Most staff agree that it is essential to listen and explain reasons for decisions to prisoners with mental health problems, and that it is important for the initial assessment to

be sensitive to mental health. Over a third of the sample experiences that they are coping day to day, and the majority of staff report that they are doing the best they can with the facilities and knowledge they have.

Moreover, participants in Phase Two agree with those in Phase One that there are not enough mental health nurses, and that they do not have the facilities to be managing prisoners with mental illness. Over half report that limited access to the psychiatrist is problematic and that mentally ill prisoners have different needs from the general prison population. The majority of staff report that mental health clients are vulnerable and need to be in a more therapeutic environment, however a third of the sample also reported that mental health prisoners have committed a crime and should be in prison. The majority of staff agreed that it is prison officer's job to care for prisoners with mental health problems.

Additionally, regional prisons report less satisfaction with the level of service provision, facilities and staff (particularly mental health nurses and psychiatrists) they can provide than metropolitan prisons. The data also shows differences across staff groups in attitudes to mental health clients. Almost three quarters of the staff sample report that they are part of a great team who work well together. Over half of the sample report that they get to know clients and their needs well however, this statement is supported more strongly by staff at regional prisons.

Section Five: Management, Consultation and Context

This section presents the staff results for questions in the surveys that related to the construct - management, consultation and context. No prisoner patient results are presented, as the offender questionnaire did not contain questions relating to this theme (the theme did not emerge for this group in the Phase One findings). Some general frequencies are presented and then the findings are broken down as per the analyses. That is, looking at the findings by regional and metropolitan prison groups. In some cases, the findings are analysed in terms of staff position group, and age. Significant findings for parametric and non-parametric tests are presented in Appendix Q with summaries provided in this section.

Staff Results

Question Ten: Management and Consultation (10A to 10G Statements)

Table 32 presents each statement with the mean and standard deviation. In addition, it presents the percentages and frequencies for each response.

Table 24: Question Ten Staff Frequencies

Statement Question Ten	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
10a) There is inadequate management support when faced with mental health crisis issues	2.74	.992	8.3% (n=10)	38.3% (n=46)	25.8% (n=31)	25.8% (n=31)	1.7% (n=2)
10b) There are inadequate operational guidelines and policy to operate within when dealing with prisoners who experience mental illness	2.57	.905	8.3% (n=10)	46.7% (n=56)	25.0% (n=30)	20.0% (n=24)	0.0%
10c) There is an appropriate level of consultation with people in the field about mental health	3.10	.893	1.7% (n=2)	25.0% (n=30)	40.0% (n=48)	28.3% (n=34)	5.0% (n=6)
10d) The policy and guidelines need revising in relation to the role of mental health and what happens on the ground	2.20	.751	16.7% (n=20)	50.0% (n=60)	30.0% (n=36)	3.3% (n=4)	0.0%
10e) There is a total lack of health management support for mental health	3.03	.995	8.3% (n=10)	19.2% (n=23)	36.7% (n=44)	32.5% (n=39)	3.3% (n=4)
10f) There is a total lack of prisons management support for mental health	3.04	.956	5.0% (n=6)	25.8% (n=31)	31.7% (n=38)	35.0% (n=42)	2.5% (n=3)
10g) I have never seen or heard of any policies relating to mental health	3.00	1.02	5.0% (n=6)	32.5% (n=39)	24.2% (n=29)	34.2% (n=41)	4.2% (n=5)

Statement Question Ten	Mean	Std. Dev	Strongly Agreed	Agreed	Undecided	Disagreed	Strongly Disagreed
10h) Management support from upper levels of health is very poor and totally inadequate	2.73	1.05	15.8% (n=19)	22.5% (n=27)	35.8% (n=43)	24.2% (n=29)	1.7% (n=2)
10i) Policy and practices are imposed from the top down rather than the bottom up	2.21	.893	20.0% (n=24)	45.8% (n=55)	27.5% (n=33)	6.7% (n=8)	0.0%
10j) You get callous working in prisons because everybody who is outside of the prison thinks that they know how to do the job better	3.09	1.18	10.0% (n=12)	26.7% (n=32)	16.7% (n=20)	37.5% (n=45)	9.2% (n=11)
10k) Quite often things get imposed on us that are ineffective and do not work on the ground	2.19	.863	19.2% (n=23)	52.5% (n=63)	18.3% (n=22)	10.0% (n=12)	0.0%
10l) We are never asked what we need and why we need it, people just make decisions that affect us with no consultation	2.24	.996	25.8% (n=31)	38.3% (n=46)	21.7% (n=26)	14.2% (n=17)	0.0%
10m) Health is a difficult area because in the prison security always comes before peoples health	2.28	1.01	20.0% (n=24)	50.8% (n=61)	11.7% (n=14)	15.8% (n=19)	1.7% (n=2)
10n) We need effective guidelines and policy that are not to general or overbearing	2.15	.774	13.3% (n=16)	65.8% (n=79)	15.8% (n=19)	2.5% (n=3)	2.5% (n=3)
10o) The interface between health and justice needs to be reviewed	2.00	.745	25.0% (n=30)	52.5% (n=63)	20.0% (n=24)	2.5% (n=3)	0.0%

The findings for this construct demonstrate a greater degree of divergence amongst participants with a number of undecided responses. It is likely that the undecided responses are accounted for by differences in the staff groups/occupations. However, despite this variation the table shows there is still a high level of agreement in experiences and attitudes across the phases. The results show varied responses to statements relation to management support. Participants either agreed (n=46), were undecided (n=31) or disagreed (n=31) that there is adequate management support when dealing with crisis issues (10a). The results are similar for health management support (10e, 10h), and prisons management support (10f), with a pretty even spread of scores. These findings may vary across prison location as it is likely that each site, superintendent, and senior staff will adopt different management styles?

The table shows staff have a perception that ineffective practices are imposed on them (10k, SA/A n=86). However, when asked about consultation in the field (10c) the responses are again varied with 40.0% (n=48) of the sample unsure if they are consulted about mental health. The findings then contradict themselves in statement 10l were the majority of the sample (SA/A, n=77) believe they are never asked what they require. However, over 30% (n=43) of the sample were undecided or disagreed with this statement. The statement in 10l is more generic than 10c and all participants may have therefore felt more confident to respond?

There was variation across the statements that related to policies and operational guidelines. Staff agreed they require effective guidelines (10n). Over half of the sample agreed that there are inadequate operational guidelines (10b, SA/A n=66) however a quarter were undecided (n=30) and a fifth disagreed (n=24). The results were similar for statement 10d - 80 people strongly agreed or agreed, and 30 people were undecided; and for 10i - 79 people strongly agreed or agreed, and 33 people were undecided that policy and practices are imposed top down. The number of undecided responses to these statements may be accounted for by the fact that 34.2% (n=41) of the sample have never seen or heard of policies relating to mental health (10g).

There was agreement across statements relating to the issue of security/treatment (10m, SA/A n=84, U n=14, D/SD n=21), and that the interface between health and justice be reviewed (10o, SA/A n=93, U n=24). However, both

statements also show a percentage of participants who were undecided. The scores were more evenly spread showing that some people become/ are callous working in prisons and others do/are not (10j, SA/A n=44, U n=20, D/SD n=56).

Metropolitan/Regional

A Pearson Chi-Square Test, Independent Samples 2-tailed T-Test, the Mann-Whitney Test and the Wilcoxon rank-sum test were chosen to analyse the interaction between prison location broken down into regional (*Eastern Goldfields and Albany*) and metropolitan (*Hakea and Casuarina*) prisons, and prison staff group, and the statements in Q10. The result that revealed a significant relationship is presented in Appendix Q. Overall, regional prisons agree more strongly than metropolitan prisons that there is a lack of health management support within the prison.

Prison Staff/Occupation

There was a significant difference for occupation with prison officers more likely to have never seen or heard of prison policies relating to managing prisoners with mental illness and prison/senior officers agreeing more strongly that they get callous working in prisons.

Age

Not many differences were found across age in the Chi-square, ANOVAS and Kruskal-Wallis tests. There was a significant difference between age groups for Q10i only: "policy and practices are imposed from the top down rather than the bottom up" [$F(4,115) = 2.834, p < .05$]. The difference was between those in the 40-49 age bracket ($M = 2.40, SD = .840$), who agreed less strongly with the statement than those in the 50-59 age bracket ($M = 1.89, SD = .843$) who agreed more strongly.

Summary

The data in relation to this theme shows greater variation across the sample than for the other constructs. Over half of the sample expressed that there were inadequate operational guidelines and policy to operate within when working with mentally ill clients. Over half of the sample reports that they think health policy and guidelines need revising to reflect what happens on the ground. Moreover, over half of the sample reported that things are imposed from the top down

rather than the bottom up and that when these practices are imposed they very often did not work at the ground level. Staff believed that health is a difficult area due to security requirements in prisons, that effective guidelines are important, and that the interface between health and justice needs to be reviewed. Prison officers agreed more strongly that they have never seen policies relating to mental health, and that they get callous working in prisons.

Section Six: Survey Questionnaire Free Response Questions

This section presents the qualitative prisoner patient and staff results for the additional free response section attached to each questionnaire. This section was optional if participants had additional information they wanted to add or felt strongly about. Many findings repeated what was already contained in the questionnaire and although this provides further support for the findings, it was decided not to present this information as it is already adequately expressed in the results section above. Unique findings are presented for each question as they appeared on the survey.

Prisoner Patient Findings

Of the 48 prisoner patients who participated in the research, 30 completed the additional qualitative section on the questionnaire. A breakdown of prison location and ethnicity will not be provided to ensure confidentiality.

QUESTION 13: What are the key issues/problems that arise for you living in prison with a mental illness/disorder?

A range of issues and problems are experienced by prisoner patients. The responses were divided into four themes - Medication and Conversation, Overcrowding and Paranoia, Bullying, and Cultural Issues.

Preferred Mode of Treatment

Many challenges are experienced by prisoner patients living in the complex prison environment. Prisoners reported that it is difficult *“getting used to new and increased medication”* and that overmedication can be a problem. As one prisoner reported - *“ it is very scary, sometimes they get you so dosed up you feel like you are going to fall over from loss of balance - very scary experience - before people get sent to Graylands they should be asked.”* Prisoners feel the massive stresses

and traumas of prison life and commented that people do not understand their mental illness or really listen to them - *“other prisoners don’t understand and it is very hard to talk about [mental illness] there are not many people who really listen”*, and *“having qualified people to talk with. I have tried to talk with the officers but they are unable to talk about mental health and it is hard to access PCS.”* Prisoners commented that they find it difficult to cope, that it is hard to talk to people for fear of appearing weak and that they find it difficult most of the time to access medical staff.

Additional Stressors

Issues of overcrowding and feelings of paranoia were expressed as additional stressors for prisoners. Prisoners said they feel confused, as if they have no time to themselves and that there are *“always people around.”* This closeness can often cause dramatic increases in rates of violence as one prisoner reported: *“if something happens to hurt my feelings I get very aggressive and angry. I try to stay calm but my illness and paranoia just kick in and it makes it hard.”*

Vulnerabilities

The issue of bullying was not strongly addressed in the questionnaire but prisoners were asked questions regarding feelings of vulnerability, whether they are treated differently by staff, and if other people understand them and their illness. The findings on bullying are not unexpected given the nature of the environment but they are still rather confronting and concerning. The prisoner patient quotes help to provide insights into the nature of bullying in prisons and some selected ones are presented below:

Officers go out of their way to annoy prisoners and they seem to get a kick out of it. If you are mentally ill is not very good as you are unsure of how to take them, sometimes they are joking around but it is not a joke to me.

Other staff members talk about me and that makes me fearful and I keep to myself.

People do not understand others with mental illness and so they talk about them and laugh.

New school officers are more understanding than old school ones.

The screws and other prisoners deliberately do things to upset you. They make and put suicide packs of torn rugs, sheets, blades and glass, and they are hidden under the beds.

I hate getting called loopy by the prison officers.

Cultural Issues

One prisoner reported that there is a *“lack of communication on cultural issues and people are treated differently. Lots of the time, white people and Aboriginal people have the same problems and it is not about culture it is about people and how to change people’s attitudes. People have the same similarities and problems and it is not always a cultural thing.”* Another Aboriginal prisoner expressed that a major issue for him was that he really missed his family supports in prison; this made his mental illness more difficult to cope with.

QUESTION 14: How do you feel (what are your attitudes) about the current level of treatment, services and facilities for prisoners with mental health issues in the prison you live in and prisons in Western Australia?

Many of the strong responses to this question were from prisoners who felt cheated and hard-done by the system. The responses were divided into two themes - Education and Understanding and Additional Services.

Education and Understanding

Prisoners expressed that they did not feel understood and that people did not really listen to them: *“it needs to be highlighted that people have illnesses and listening to people when they ask for help is important.”* In addition, prisoners highlighted the need for staff to have additional training: *“everyone from administration down to the officers need to have an understanding of mental illness. People just need understanding and care. It is a lack of understanding that leads to suicide and deaths in custody.”*

Additional Services

Repeatedly prisoners spoke about trying to access services in the community and being turned away by hospital emergency departments, community facilities and the Police. As one prisoner commented, *“community care is so bad that it is almost non-existent, and then the court sends people to prison, and we don’t belong here.”* Prisoners wrote about the need for additional services in regional

areas - *"more services out country way"*; and again the need for improved services in prison - *"I believe that it is very hard to see the psychiatrist at all when they come in"*, and *"I feel that the services in prisons are inadequate."* Other prisoners expressed a need for *"more natural therapies - meditation and relaxation and learning how to integrate with other people."* It seems that many prisoners would like to try alternative therapies such as meditation, relaxation and art therapy as a way to reduce stress, give their hands and mind something to do.

QUESTION 15: What are your main experiences of living in prison with a mental illness/disorder?

Although rather short answers, the responses to this question are informative:

Things mean so much and it doesn't impact on anyone else but you, so if someone stuffs up then you really notice it and it really, really affects you. There is a lot of responsibility in them handing out drugs and treatment, and it needs to be made aware to them that it really affects peoples' lives.

There is a lack of recognition by the courts and by prosecutors for mental health. We need to look at why people commit crimes and prison is not always the best answer. There needs to be a lot more understanding of mental illness.

Lots of paranoia days due to being on top of people all the time.

Scary and Evil all of the time.

When in the deepest darks of the illness - sometimes I feel like the too hard basket.

QUESTION 16: As someone living in prison with a mental illness/disorder what are your short-term and long-term needs?

Many prisoners were unsure of what their short-term and long-term goals were in life, or in relation to their illness, (most had never been asked). Some spoke about their previous experiences in the community and their difficulty in finding help. As one prisoner stated; *"I need to be getting help when released. I got released from*

Graylands and then no-one would help me. I went to Mirrabooka mental health but they would not help." Similar experiences were reported by another prisoner; *"I will need to get help on the outside - community mental health in Northam was very little help to me last time."* Both of these prisoners and many others seemed scared at the prospect of needing help in the community and not being able to find it. As one prisoner states in relation to his drug problem - *"I need help when I get released so I don't use amphetamines to extinguish my disorders as it brings much relief... and much jail after that. Just have to find someone who cares enough to help."*

Other prisoners had clearer ideas of the kind of things they wanted to do, such as going back to their homeland - *"I want to go back to my people in Alice Springs"*, or enjoying hobbies - *"I want to keep going with my Art."* Prisoners reported that they want *"to be more involved in treatment"*, and that they need further *"medication and re-evaluation"* in the future. Others have more of a philosophical point of view and are going to *"take one day at a time."* All of these prisoners had a willingness to work towards the future.

Staff

Of the 120 staff that completed the questionnaires, 94 completed the written section. Responses varied in length and depth, and many provided support for the findings already outlined in the quantitative results section. It was difficult to put some comments in context, as I was not present to discuss thoughts with staff participants, as was the case with prisoner patients. The quotes that are presented were not isolated responses, and in most cases similar quotes and supportive evidence was found in other participants' comments. The quotes that are presented were selected because they provide additional insight and perspective into the experiences and attitudes of prison staff across Western Australia.

QUESTION 15: What are the key issues/problems that arise for you when working with prisoners who experience mental illness?

Staff commented on issues they experience ranging from lack of services and infrastructure, to frustration with levels of support and training, and information sharing. The responses to question 15 were divided into seven themes - Service Provision, Diagnoses and Vulnerability, Safety and Security, Medication and Illicit

Drugs, Prison Culture and Environment, Cultural Issues, Support and Training, and Information Sharing. Significant quotes are presented below.

Service Provision, Diagnoses and Vulnerability

Staff wrote that limited service provision after hours is difficult as there are no health staff in the prison. As one staff member wrote; *“dealing with prisoners after hours is difficult as you can only talk to people over the phone which is inadequate.”* Staff further wrote that often the *“diagnosis is very difficult and often wrong.”* Staff feel concerned about mental health clients and report that treatment is often seen as complicated and problematic, and there is a perception that these prisoners are difficult to manage. One staff member writes that mental health clients *“are often not understood by prison officers and treated as problem prisoners. They are also vulnerable from other prisoners because their behaviour can be erratic. It is therefore hard to implement consistent and long lasting interventions. Sometimes it can be difficult to separate mental health or psychiatric issues from cultural issues especially for Aboriginal clients.”* Problems of having no *“specialist mental health service”, “lack of experienced staff”, “lack of resources”* and *“trying to manage that prisoner within a ‘normal’ unit”* were also reported as frustrating and challenging for staff. Staff reported that prisoners *“with mental health issues can consume a normal working day”*, that it is difficult *“trying to make them understand and to conform to prison rules and regulations”*, and that general communication with mental health clients is difficult.

Safety and Security

Staff felt concerned about their personal safety and security. One staff member wrote, *“These prisoners can be very unpredictable. Of the few officers that are assaulted it is usually by mental health patients who have not complied with medication. It is hard to know what is going on in their heads, they can appear outwardly calm and then ‘go off’.”* Other staff members expressed that it is difficult maintaining effective boundaries with mental health clients.

Medication and Illicit Drugs

Problems and concerns regarding medication and illicit drug use were raised by a number of staff with comments such as: *“Clients are overmedicated or clients*

needing medication are too readily judged by mental health nurses as trying to scam medication.” Another staff member expressed concern that there is “no support system for when prisoners are released, and therefore prisoners do not take medications when they are released from prison.” Comments also highlighted “problems with access to illicit drugs in prison that interacts with their medication.”

Prison Culture and Environment

Difficulties with the prison culture and environment were discussed as barriers for service provision and issues that staff find challenging. Staff feel that the prison environment is not conducive to treating mental illness and that prisons incubate and are *“exacerbating mental ill health.”* Staff feel that they get ‘dumped’ with mental health clients because other people are not willing to help - *“it’s a common problem that when people become hard work it’s better to offload them even though there are not enough staff to cope”* and that there is *“intervention only when major issues arise rather than adequate on-going support and mentoring.”* Furthermore staff feel that they are left to deal with issues alone as there is a *“reluctance of many staff to want to handle these mental health issues.”*

Cultural issues

Concern regarding cultural issues was raised by a number of staff particularly in relation to Aboriginal Customary Law - *“We all need more knowledge about Aboriginal Customary Law and cultural approaches to mental health.”*

Support and Training

A lack of management support and training issues were raised by staff with comments such as:

- ❖ The prisons need to *“implement management and support strategies to ensure that staff personal health does not suffer as a result of the way we engage with students”*
- ❖ Staff report a *“total lack of direction and leadership from Health Services”* and that the *“prison administration attitude is manage as best you can with no support.”* In addition there *“appears to be a lack*

of understanding of the time that needs to be spent with mentally ill clients, this unfortunately stems from head office...too many people in head office are driven by their own promotional agendas or comfort zone and this affects the mentally ill in prison every day."

Information Sharing

Staff reported that it is difficult to provide services to mental health clients when they are not given adequate information - *"lack of specific information on individual prisoners as to their condition and expected behaviour"*, and when files are duplicated at each prison - *"lack of shared information between prisons and a duplication of paperwork between prisons."*

QUESTION 16: What are your feelings/attitudes/thoughts about the placement of mental health patients in Prison?

Staff comments relating to their feelings, attitudes and thoughts about prisoners with mental illness were divided into themes - Correctional Facilities and Mental Health Clients, Prison Officer Training, Service Provision, and Bullying. Significant quotes are presented below.

Correctional Facilities and Mental Health Clients

Staff reported concerns about the placement of prisoners with mental health problems in prisons, whilst other staff felt that they should be in prison as they have committed an offence and need to serve the punishment. However, these same staff reported that prisoners are vulnerable and that an adequate service for these individuals needs to be provided in the prison. As one staff member wrote;

If they have committed a crime then I believe that for the protection of the community they should be placed in prison. However, whilst in prison they should have access to a well supported and resourced therapeutic environment..." Other staff expressed that, like other prisoners, *"they have committed a crime and need to do the time. But there needs to be trained people (nurses and doctors) available to help them in a protected environment."* Another staff member wrote, *"Some have very antisocial behaviours and there may be a place for them within a correctional facility, but many are also very vulnerable and a mainstream prison may not be suitable."*

Prison Officer Training

Comments from prison staff regarding training varied. Some staff welcomed additional training, however other staff were not as supportive of additional mental health training. For example, *"...My feelings are that we are not social workers and not qualified enough to deal with mental health issues."* Further comments are provided below for question seventeen.

Service Provision

Staff felt strongly about the lack of service provision and resources in prisons, however much of these thoughts mirrored information already contained in the questionnaire. Some additional quotes are included here for support and interest:

Many mental health patients are placed in the prison system due to a lack of alternatives and it seems that the prison system is picking up the slack of the ailing mental health services.

Patients need to be somewhere but I wonder if the prison environment is suitable as they are locked in for 12 hours a day.

Court based issue - the judiciary often places the mentally ill in prison because they know they will be cured far better than in the community. There is something wrong with this picture!

Services are very poor. A prisoner can come to prison for throwing a rock at a police van and spend the rest of his life inside because he has an indeterminate sentence under the Disabilities Act.

Bullying

Issues' relating to bullying by other prisoners and staff was a topic that emerged in the Phase One findings and was again reinforced in the questionnaires. Many staff had additional comments regarding the bullying of mental health clients including:

...they can be the victims of cruel jokes by both other inmates and by officers.

There is a culture of violence in prison that doesn't mix well with vulnerable people like the mentally ill.

There tends to be a culture within officers to respond to mental health prisoners as 'loopers' or whatever, and as a supervisor of staff I have to deal and try to overcome this systemic prejudice.

[Psychiatric clients are] withdrawn, quiet clients tend to be overlooked in mainstream and only come to attention when a degree of bizarre behaviour is noticed. Clients who exhibit this unusual behaviour, even when relatively mentally stable are bounced back and forth from crisis care due to officer discomfort and inexperience in dealing with mental health clients.

QUESTION 17: What kinds of additional mental health training would you like to undertake?

Most staff reported wanting additional training in: medications and side effects, counselling, recognition (identification) and management of mental health problems, general mental health guidelines, effects of drug/substance abuse on learning, cognition and coping skills, management of personality disorders and how better to manage and respond to other mental illnesses including alternative disciplinary actions and "the opportunity to regularly reflect, with a highly skilled facilitator, on my approach to mental health issues."

Some prison officers reported that general and very basic training may be all right but they also report that..."if I wanted to be a mental health worker I would have applied and studied for it. Prison officer work is taxing enough without additional work load" and "some training to be able to carry out basic assessment and recommendation procedures. But then again I don't want to be a psychologist or doctor either. I am happy being a prison officer!"

QUESTION 18: How do you feel (what are your attitudes) about the current level of treatment, services and facilities for prisoners with mental health issues in Western Australian Prisons/the prison you work in?

Strengths of Service Provision

Some positive comments and strengths of service provision were identified by staff including:

Positive Statements about Mental Health Teams and Staff within Prisons:

It is great to have mental health nurse on staff.

Everyone pitches in and helps.

Staff do the best with the limited resources that are available.

I believe that the prisoners with mental health issues are well looked after. The staff are dedicated and 'make a difference' where they can.

Given the lack of adequate facilities and continuous support of mental health services in this prison, I feel that the support staff do an excellent job with the resources available to them.

Positive Statements Regarding Service Provision:

It is pretty good given the prison environment and the severity and frequency of mental health prisoners.

It is improving. I am a little wheel on a big cog so to speak.

There is a high level of support within the prison system.

Currently Lacking

Other comments centred on the current deficits in mental health service prison. The comments fell broadly into the following areas:

Inadequate Staffing Levels and Stability

Staff felt that the levels of nursing and other clinical staff was inadequate - "Monthly visiting psychiatrist totally inadequate."

Lack of Communication and Information Sharing

Staff felt that there was a lack of communication between staff and agencies when it comes to mental health. For example - *"the lack of communication between justice agencies is appalling, as well as with Disability and Community mental health."* And - *"Information regarding treatment from Health Services is limited due to confidentiality issues. If we are to continually manage prisoners mental health issues/needs in a general environment (not a health one) this information must be available, particularly as unit staff manage the prisoners needs 24/7."*

Limited Resources

Again staff reported the frustrations of limited funding for mental health - *"the word that comes to mind is limited - all our staff do the best they can with limited resources and limited support from psychiatric professionals."*

Lack of Understanding and Knowledge of Mental Health

Staff expressed feeling distressed and concerned about levels of mental health knowledge and understanding. For example:

I feel distressed, particularly re the high emphasis on medical model interventions and the lack of knowledge by some of my peers of the relationship between traumatic child-hood up bringing and behavioural problems exhibited by prisoners.

Many clients are not diagnosed and lack a specific mental health problem however, their emotional issues and ensuing behaviours may still have a negative impact on health (and society) for which they require help and for which they have limited coping mechanisms. It seems that in prison they are 'blamed' for this rather than supported to change beneficially.

There is a strong focus on medication treatment and compliance by mental health staff. There is a lack of attention devoted to constructive interventions, such as, developing and maintaining coping strategies and accessing support. There are also gaps in the exchange of knowledge between staff.

Staff feel out of their depth and scared.

Generally staff are not sympathetic, not empathetic, not nurturing and they have the same expectations from all prisoners.

QUESTION 19: *Do you think that metropolitan and regional prisons have different experiences, issues and needs in relation to the way they treat and manage offenders with mental illness? What are these differences? Can you please share some of your experiences with me?*

Responses to question 19 fell broadly into the following areas:

Regional Positives

Although highlighted in the Phase Two quantitative analysis the following quote from a staff member at Albany Regional Prison provides a positive example of service provision -

This small prison I believe operates much smoother. This size allows you to get to know most prisoners and establish relationships, recognise problems early and act quickly. I believe in larger metropolitan prisons this is not possible.

Communication

Staff raised ineffective communication as a problem in a number of capacities.

The following quote highlights the problems experienced between the prisons and the State Forensic Mental Health Service; *“Communication and integration between regional, metro and Frankland is non-existent and damaging.”*

Lack of Resources in Regional Prisons

The lack of service provision to regional prisons was highlighted at all stages of this research. The following quotes further highlight the problems experienced by staff and prisoners.

All mentally ill prisoners are a drain on staff. We have one prisoner kept in a cage, he has been in a cage for weeks and he never gets any fresh air, he has to beg for smokes from staff when they go to feed him.

Metropolitan prisons have better access to the Psychiatrist. If we have an acute psychiatric problem with a prisoner then the usual cry from the uniform staff is 'Graylands'!. We also do not have sufficient facilities or experienced staff to manage them.

...the lack of services provided for these people is a disgrace in regional prisons. How can we provide services with one part-time psychologist and the psychiatrist for 7 hours one day a month?

Due to a lack of services at regional prisons many prisoners with severe mental health issues get sent to metropolitan prisons. This can be problematic for the prisoner as they are moved away from family support.

Regional prisons, by the nature of location, do not have ready access to the psychiatric support services of their metropolitan counterparts. This does not stop the metro institutions from transferring their labour intensive 'too hard' mentally ill prisoners to regional prisons (either as management reasons or just plain subterfuge) where they are out of sight, out of mind.

Additional Services and Facilities

The following two quotes provide further information regarding the need for additional services.

It is impossible to place resources at every prison so a dedicated mental health facility and smaller state facilities need to be established at some prisons where all mental health [cases] are transferred and fulltime staff can support them.

All country prisons are the 'poor cousins' in comparison to city prisons, however there is a need for psychological services across the board to be updated and we need more numbers at the ground level.

Cultural Issues

Again, cultural issues were highlighted by staff and in particular, the nature of regional prison populations and the effect that this has on service provision.

Many regional prisons have a high level of Indigenous prisoners whose rehabilitation relates directly to their experience of community and culture. This is an extremely complex area and staff working here need to be acknowledged as specialist staff, and be given quality opportunities for training and networking

Different prisoners. Many cultural and substance abuse issues that staff simply do not understand

They really need to employ aboriginal psychologists etc...in regional prisons

The qualitative responses presented here provide additional support for the interview findings obtained in Phase One and for the material presented in the Phase Two survey. The findings from both Phases are complementary and common themes and issues are present throughout all stages of the interview material and data gathering. These findings will now be explored in more detail in the discussion chapter below.

CHAPTER SEVEN: DISCUSSION OF THE RESEARCH FINDINGS

*We shall not cease from exploration
At the end of all our exploring
Will be to arrive where we started
And to know the place for the first time
T.S. Eliot*

Introduction

To reiterate, the research question and objectives are as follows:

Central research question: What are the experiences of staff and prisoners in Western Australia in relation to mental health/psychiatric service provision and mental illness in the prison environment?

Research objectives/aims:

1. To investigate and provide insight into the issues facing prison staff when working with prisoners who experience mental illness¹³.
2. To investigate and gain insight into the attitudes and feelings of staff in relation to current services, treatment and facilities.
3. To investigate the issues, experiences and needs of prisoners who are diagnosed with mental illness in custody in Western Australia.
4. To investigate develop an understanding of experiences in urban and regional prisons in Western Australia.

Mixed Methods Considerations:

1. To what extent do the staff and prisoner findings support each other across the qualitative and quantitative Phases? What insights can be generated, and meanings drawn-out, by merging and exploring both forms of data?

The purpose of this chapter is to discuss the findings from both phases of the research in relation to the research objectives and the themes which emerged during the research. Firstly, the third objective, relating to the prisoner patient findings is discussed, with reference to the research themes and literature. Objectives one and two are then discussed together as these relate to staff experiences. The fourth objective is discussed throughout as it relates to both the

¹³ That is, prisoners identified by the Department of Justice as having a Psychiatric Alert on TOMS.

staff and prisoner patient findings. The themes to emerge in the research highlight the experiences of prisoners in a meaningful way and give voice to this unique population. They also highlight the issues faced by staff and provide insight into staff attitudes and experiences. Urban and regional differences are explored and the Phase One and Phase Two findings are integrated to highlight the ways in which they support on another.

Prisoner Patient Findings and Interpretation

Objective:

3. To explore the issues, experiences and needs of prisoners who are diagnosed with mental illness in custody in Western Australia.
4. To develop an understanding of experiences in urban and regional prisons in Western Australia.

Mixed Methods Considerations:

1. To what extent do the staff and prisoner findings support each other across the qualitative and quantitative Phases? What insights can be generated, and meanings draw out, by merging and exploring both forms of data?

There is a dearth of research investigating the experiences of prisoners with diagnosed mental illness. Research in the social sciences has studied prisoners, offending behaviours, the incidence of attempted suicide and self-harm, and provided key statistical analysis and information. Prisoners have rarely been asked for more in-depth information about how they feel and why; and are rarely asked to participate in research about their experiences and attitudes towards prisons, prison administrators, and the services the system provides. Research of this nature seems logical; who better to tell you what they need in order to manage their illness, move out of offending and improve their lives, than the prisoners themselves? In this research, the majority of participants offered ideas about what services and environment they require. This is an important finding and calls into question much of the research literature where it is claimed that people with mental illness and prisoners, are unreliable self-reporters (Lebow 1982). In many cases participants provided significant insight about their illness. This may have been because all of the prisoner patient data was collected face-to-face with the researcher. This finding suggests that research and evaluation focused on the target group will generate new knowledge, and better inform policy, program

development, service implementation and outcomes. The exploratory approach to the current research was somewhat innovative in Australia as there is not a great deal of work that utilises this approach in the mental health literature. In some cases it was not possible to relate the findings to past research in a meaningful way. Where possible the findings are discussed in relation to previous research on prison populations, and in other instances the results from Phase One and Phase Two are discussed in relation to my interpretations and conceptualisation of the findings.

Current Service Provision and Prisoner Experiences

Prisons have become the new kind of institution for people with mental illness

Prisoners in this research supported the widely held view that mentally ill clients are over-represented in prison populations and in their view the number of prisoners who experience psychiatric illness is increasing. A comment to this effect was made by a participant in Phase One, "*prison is becoming like the new kind of institution for people with mental illness...*", and was strongly supported (83.3%, n=40, of the sample strongly agreed or agreed) by participants in Phase Two (both staff and prisoners). Prisoner patients attributed this over-representation to increases in illegal drug use, social issues and family breakdown. Both staff and prisoner participants had similar beliefs in relation to the reasons for this increase. That is, both groups attributed it in part to increases in illegal drug use. Staff were more likely to link the increase to deinstitutionalisation and offenders were more likely to point out the significance of social issues and family breakdown. These findings are consistent with those of Ogloff et al. (2007) who suggested that common reasons for over-representation include the deinstitutionalisation of the mentally ill, an increase in the use and misuse of drugs and alcohol, and the limited capacity of current community services to meet the needs of the mentally ill.

The majority of prisoner participants shared stories of their fractured lives and/or family relationships. Many participants considered these stories the norm, and perhaps they are amongst their peers. For example, one participant shared a story about an interaction between himself (aged 10 at the time) and his little brother (aged 8 at the time). He and his brother were fighting over something trivial (the participant stated that he could not remember what it was specifically but said

something like the TV remote) and he became so frustrated that he stabbed his little brother. He continued a violent pattern of offending throughout his childhood and early adult life, exacerbated by the onset of mental illness in his later teen years. When we were chatting I asked him why he had stabbed his brother rather than react in some other way that would not hurt a family member. He responded that he behaved in that manner as that is what his dad would have done in a similar situation. Prisoners talked a lot about negative social and family relationships and how these impacted on their lives, their illness and their subsequent imprisonment. They also discussed an inability to get help in the community for their illness, despite turning up at Police Stations and Public Hospitals asking for assistance (many prior to the commission of the offence). This is in keeping with much of the historical mental health literature where the significance of linkages with deinstitutionalisation, increases in the use of psychiatric medications, and a lack of adequate community care for the mentally ill, are well documented (Baldry 2006; Forshaw, cited in Soothill, Rogers and Dolan 2008). These forms of social breakdown, and limited service provision, shaped prisoners' experiences and lives in significant ways and have no doubt contributed to trans-institutionalisation.

Considering the findings here along with those of Ogloff and many others (e.g., Baldry 2006), there is a need to recognise the disadvantaged backgrounds of the individuals that compose our prison populations and work to address some of these issues in our community. Prison is the revolving door that is tasked with punitive, deterrent, protective and rehabilitative functions - functions that are counterintuitive - and many of which, would be better addressed in a community setting.

Are Prisoner Patients Undecided?

The findings show that a number of prisoners were undecided whether they were provided with adequate care and services. The high percentage of undecided responses came when prisoners were asked to rate staff groups and the quality of services. It is possible that the skew in the data is in relation to prisoners' concerns over the confidentiality of responses. Some of the questions were quite confronting for those who are dependent on the people and services they were asked to assess (for example - 'do you feel that uniform staff adequately care for you' - 37.5% (n=18), strongly agreed or agreed 29.2% (n=14) were undecided, and

33.3% (n=16) disagreed or strongly disagreed). They could not be sure that their responses would be kept safe and confidential. They had my word and the ethics approval, but that is just a piece of paper, and they had never met me until I was talking with them in the interview. They also knew that I worked for the Department. Some participants had deep seated issues with a system that they felt was out to get them and they therefore may have had suspicions and fears about repercussions from the research (real or imagined). This could have affected the way prisoners responded and may account for the high rate of undecided responses to some questions. The statements of participants help to illustrate the level of concern: *"Officers go out of their way to annoy prisoners and they seem to get a kick out of it. If you are mentally ill it is not very good as you are unsure of how to take them, sometimes they are joking around but it is not a joke to me"; "other staff members talk about me and that makes me fearful and I keep to myself"; and, "people do not understand others with mental illness and so they talk about them and laugh."* Additionally, prisoners may have had no benchmark in relation to standards of care and could not therefore rate the services as there was no point of comparison.

In the free response questions, and during the survey completion, many prisoners wrote and spoke about their anxieties in prison, other prisoners and staff. Some prisoners spoke about how this fear increased their thoughts and actions of self-harming behaviour and paranoia, and shaped the way they interacted with others. Some prisoners did not want me to write their answers on to the hard copy of the questionnaire; it was all right to talk about it in hushed tones but to have it written down was too much, or perhaps they were worried they would be identified.

Attitudes to Mental Health Services

Prisoners' experiences of mental health services varied across the prison locations. Some positive experiences were noted in Phase Two with over two thirds of the sample (70.8%, n=34) reporting having been seen by medical staff promptly when arriving in prison, and just over half (56.3%, n=27) were happy with the mental health treatment they currently received. In contrast, other prisoners expressed having minimal input into their treatment, and that additional programs, work and activities were not made available to them, despite the fact many cannot participate in more formal work (usually due to the effects of

medication). As one participant stated in Phase One, *"they need to have more activities and games, and people to talk to, so that you understand your illness and yourself better..."* The findings show prisoners have a perception that overall the system is failing people with psychiatric disorders (72.9%, n=35 strongly agreed), and that prison has become the new kind of institution for individuals living with mental illness. There is a perception amongst prisoners that prison is not there to help rehabilitate them or even provide adequate access to medical care. The research found that there were mixed results about whether prisons had adequate access to ongoing mental health care, services and treatment (31.3%, n=22 strongly agreed or agreed and 22.9%, n=11 were undecided).

Prisoners in Phase One articulated that they would like access to counselling, and in Phase Two a percentage of participants (37.5%, n=24) were undecided about the helpfulness of the PCS. This may reflect the fact that they have had limited or no access to PCS in some prisons. In addition, participants had a desire for further insight into their illness in the hope this would improve their understanding of themselves, their behaviour, their place in the world, and better equip them to manage living with a mental illness or to try and grasp some perspective on current medical meanings. Several prisoners were only responding to the diagnosis they had received - 'schizophrenia', 'major depression', 'personality disordered' - without having any real understanding of what this actually means from a psychiatric or psychological perspective. A number of prisoner patients had a genuine desire to improve their current understanding of their mental illness and work towards a more stable future; they wanted to get off the conveyor belt and stop their cycling in and out of prison but they didn't know how. It was concerning that some participants had a Western diagnostic label and were on medication, but had no real understanding beyond their own symptoms. Participants' desire to engage in self analysis could better be embraced through formal treatment but it is not clear whether prison is a suitable place to provide such treatment.

It should be noted that no major differences were found in this research according to participant ethnicity; attitudes to mental health services and perceptions of service need did not differ for Aboriginal and non-Aboriginal prisoners. That is, both groups responded that they required similar services and had similar needs. However, this is not to say that differences do not exist. In Phase One an Aboriginal prisoner stated that his mental health was a "very spiritual thing" for

him. In Phase Two 45.8% (n=22) of the sample strongly agreed or agreed with this statement but the findings were not significant according to ethnicity. This was somewhat surprising as many studies report the necessity of differentiating between the needs of Aboriginal and non-Aboriginal offenders and the requirement for services to be tailored to the needs of Aboriginal people (The Report of the Royal Commission into Aboriginal Deaths in Custody 1991; Vicary and Westerman 2004). Furthermore, research findings show that Aboriginal people are less likely to report having accessed services or treatment (Kramer, Gately and Kessell 2009), and that mental illness in Indigenous populations is often undiagnosed and untreated (HREOC 1993). This unwillingness or restricted ability to access services may extend to Aboriginal offenders being fearful of criticising the services offered in prisons or expressing their needs. The sample may also have felt uncomfortable fully expressing their perceptions and needs to a young white female interviewer. It may also be a reflection of the sample having little insight or experience of what they require to improve their health or that they have little point of comparison with other services. As these findings challenge much of the literature in the area it seems they demonstrate the need for additional research with prisoners themselves, particularly Aboriginal people given their over-representation in Western Australian prisons.

Access to Staff

Staff and prisoner patients, across both phases, expressed a perception that there are acute staffing shortages in Western Australian prisons; an issue which is particularly concerning given the rapidly rising prison musters. Correctional staff and health professionals reported feeling understaffed and under pressure, resulting in an inability to provide prisoners with adequate access to holistic treatments, and an overreliance on a community medical model (i.e., medication and 20 minute treatment times) rather than a tailored correctional model of health care serviced by suitable staff. These findings were particularly pertinent in regional areas where staffing shortages were reported to be more acute. The sentiments shared by staff were supported by the prisoners in this research. Over half of the prisoner sample were unsure or did not feel they had adequate access to psychiatrists and specialist mental health staff - this was very much the case for those in regional prisons. The shortage of access to psychiatrists noted in the current research may be isolated to, and reflect the current climate, in Australia and specifically Western Australia in terms of employing staff. Attracting

specialist staff to work in remote areas presents considerable challenges, when combined with the relatively low wages and the perceived difficulty of the clients and work conditions, in comparison to private practice.

Attitudes to Staff

There was a close to even spread of views from prisoners regarding the level of care they received from correctional staff, with some prisoners reporting they are adequately cared for by prison officers (37.5%, n=18), others who were undecided (29.2%, n=14), and another group not feeling adequately cared for (33.3%, n=16). Some prisoners were very positive and supportive of their treatment by prison officers as the quotes of two prisoners show - "*the prison staff and officers are all really nice*" and "*some of the officers are great.*" Prisoners who stated they are not adequately cared for said this was because of the personality of prison officers, because officers do not have enough training, because of a low level of awareness of mental illness, and due to bullying. Over half of the sample stated that prison officers should not be looking after them as they are not qualified medical staff. Research has shown that negative aspects of care are associated with discipline and control, and concerns with restrictions of personal liberties (Hinsby and Baker 2004). This may account for prisoner patients' feelings of inadequate care from prison officers, as 52.1% (n=22) of the sample supported the claim that prison officers 'do not care' and 'prison is about discipline and not treatment'. These findings support the view that participants associate prison officers with a disciplinarian and not a caregiver role, and prison with a punitive rather than a therapeutic philosophy.

Despite this view, and many reporting earlier that they could not confide in other people as the information does not remain confidential, the majority of prisoners (77.1%, n=37) reported that mental health staff/nurses were helpful and understanding, and 54.2% (n=26) of the sample responded that staff listen to them and they have people they can talk to. Prisoners' attitudes towards health professionals were positive in comparison to attitudes towards corrections staff. This may be understandable given that prison officers spend a considerable amount of time with prisoners and are responsible for regulating behaviour, strip search's, urine tests and other behaviour management tasks in the units. The nursing staff have less day to day contact with prisoners and when they do meet

these interactions are to offer medical help, advice and services and are usually one-on-one visits.

These findings lend support to the research literature. Specifically, that the formation of positive and therapeutic relationships between staff and patients correlates with improved attitudes to the services received (Byrt and Reece 1999), and that relationships in forensic and prison mental health settings can be characterised as supportive, understanding and helpful (Caplan 1993). However, it should be noted that much of the literature does not support Caplan's findings (Skelly 1994a, 1994b; Visher, Naser, Baer and Jannetta 2005) in that generally prisoners have mixed responses in relation to their attitudes to treatment.

The findings here suggest prisoners' overall experiences with health staff and the prison counselling service are perceived in a positive and therapeutic light and are described as helpful and understanding. However, both prisoners and staff discussed the need for additional access to a multi-disciplinary team of staff for ongoing treatment, and staff would like increased treatment times to meet with patients. These findings show that even though neither party has enough access to what they say they require, when services are provided, over half of the prisoners in this sample were satisfied with the interaction with staff.

Mixed Attitudes to Staff and Services - Normalising of Prison Life?

The findings demonstrate prisoners had mixed perceptions about prison mental health services. This indecision may be for the reasons outlined earlier in the discussion, that is, anxiety regarding confidentiality, however prisoners were more forthcoming on the subject of their attitudes towards health staff. As stated earlier, it is possible that the prisoner sample had no point of reference to measure the current services against. If they have been in prison for a considerable period they could have come to accept the situation; they may have been diagnosed in prison and never had any treatment in relation to their illness outside the current service; they may not have had contact with services in the community; or, they may simply not have ever been asked their opinions on these matters. Under these circumstances it would not be surprising if prisoners were unsure as they have no benchmark or standard for comparison. Bourdieu (1977) explains this as 'habitus' - we are limited to and by what we know. These

prisoners may not have had a wide range of experiences, or they may be socialised to the prison experience, and so therefore cannot imagine anything different.

According to Bourdieu the habitus is a system of dispositions that are acquired and are then lasting schemes of perception, thought and action. The individual is exposed to situations and objective encounters that foster these dispositions. This thinking is somewhat in line with the concept of socialisation. The findings of the current research both support and extend Bourdieu's ideas. The prisoner patients in the sample have spent considerable periods incarcerated in prison, institutionalised in mental health facilities, or cycling between the two and the community. Therefore, the habitus of the participants, their experiences, perceptions and thoughts, are shaped by the objective environments they have encountered; they are socialised by institutionalisation. Due to this cycling in and out of prison, or because of spending large blocks of time in prison or other psychiatric facilities, an institutionalised way of life has become their norm.

The findings of this research extend Bourdieu's ideas by showing that new contexts are created as individuals normalise environments that should be temporary (or none existent). These environments, prisons today and in the past psychiatric facilities, become a way of life. This normalising of the prison experience as a way of life has created a new context for persons with mental health disorders; a context in which the objective social structure of the prison becomes the subjective mental experience of the individual (or agent). This objective social field places requirements on the individual, the prison code, rules and values (Goulding 2007; 1999; Toch and Adams 1989), and the agent or individual learns to operate within the environment (Bourdieu 1972). The institution almost becomes the identity. This is in keeping with the idea of trans-institutionalisation; we have seen the mentally ill moved from psychiatric hospitals to prisons. Moreover, it is connected to the idea that prisons (total institutions) remove the stigmatised (the mentally ill) from society and contribute to the "mortification of self" (Goffman 1961) resulting in an individual further normalising their environment.

The Prison Experience and Mortification

The findings across both phases show that prisoners had varying experiences and levels of insight into their mental illness, the prison environment, and psychiatric

hospitalisation. Some prisoners were accepting of their situation and their experience of mental health treatment was generally positive; that is, they were accepting, open, aware and optimistic about their illness, their life in prison, their offending history and behaviour, and their prospects for the future. They were accepting of their life in prison and experienced it as an inclusionary place. This may be because they find life in prison less challenging than other prisoners in the sample for a variety of reasons; they may be housed in a different unit or prison, have stronger support networks, have better coping skills, have positive relationships with prison officers, staff and other prisoners, or be stable on their medication. It could also be that they are comfortable in prison, have what they think they need, and therefore do not have a desire for something more or different.

Other prisoners in the sample commented negatively regarding the prison system and their treatment and reported that they want (desperately) to be housed in a special mental health or psychiatric facility. It is interesting to note that these prisoners tended to appear physically and emotionally 'fragile' and less able to cope and had also spent time in psychiatric facilities in the past. Prison is experienced as a barbarous place for these individuals. Negative experiences can be attributed to any number of personal, situational, and environmental factors, including individual coping mechanisms, length of sentence, support networks, prison location, diagnosis, and current access to their desired mental health treatment. The way an individual interprets and experiences his/her environment is very personal and individualised, and is related to a number of interacting factors, which in the prison context are often not within the prisoner patient's control.

According to Goffman (1961) prisons contribute to the 'mortification of self', that is, the stripping away of one's identity in order for it to be replaced with the institution's values. The self is redefined according to the current environment, as the stable identifiers one associated with and that provided meaning and a framework in the past, are removed. Prison life is often experienced as a series of high stress situations that "undermine self respect and foster apathy and dependence. [Institutions] encourage pliability, but they do so by making the sick sicker and the helpless more helpless" (Toch, 1977). These vulnerable prisoners

shared their experiences of fear and disbelief that they feel so unwell, but are forced to live in situations that make them increasingly desperate and afraid.

Goffman's theory fails to fully explain the findings as not all prisoners experienced the prison environment in the same negative way. That begs the question - do all prisoners experience a mortification of self as Goffman claims? As stated above, some prisoners were more positive about staying in prison to receive treatment. Have these prisoners avoided Goffman's mortification process as it appears that they experience prison as an inclusionary place. It could be that they have better coping skills and are therefore able to negotiate the prison code. Alternatively, perhaps it is these prisoners who have experienced a true mortification of the self; they have had their identity stripped over time due to incarceration, have normalised the prison experience, and are therefore satisfied to stay in prison and receive treatment. These prisoners do not want to be transferred elsewhere but at the same time do not experience prison as a negative context. Is it possible to experience a stripping of the self, to be institutionalised, but to experience prison positively? This is a difficult question to answer as the findings can be interpreted in a number of different ways. The findings do lend support to Toch's idea that prisons make the helpless more helpless; if individuals experience prison in a positive way it is because they identify and feel somewhat safe and comfortable in the environment. Whether the sample were happy to stay in prison or wanted to be transferred to a psychiatric unit what the findings show is that a large percentage of the sample are locked into a cycle of serial institutionalisation. It is likely that prisoner patients have become dependent on prison living skills; this experience will actively erode an individual's ability to live independently in the community (Baldry 2006).

In Phase Two the majority of participants responded they have good days and bad days (95.8% of the sample, n=46), and 72.9% (n=35) strongly agreed or agreed that they find it hard living in prison with a mental illness. Additionally, 70.8% (n=34) of the sample reported they find prison to be a very negative and difficult environment to live in. So, even if some prisoners were positive about their treatment and relatively accepting of prison life it is not because they were 'happy' as the findings show that the environment is a negative one for the majority. As stated above, it is likely that prison is a sanctuary for some

participants, a place they identify with as they have spent so much time institutionalised.

Overall, the results indicate that individuals react differently psychologically to imprisonment. While some find the experience extremely stressful, at the other extreme, those who are dependent and passive may find that the prison structure offers them a positive experience or as one participant stated 'a helping hand'.

These are significant findings and represent real issues for both groups. It is particularly concerning given that many mentally ill prisoners are over-represented in self-harming and other potentially destructive behaviours. It must be unfathomably difficult to be battling an illness of the mind and be housed in a place with such high volatility, violence and distrust. It also represents real issues for the release of many of these prisoners who so readily identify with life in prison and psychiatric facilities. Living in the community for any length of time will be difficult and perhaps this is a key contributing factor to the conveyor belt of incarceration for the mentally ill.

Loneliness

The Phase Two results show that half of the prisoner sample felt isolated and alone and that they could not confide in anyone in prison. These findings are supportive of the research literature discussed where, as stated above, it has been found that prisons and asylums contribute to the 'mortification of self' which increases feelings of isolation and loneliness (Goffman 1961 and 1969; Goldsmith 1997; Goulding 2007). The literature has found that prisoners find the moral codes, rules and structure of prison life difficult to cope with (Gukkespie 2003; Kupers, 1999). This was evident in the current research where prisoners reported difficulty coping with their lives in prison. To me their struggle was tangible and thick in the air during the interviews. I could hear the emotion in participants' voices and also in some of their jumbled and disjointed thought processes as they endeavoured to paint me a picture of their existence. It was evident why some of these prisoners were unable to cope, as the findings strongly suggest that prison is the last place you would want to be if you were evidently weak and vulnerable. The findings suggest that the mentally ill do not really 'belong' anywhere. Some are complacent to stay in prison and appear to be able to cope as it is all that they know, however many of these participants still report that prison is very

negative; others experience prison as a place of high stress and want to be transferred to a psychiatric facility; others really are stable on medication and able to cope (as best one can in prison); and others are undecided. It would be interesting to speak with these prisoners after release to determine how they feel living in the community. I wonder how many would want to return to prison or would prefer the security of a psychiatric facility?

Prison Regulations and Staff to Prisoner Bullying

Conversations with prison staff pointed to the fact that mentally ill clients are over-represented in rule infractions, creating difficulties for prison administrators when managing these prisoners and issues for prisoners' as they are then over-represented in segregation units (punishment cells). This finding strongly supports the research literature where it is commonly found that those with mental illness earn themselves problematic reputations and that mental illness increases the likelihood of rule infractions, disciplinary action, and segregation (Edgar and Rickford 2009; Kupers 2008; Morgan, Edwards, and Faulkner 1993; Toch 2008, Toch and Kupers 2007). This segregation is often associated with negative consequences and is counter productive for prisoners who are mentally ill (Carothers 2003; Fellner 2006). Lovell (2008) claims that there is a need to "establish greater flexibility in prison classification and disciplinary procedures" (985).

Both the staff and prisoner participant groups revealed that prisoners who are diagnosed with mental illness are often vulnerable and isolated making them likely targets for disciplinary action and bullying. Some of these prisoners then 'misbehave' because they do not understand the significance of prison regulations; have little comprehension of the prison 'code'; want to come off their medication; are acutely unwell and locked in a cell; are brutalised and would rather be in a punishment cell to get away from their aggressor/s; and so on. Staff stated that the prisoner then creates a drama (both intentionally and unintentionally depending on the circumstances) in order to be moved from the unit. Staff outlined that in some instances this may be as an act of self-protection.

This vulnerability and isolation was confirmed by the fact that prisoners shared their stories of being harassed and bullied, or at the least, treated differently (in a negative way) by prison staff and other inmates. Prisoners shared awareness

that this treatment occurs due to their mental illness and this motivates them to further isolate themselves from prison life and their current reality (not a great position when someone is unwell and already disengaged from reality). These participants essentially turn inwards, distance themselves and in some cases experience elaborate visions/worlds/thoughts as a way of escape. This removal from reality is a symptom of some disorders, however, it appeared to be exacerbated when victimisation was reported. As one prisoner stated in Phase One - *"The officers sort of make fun of you, they are real rude. You go and ask them something and they just say go away to you and then you would hear them say stuff under their breath about you like you are nuts or something, calling you nutter and names, it was the worst."* This prisoner went on to say that one coping mechanism was to either annoy prison officers until he got what he wanted or to avoid them and forget his needs.

These findings were somewhat supported in Phase Two where 33.3% (n=16) of the participants strongly agreed or agreed that they are treated differently (in a negative sense) by prison officers, and 20.8% (n=10) were undecided. However, it should be noted that 45.8% (n=22) of the sample disagreed or strongly disagreed that they are stigmatised. Although a large percentage were undecided or disagreed, in survey a further 52.1% (n=25) strongly agreed or agreed with the statement - 'prison officers don't care and prison is about discipline not treatment'.

These findings suggest a mismatch between the needs of prisoners and the role of prison officers. Moreover, they point to the fact that some prison officers are unable or unwilling to work with the mentally ill, do not understand their needs, and therefore turn to victimisation. These findings support the research literature where prisoners are often reported to be labelled and victimised in prison environments (Kupers 1999). Butler, Allnut and Yang (2007) argue that mentally ill prisoners are vulnerable in prison populations. This was reflected in their research where prisoners reported "increased fears for their safety." In the case of the current research the participant results were also supported by my own experience. When I was undertaking data collection in the Units some prison officers would call prisoners up for the interviews saying to another officer *"can you go and get that crazy"* or in front of the prisoner they would say something like *"hey, this young lady would like to chat with you about your bizarre/loopy"*

behaviour." Prison officers openly referred to prisoners as 'loopy', 'nuff nuffs', or 'crazies/crazy'.

These were difficult situations to manage. Nursing staff confirmed that they struggle with this regularly from a number of staff members. Name calling was used in an everyday way, incorporated into the vernacular of some prison officers as a joke or a way of coping with the stress of the job. It often did not appear to have a nasty or malicious basis but regardless of the tone it has the effect of upsetting prisoners and creating an environment that ridicules the mentally ill. Some prisoners appeared not to notice and others joined in the joke as a coping mechanism, but there was evidence that they were crushed and embarrassed (from their body language, facial expression, energy shift and some told me during the interview) by the name-calling and did not know how to respond or react, particularly in front of a female stranger who was about to interview them. Prisoners were defenceless in these situations and in this context due to the power imbalances between prisoners and prison officers.

This power imbalance can be very influential as was dramatically illustrated by Zimbardo's 1971 Stanford Prison Experiment. The findings of this experiment show just how quickly roles can shape behaviour. The guards imposed arbitrary and degrading punishments whereas the prisoners became accustomed to their impersonal status and endured escalating humiliations from the guards. For their part, the prisoners exhibited pathological and withdrawn behaviour. The guards were quick to dispel any rebellion or solidarity exhibited by the prisoners. Zimbardo's experiment lends support for Goffman's ideas discussed above - of the stripping of identity in total institutions. Further, it highlights how quickly individuals 'become' the roles that they believe are expected and assigned to them. There appears to be an almost unspoken culture, or cultures (a staff culture and a prisoner culture), in prisons based on these power associations. I did not witness one of the prisoners talk back to the prison officers or ask the officers not to call them names. Moreover, I did not witness any other staff member tell an officer they were out of line; everyone was in on the joke, and if another staff member was uncomfortable that was not apparent to me. These prison cultures will be very hard to dispel. The findings lend support to the idea that under the current philosophy prisons cannot act as a therapeutic community as the purposes of a prison are antithetical and prison's primary focus is security not therapy.

Prisoner to Prisoner Bullying

In addition to staff bullying prisoners, the findings also highlight that bullying occurs prisoner to prisoner. These findings were consistent across both phases of the research. A quote from Phase One emphasises this view -

Many of the prisoners are vulnerable and are easily taken advantage of [by other prisoners], especially the guys with mental illness. They give their stuff away and people take their smokes and use them to do things...errands in the prison, that kind of thing...if we had reliable sexual assault statistics they [the mentally ill] would be over-represented...in my experience...

In Phase Two, 56.3% (n=27) of the sample strongly agreed or agreed that they are treated in a different (negative or ambivalent) manner by other prisoners and 83.3% (n=40) strongly agreed or agreed that prisoners with mental health problems are a vulnerable population. Participants frequently reported being harassed by other inmates. This is not surprising given there is a culture between prisoners that is based on intimidation, paranoia and violence; there is a pecking order and generally the young and weak are those at the bottom of this chain of survival. The findings here are consistent with the research literature where it has been stated that "everyone is afraid. It is not an emotional or psychological fear. It is a practical matter. If you don't threaten someone at the very least, someone will threaten you...Many times you have to 'prey' on someone, or you will be 'preyed' on yourself" (Tosh, 1982, 86). Moreover, the literature shows that prisoners with mental illness are often taunted for cigarettes, are over-represented in sexual assault statistics and are generally taken advantage of by other prisoners (Hodgins and Cote 1991).

One finding that stood out across both phases was that prisoners in the sample reported being scapegoated and chastised by other prisoners for taking medication. This finding first emerged in Phase One with many inmates discussing being put under pressure by other prisoners, including prisoners they call their friends, who are of the view that the prisoner should not be taking medication. These 'friends' actively encouraged the participants to '*be a man*' and stop taking the medication as '*it's [the illness] all in your head*'. This is an interesting finding and not one discussed elsewhere in the literature.

Prisoners' taunting one another about medication is directly related to a number of issues. The first relates to levels of awareness, support and education about men's health and the need for all prisoners to be educated about mental illness, and the important role that medication plays in the lives of many mentally ill individuals. Previous research has found that it is imperative that prisoners feel supported about their treatment or at least are not encouraged to stop medication. This is especially the case for disorders such as schizophrenia where stopping treatment could have very serious consequences for the individual, for prison administrators, and for the rest of the population. Prisoners should be able to make decisions regarding their medication without significant peer pressure from friends or other prisoners. The second is that this finding may be related to drug taking behaviours and attitudes towards drugs in prisons. Other prisoners could be jealous that a prisoner has medication, receives medical attention, and it is a way for prisoners to manipulate vulnerable inmates and the system for some other personal gain. The third is medication bullying or standover tactics by other prisoners to take mentally ill individuals' medication. It was interesting that participants did not discuss being 'stood over' although it is anecdotally known that this happens frequently in Western Australian prisons. Prescribing regimes are relatively strict, especially in relation to pharmacotherapies for drug addiction. However, the prescribing and trafficking of medication in prisons warrants further consideration and research, as does the dosing of the mentally ill in comparison to community samples.

These kinds of bullying behaviours further isolate already vulnerable prisoners and may contribute to them acting up and becoming persistent management problems in order to be moved to another area away from perpetrators. It is important that bullying and violence are minimised and managed as much as is possible in prison environments. If I heard a number of staff referring to prisoners in a particular way during the course of the interviews then other staff and management must be aware that this language is used. The vernacular and actions of correctional staff needs to be appropriately managed by peers and senior staff. The discourse of prisoners is probably more difficult to police.

Protection units, crisis care and prison mentoring goes some way to recognise and minimise the effects of bullying. The current research highlighted the importance of the prison peer support program for some participants, with 47.9% (n=23) of the

sample strongly agreeing or agreeing that it is helpful. The improvement of training practices for prison officers and information sharing with prisoners will help to improve this further; however it needs to be recognised that this will never completely change as mental illness is still stigmatised in the wider community. Separate facilities for the mentally ill, with specifically trained medical staff and prison officers, would further reduce the impact of victimisation on the psychiatrically ill, particularly those who are most at risk. However, society at large and prisons as a subculture need to be careful as there is a fine line to be walked here. On the one hand it is important for mentally ill people to feel safe and for those most at risk to be housed in appropriate facilities. However, it is also important not to hark back or support the segregationist policies that were one of the major arguments for closing psychiatric hospitals down in the first place (Foucault 1967; Szasz 1961, 1963, 1970, 1973). These policies isolated and segregated the mentally ill with people like Foucault and Szasz voicing the inappropriateness of locking or hiding 'the mad' away from the rest of the 'sane' community, stripping individuals of their autonomy and ignoring their basic human rights. It could be said that we live in a culture of blatant self interest where it is easy for many to turn a blind eye; locking people up against their will is easy when you don't have to face the issues. It is important to take a measured but proactive approach to addressing these issues and to respect the wishes, rights and needs of minority groups in our communities. As stated above, these findings suggest that prison cannot act as a care institution as it is philosophically opposed to its main function of punishment. However, the findings suggest prisoners have positive attitudes to some staff, particularly health staff. A culture shift amongst prison officers through strong leadership, training and education could see multi-disciplinary teams that correctional staff are a part of work to provide mental health care. This needs to be balanced against the other known detrimental effects of incarceration. Moreover, this culture shift will take time and strong leadership.

Confidentiality

The findings pertaining to confidentiality and privacy of health records support the conclusions of Skelly (1994) with prisoners wanting increased access to information about mental illness and a desire for their personal medical information to be private. The need for confidentiality of medical information was discussed by a number of participants with some prisoners feeling further isolated

due to worries about sharing what they perceive to be private medical information and conversations. This was highlighted by one participant in Phase One who commented that you cannot "*confide in people here, officers, health staff or prisoners as they share the information with other people which is difficult.*" Half of the participants in Phase Two shared this participant's concern. A related issue was discussed by another prisoner in Phase One who stated - "*...they use your personal medical information against you.*"

In Phase Two the majority of the sample (83.3%, n=40) strongly agreed or agreed that health information should remain private and only be accessible to medical staff. As it stands, medical records are only privy to health professionals, with some general information, such as a psychiatric or medical alert, available to other prison staff on the TOMS System. Despite the security of file records, concerns were still raised about the privacy of conversations and information between staff and prisoners. Some participants commented they do not think their medical information remains as confidential as they would expect.

Correctional staff articulated issues with reference to their limited ability to access information. It is interesting that staff reported wanting access to information in order to improve service provision, but prisoners felt that access to private records would very possibly result in this information being used against them. The findings from the staff sample support prisoners' concerns as does the literature review. Mullen's (2001) research in Australia looked at the relationship between mental disorders and offending behaviours and the management of mentally abnormal offenders in the health and criminal justice services. The findings support the current staff and prisoner concerns in that personal information is often used in inappropriate ways and as ammunition for increased bullying. Again, this relates to the notion of power as discussed above.

Prison Control, Medication and Segregation

According to Visher et al. (2005) prisoners in their sample felt that if they complained about their medication or treatment they ran the risk of being sent to solitary confinement. This finding was supported across both phases of this research. Moreover, prisoners in the sample expressed having little input into their treatment and felt that medication was their main/only option for treatment in prison. A number of prisoners shared their concerns that if they expressed

opinions in relation to their treatment they ran the risk of being 'sent down the back' (i.e., punishment in the form of solitary confinement). Prisoners in the sample believe vehemently that prisons should not use disciplinary action to force inmates to take their medication or comply with prison regulations. This is a common finding in an environment limited by "space, time and/or money" (Parker 2006). Drugs are often the first treatment modality and may also be used as a behavioural control device with some prisoners. This research supports these findings and suggests that pharmaceuticals are used widely in prisons, they are the main treatment available to prisoners with mental illness, and many prisoners feel 'punished' if they suggest a reduction in, or desire to stop taking, their medication.

At present, compulsory powers of mental health legislation to compel prisoners to accept drug treatment in prisons is outlawed in Western Australia. If this form of treatment is viewed to be necessary by medical staff, and the prisoner is refusing, they can be transferred to the Frankland Unit (a secure forensic unit in a State psychiatric facility). However, with the realities of bed shortages at this facility, disciplinary action in prison to compel prisoners to take medication is likely, is supported by the research literature, and was discussed by a number of staff and prisoner participants in this research.

During the Phase One interviews prisoners discussed the problems they experienced regarding disciplinary action for failing to comply with the medication and treatment prison services stated they needed. Some prisoners were compliant with taking medication at first but then felt it was not working for them, or they wanted to assert their right to stop the treatment, but were then punished for doing so. They felt victimised and fearful when they stated they did not want to take the medication again. Participants discussed being moved 'down the back' and other punishments ('making life difficult') for what are perceived by the system as non-compliant behaviours. A poignant example was shared by one prisoner -

Yeah, I had my injection and the pills and I got into a paranoid state and I could not breathe. They restrained me and stripped all of my clothes off and put me in the IOU [intensive observation unit]. It was terrible! They strip all of your clothes off and cut your jocks off because you won't let them take

them off, it is terrible to be man handled like that when you are paranoid and freaking out anyway. I was having a panic attack, and they put me in observation and you have to wear a special gown. This was at Canning Vale [now Hakea Prison] - it was terrible. They have real strict rules there and they don't seem to understand that you are unwell, it is like you are getting raped...

There is no doubt that medication is a tricky issue. If people are not stable on medication in the community and know that it works for them, the process of working out the right combination of medications and the dose that has a positive effect is a difficult task; it is pretty much trial and error, as what works for one person with schizophrenia will not necessarily work in the same way for another. People can also have unpredictable reactions and debilitating side-effects to medications. It is reasonable that prison administration has to deal with this in some way, to keep people safe, and under observation. However, it is a particularly scary experience for prisoners who are in a challenging environment, are unwell and unstable, and are then seemingly punished in an effort to keep them safe. The needs of the prison and of the individual are in direct conflict under these circumstances (as are the roles of the prison - again, treatment versus security). An incident like the one described above would be further complicated if access to the psychiatrist is limited and the local doctor (who may have restricted mental health experience) is relied on for judgment regarding ongoing treatment. Placement in an institution solely designed to manage these types of occurrences may be more ethical and sensible when symptoms are acute.

Treatment and medication also raise other issues for prison administrators and prisoners. On the one hand prisoners should have the right to make a choice about treatment options and to choose if they wish to take medication and deal with the side effects, as they would have that choice in the community. On the other hand prison management has an institution to run and they need to keep all prisoners' interests and their own in mind (i.e., staff safety) and somehow balanced. It is the responsibility of the prison system to keep people safe. It may be the strong recommendation of the psychiatrist and other medical staff that the prisoner needs medication. Moreover, it was reported during conversations with staff that many mentally ill clients in the community, and in prisons, are compliant with medication whilst they are acutely unwell but when they start to feel better they

go off it as they believe they no longer need it (they feel there is nothing wrong with them as many of their symptoms have disappeared). They then spiral down and become very unwell, creating problems for themselves, their families, services in the community, and for staff in prisons who then have to manage the person who is unpredictable and potentially violent towards others and themselves. Prisons will try to transfer the prisoner to the Frankland Unit where they can involuntarily be put back on medication and restabilised before returning to prison. The way staff discussed this routine (on medication, off medication, on medication etc...), particularly nursing staff, was like predictable clockwork; they had seen the same thing happen with an immeasurable number of individuals both in prisons and with community patients.

This is a very difficult issue that, as discussed above, has a number of ethical and moral implications and consequences attached to it. The use of segregation cells is often employed by prison administrators as it is deemed to protect staff and other inmates from dangerous behaviours, removes the inmate and prevents situations from escalating, and protects the disruptive inmate from further victimisation (i.e., self harm). However, the use of segregation is often associated with negative consequences (Carothers 2003), and is seen as punishment; this was particularly the case for the mentally ill prisoners who took part in this research. They viewed segregation as punishment for exercising their right to not take medication, for displaying behaviours they were then unable to control, or for taking 'the rap' for someone else.

There is a very fine line between punishment and treatment with regard to isolation. A report by Human Rights Watch (2003) supports the view that segregation exacerbates the symptoms of mental illness and increases the risk of suicide for all inmates, but more so for the mentally ill. Fellner (2006) noted that "punishment is particularly counter-productive indeed dangerous to the prisoner when it consists of placing mentally ill prisoners in prolonged segregation" (401). These findings are concerning given the over-representation of prisoner patients in rule infractions and segregation units due to their inability to conform to the prison 'code'.

This issue will not be solved here as it very much depends on a huge range of factors and individual perspectives. For example, factors relating to the individual

facts of the case; the prisoner's motivations for coming off the medication; the form of punishment; risk of self harm and suicide; the severity of the illness and behaviours (is it justified to force medication if someone wants to take their own life, for example); the individual's psychiatric history and the side-effects of the medication; and the services available to treat prisoners beyond medication. It should be remembered that most of these prisoners are in prison populations because they did not satisfy an insanity defence. That is, it was determined they had capacity to understand their actions and make choices about their behaviour and its consequences. I would argue that in the absence of legislation to compel prisoners to take medication is it an abuse of their human rights to punish them for exerting their right to choose their treatment. If it is deemed by a psychiatrist that they are not competent to make this choice then they should not be in prison but in a facility designed to manage their treatment needs.

Prisons need to make decisions based on the collective good rather than necessarily the best interests of the individual and may therefore not be best placed to manage, treat and care for individuals with mental illness. However, this is not to say the findings here support moving all mental health clients from prisons to psychiatric facilities to involuntarily medicate them. What this thesis demonstrates is a need to provide responsive services that manage people in an individualised way; services that inform clients about their illness and work with them to make the best choice when all angles (i.e., periods of wellness and period of crisis) are considered and understood. This will take a multi-disciplinary team of professionals who can work to provide treatment but also maintain security.

Regional Prisons

In regard to regional and metropolitan experiences the findings show that on average prisoners at metropolitan prisons reported less satisfaction with service provision and prison life generally than participants at regional prisons. Metropolitan participants supported statements such as *"I do not feel that I have adequate access to care, services and treatment"*, *"you cannot confide in people here, officers, health staff or prisoners as they share the information with other people"* and *"I don't think prison officers should be looking after us as they are not qualified medical staff"* more strongly than regional participants who were undecided with a tendency to lean towards disagreeing with statements of this nature. Upon further analysis of the Phase Two data (prison location by location)

it was found that prisoners at Albany Regional Prison are generally happier with service provision and their environment than at any other prison

The findings here are interesting for a number of reasons and seem to support that prisoner patients are more cautious and distrustful of service provision at the larger metropolitan prisons in the sample. There was a definite difference in atmosphere across the prison sites. This finding could be attributed to smaller prison populations in regional prisons (less overcrowding); that staff are more integrated and more likely to work as a team in regional areas (from the experiences of participants this is particularly the case with prison officers); a better management team or superintendent that operates with a unique philosophy and good leadership skills; the environmental design; that the smaller population means prisoners have access to a greater number of activities and more time outside their cell; and the environment is more responsive in regional centres. Maybe it has something to do with the fresh country air and relaxed regional mentality. It could also reflect differences in the demographics of the populations, with less 'difficult' or acutely unwell prisoners in the regions, and therefore a less stressed and emotionally charged environment at some of these regional locations. However, this finding was only for Albany Regional Prison. I could not isolate any one factor at Albany that contributed to these findings and it is likely to be a combination of the above. The staff interviewed at Albany appeared to be less 'stressed' and negative than those at other prisons. Perhaps healthy staff relationships and general job and life satisfaction translate into a calmer prison population.

Particularly interesting was that even though regional prisons had fewer resources, less access to staff, particularly highly qualified staff, and staff who have received minimal training in mental health, prisoners report positive experiences. The inverse was found for the larger metropolitan prisons where there is better access to resources, more treatment options and availability of professional staff. Despite this prisoners report less positive experiences. This may be due to larger and more difficult prison populations and therefore higher case loads. Higher case loads could result in staff only having the ability to crisis manage prisoners resulting in less personalised and therapeutic relationships being formed between staff and prisoners. Differences in prison 'mood' are commonly reported in the research literature - "some prisons seem quiet and reserved,

others seem noisy and active, whereas others seem safe and predictable. Within prisons, environments also vary from cell block to cell block, or from one program or work setting to another" (Adams and Ferrandino 2008, 920).

According to Toch (1992) it is possible for prisoners to find niches in the prison environment that may best suit their needs and where they are likely to function better. These positive niches will reduce stress or other detrimental experiences. Research has shown that there are distinct environmental triggers, such as heat, overcrowding, direct insults, and increased frustration, which will exacerbate aggression and violence (Ax et al 2007). Careful matching and housing of prisoners with mental illness will likely result in a reduced incidence of violence and general disruption. If prisoners are housed with prison officers or other prisoners who are name callers they will be more likely to lash out. It is clear from the findings that many mentally ill prisoners in the larger metropolitan prisons need to be insulated from certain aspects of the negative environment. This is pertinent given the findings that mentally ill prisoner patients are over-represented in rule infractions and have greater difficulties integrating with other prisoners (Carr et al 2006). Lovell et al (2001) found the following features, as rated by prisoners, to be the most positive in terms of reducing the incidence of psychiatric symptoms "architecture, freedom of movement, protection from the stressors of the general population and availability of activities" (484). Prisoners in this research reported the need to be able to 'walk around in open spaces'.

This research shows that environment plays a crucial role in the functioning and wellbeing of prisoners. It is evident from the findings that not all prison environments are the same and there was a marked difference between Albany Regional Prison and the other prisons in this research. Further research would need to be undertaken across a wider range of prisons in the State and using a larger sample to explore these findings and to ascertain why, despite limited access to services, prisoners are happier, particularly at Albany Regional Prison.

Education and Training

Understanding through Knowledge

The findings from both phases illustrate how strongly prisoners felt about the level of education and training their caregivers receive. This was the case across all prisons in the sample. A participant in Phase One commented that "*the officers*

have no idea of what mental health is and are not properly trained to help us." In Phase Two 83.3% (n=40) of participants responded that prison staff require additional training in mental illness and psychiatric illness, 100% (n=48) of the sample responded that training in mental health/illness is vitally important, and 97.9% (n=47) agreed that ARMS, risk prevention and suicide training were very important. Furthermore, over half of the sample agreed that only qualified medical staff should be working with mentally ill prisoners, that staff need to be well trained to care for prisoners who are mentally ill, and over half have the perception that prison officers have a limited understanding of mental health/illness and are not properly trained to work with those who experience mental illness. Moreover, 97.9% (n=47) of the prisoner sample responded that officers who work in the Crisis Care Units should receive specialist mental health training. It is noteworthy that the prisoner and staff findings in relation to this theme strongly support each other.

These findings were somewhat unexpected. I had not anticipated that prisoners would take such an active and responsive position on the role of staff within the prison. The findings suggest that prisoners take a strong interest in their treatment and feel that by increasing the knowledge and awareness of staff they in turn may receive improved services. The desire to be understood, or more importantly, not misunderstood and victimised, was very important to participants. The findings also stress the reliability of adopting a self-report approach to research with mentally ill prisoners. It was suggested to me more than once, and by the research literature, that mentally ill prisoners are an unreliable and often inconsistent source of information. The findings here suggest the opposite in that prisoners take an active interest in topics that affect them and they can eloquently express their views.

This research also found some interesting results in relation to prisoners' attitudes about their own and other prisoners' education. Participants felt that the general prison population did not understand mental illness and that this contributed to feelings of isolation and harassment in the prison. 89.6% of the sample supported the view that prisoners have no idea about mental illness and that it would be good for people to have an increased understanding. Prisoners articulated a need for more information, in the form of pamphlets, to be made available on mental health and psychiatric illness. They stated that pamphlets would provide

information that could be taken away and read in the prisoners own time. The prisoner could then approach a nurse or other staff member confidentially if they had questions. A staggering 97.9% (n=47) of participants responded that mental health education is important, and 95.8% (n=46) agreed that prisoners need to be educated about their own mental health in order to be able to ask for help and to understand the behaviours of others (and their own behaviour). Prisoners agreed with the staff findings and would like programs specifically designed to cater for their needs. It is important that any programs and education consider the needs of Aboriginal people particularly in regional areas where prison populations can be over 80% Aboriginal.

There were a number of questions relating to education and training in the questionnaires, worded both positively and negatively, and in different ways. Regardless, participants responded overwhelmingly that there was a need for improved knowledge about mental health. These findings are important, particularly in the current prison climate where it was anecdotally recorded that funding to programs and education is being reduced. Drug and Alcohol, and Sex Offender programs are being reduced and staff numbers are struggling to provide education and programs to prisoners. This will be exacerbated by increasing prison musters.

Limited programs and education will have implications for mentally ill clients who have poorer outcomes in punitive and non therapeutic environments. It is also important given the debate on voluntary/involuntary medication. If prisoners are better informed about their illness they may be in a position to make enhanced choices regarding their treatment. The opportunity to be involved, considered, and to feel in command of their treatment, some aspect of the illness and its management, will help them to feel more in control of their illness and their lives. These findings are somewhat supported by the research literature where it has been found that nursing staff have a strong desire to undertake health promotion and education with prisoners in order to improve prisoners understanding of illnesses, mental illness and disease prevention (Flanagan and Flanagan 2001).

Training and professional development for staff and prisoners is imperative and creative ways to provide training need to be explored by those that work in social service contexts. Training needs to address health in the prison generally, and

mental health specifically, and make information accessible to prisoners. This is even more imperative with men who are often less likely than women to seek out and access health services.

Balancing Prisoner Education Needs with Management Outcomes

A factor to consider when providing information to prisoners is the need to weigh the benefits and consequences of offering this information. The findings here show that it is important for prisoners to have access to information about their illness and treatment, and to raise awareness amongst other prisoners so that they are better placed to help and understand their peers/people they live with. Perhaps this will result in reduced fear and misunderstanding of the mentally ill, and therefore reductions in the rate of bullying of those with mental health problems. However, it also needs to be acknowledged that prisoners can be creative and the information may be used to mimic symptoms and disorders in order to create an advantage, receive special treatment and to access medications. Any information or pamphlets designed for prisoners would need to consider these factors and weigh the advantages and disadvantages.

One of the most salient points from these findings is that prisoners take an active interest in their illness and in the competence of the staff that are looking after them. Prisoners are interested in self analysis and in improving their insight into themselves and their illness. These findings appear to challenge the ideas of Goffman and Bourdieu discussed earlier; the mortification of self and of the normalising of prison life. If prisoners are completely stripped of their identity, and if prison life and values have become the norm, this would lead one to assume that prisoners would not have such a strong interest in self analysis and in their caregivers' education. These strong views point to the maintaining of self-image and opinions beyond prison values. However, perhaps these views are simply self-preservation of a kind. Goffman does claim that in institutionalised settings an individual maintains an 'underlife'; the reserving of something of oneself from the clutch of an institution that is not an incidental mechanism of defence but an essential constitute of the self (1961, 305). Hence, Goffman's definition of the self as "a stance-taking entity, a something that takes up a position somewhere between identification with an organization and opposition to it" (1961, 320). An individual can therefore experience a mortification of self whilst still maintaining a kind of 'under-world' self. This under-world self is adopted as a separate

identity apart from the one that can be taken or given away. The interviews in this study may have provided prisoners with an interaction or arrangement where they felt some sense of control, where they were not denied respect and regard for their views, and where they were therefore able to freely express their feelings, attitudes and opinions.

Future Needs and Services

This research found that prisoners have a desire for additional mental health services both internal and external to prisons, and they offered a variety of suggestions regarding future service needs. These suggestions were somewhat dependent on how prisoners were feeling at any particular time (i.e., whether they were experiencing an episode of illness or a period of relative wellness). Ideas ranged from staying in prison on medication for those prisoners who are stable and able to manage, to the removal of prisoners who are unable to cope to specialist psychiatric units. It was the perception of those who took part in this research that it is the government's responsibility to provide and improve mental health services both in prisons and the community. A few prisoners expressed strong attitudes towards their current situation. In their view it is a disgrace that so many mentally ill people have ended up in prison populations and they believe the current climate is an abuse of individual human rights.

Prison Experience and Prisoner Needs

The findings demonstrate that prisoners' desire for improved and increased services is related to their overall prison and personal experiences. Participants in both Phases reported they have both positive and negative experiences of incarceration. In Phase Two 31.5% (n=15) of the sample reported very positive or positive experiences, 29.2% (n=14) are neutral or undecided and 39.6% (n=19) reported negative or very negative experiences living in prison. Prisoners who were negative regarding their imprisonment experience felt more strongly that they needed to be transferred to a secure psychiatric facility or service off the prison grounds. Other prisoners held opposite views and stated they would not want to go to psychiatric or hospital facilities and would rather stay in prison and receive treatment. As stated above, these findings show that prisoners exist on a continuum from those who find prison extremely stressful to those who are dependent passive.

Attitudes to service needs were very dependent on the individual's prison experience, their ability to manage in this environment, their stability on medication, prison location, support networks and many other related issues. Furthermore, for some it appeared to be related to their previous mental health treatment and past exposure to psychiatric facilities. Again, the sample was divided here. Some participants had spent considerable amounts of time in psychiatric facilities and found the experience to be positive and restorative whilst others were fearful and adamant they did not want to be transferred to such facilities. The findings demonstrate the importance of targeting mental health services to individual needs rather than a one size fits all approach. Both of these public institutions (prisons and psychiatric institutions) have their place in the treatment continuum, however they also create dependency and apathy in people rather than re-building individuals so they can manage their lives. Services and supported accommodation upon release into the community were discussed by participants who had anxiety regarding their previous contact with community based mental health services.

Funding and Additional Service Needs in Prisons

If additional services outside of prisons are not provided, prisoners had a myriad of suggestions for immediately improving services within the prison environment. Prisoner patients reported a desire for increased access to, and visits from health staff, including psychiatrists; to be treated by a broader range of professional staff, including occupational therapists; and to have more personal input into their treatment and medication. Additional services such as art therapy and counselling were also seen as essential and currently unavailable; 81.3% (n=39) of the sample agreed they require these services for rehabilitation. As previously discussed, research looking into the effectiveness of art therapy has reported significant decreases in depressive symptoms in prisoners who participate in art based programs (Gussak 2007), and that prisoners with severe and debilitating mental illnesses have a natural desire to participate in creative and artistic endeavours (Gussak 2006, 2004; Hanes 2005; Kornfeld 1997). There was also overwhelming support (93.8%, n=45) for prison programs targeted to the needs of mentally ill people. The findings here suggest the need for multi-disciplinary teams targeting the individual treatment requirements of prisoners. Moreover, the findings advocate for a re-conceptualisation of the current model of service delivery. The needs expressed are holistic and whole of person focused, shifting

away from the current overreliance on a medical model (i.e., medication) and also a community model of mental health treatment (20 minute treatment times). Given that prisons generally operate in isolation to the community there are grounds for a correctional model of health care to be developed. This model could start by looking at the needs of prisoners and then develop a framework and goals for service delivery. Future services need to utilise a range of staff to meet the rehabilitative needs of prisoners whilst also recognising the limitations presented by the environment and security.

The issue of providing programs (or other responsive (art therapy) rather than reactive services) to mental health clients needs to be considered by those working in correctional environments as it has been reported elsewhere in this paper that many prisoners cannot work due to the side effects of their medication and they are isolated and victimised. This results in boredom, apathy, segregation from prison life, paranoia, and in some cases a reason to misbehave or self harm in order to pass the time, gain some control, and possibly obtain the attention they are not receiving via more positive and constructive avenues. The offences committed by some mentally ill prisoners have been found to be of a serious nature, longer prison sentences are often handed down as it is often not the first offence, and release from prison is more difficult due to fractured community and social relationships. The findings of this research raise the importance of working with, and case managing, mentally ill clients over the course of their prison sentence. Participants in this research had a strong conviction that this will significantly improve outcomes for both clients and prison administrators, and therefore the wider community.

Staff Findings and Interpretation

Objectives -

1. To investigate and provide insight into the issues facing prison staff when working with prisoners who experience mental illness.
2. To investigate and gain insight into the attitudes and feelings of staff in relation to current services, treatment and facilities.
4. To investigate and develop an understanding of experiences in urban and regional prisons in Western Australia.

Mixed Methods Consideration -

1. To what extent do the staff and prisoner findings support each other across the qualitative and quantitative Phases? What insights can be generated, and meanings-draw out, by merging and exploring both forms of data?

Service Provision

Trans-institutionalisation

The over-representation of prisoners with psychiatric illness in prison populations is now widely reported (Fagan and K.AX 2003; Kupers 1999) with researchers such as Arboleda-Florez (1999) claiming that prisons have become a practical extension of mental health services. This research adds some weight to the argument. The findings show participants have a perception that prisons have become a dumping ground for people with psychiatric illness. This over-representation has significant implications for prison administrators and their capacity to provide mental health services -

Prisons have become the dumping ground for a deregulated mental health system. We have steadily seen an increase in people coming into the prison system who have mental health problems. It is not any secret and there is a large body of research on it. However, having done all of that clearly people are not doing much about it. I am not sure that people fully understand or appreciate the significance, or what the impact of trying to manage these people is within a prison environment.

The findings also demonstrate that staff face many challenges working in the prison context (81.7%, n=98, of the sample strongly agreed or agreed) including

the perception that prisons have become the new kind of institution for people with mental illness. This finding is supported elsewhere in the literature. Ruddell (2006) asked participants whether there was an increase in the admission of persons with mental illness into prisons during the last five years. Almost 80% of administrative staff agreed with the statement. It is difficult to determine cause and effect here; whether prisons have become a dumping ground for the mentally ill, or if psychiatric symptoms are more common in offender populations than they used to be. It is likely to be both. It may also represent improved assessment and diagnosis on entry to prison (or over-diagnosed with mental illness), or that prisoners are developing these disorders whilst incarcerated.

The research literature is mixed in its response to offending rates of the mentally ill (Hodgins 1990, 2008; Hollins 1993; Mullen 2000; Rabkin 1979; Steadman 1998), however it does claim higher rates of mental illness among prisoners than in the general population (Baldry 2006; Belfrage 1996; Mullen 2000, 2001). This increase can be attributed to a number of social and lifestyle factors. The staff I interviewed ascribed the perceived increase to illegal drug use and de-institutionalisation, and to a lesser extent social problems, social attitudes, and welfare and financial problems. The prisoner sample also raised drug use as a contributing factor, however they strongly emphasised the role of social issues and family breakdown. It is possible that some family breakdown is a manifestation of drug use from the prisoner's point of view or vice versa. It would be interesting to know if there is a cause and effect relationship. In chapter One, four broad categories were stated as contributing to the reasons behind these increases: 1) changes in legislation, 2) the development of psychotropic drugs, 3) the subsequent introduction and increase in community care, and 4) increases in drug related crime (Fagan and K.AX 2003). In addition, many other cultural and social factors come into play. Van Marle (2007) argues that there are a number of reasons for the increases including the "pressure on the criminal justice system for higher security, changes in community mental health care, the management of de-institutionalisation of psychiatric patients, the widespread use of soft and hard drugs and lessening social networks" (115).

The views and opinions expressed by staff and prisoners support that there are increasing numbers of mentally ill persons in prisons. There is widespread agreement that mental illness is on the rise in our society and amongst prison

populations (Birmingham 2001; Fazel and Danesh 2002; Ogloff 1996, 2002, 2006). With the closure of psychiatric facilities and limited community based services, particularly for dual diagnoses and co-morbidity, increasing rates of drug use and, most likely, a host of other interacting factors, the courts are sending individuals diagnosed with mental illness to prisons in order to remove them from the community, and in the hope that they will receive some treatment in a secure environment. The findings of this thesis support earlier claims that the closure of psychiatric institutions and increase in community care has failed, resulting in trans-institutionalisation. This has seen prisons take the place of state run psychiatric hospitals. However, prisons in Western Australia are not staffed, equipped nor financed to manage patients in a therapeutic capacity.

The findings show that all staff, regardless of their position (e.g., nurse, prison officer, psychologist or social worker), are acutely aware they work in a demanding and challenging area that is under resourced. This research found that 91.7% (n=110) of staff participants strongly agreed or agreed that they do not have the appropriate facilities to be managing people with mental illness in the prison environment. Staff are also conscious that the government is aware prisons are overcrowded and that mental illness is common, but this is yet to translate into effective service provision or acknowledgment of what is needed at the coal face. What does seem to happen is the building of more prison infrastructure. It appears there is little knowledge in the community about the high incarceration rate of the mentally ill and the limited services.

There was an overwhelming sense of frustration from participants who could not understand why others are not responding to this shift in institutionalisation, not only to improve mental health services in prisons, but to better manage people before they become offenders and to improve the overall health and functioning of the society we live in. These participants were frustrated and simply felt they were operating as best they could to avoid a crisis for which they will then be accountable. Participants expressed frustration at the level of attention mental illness receives in the media, and at the minimal changes they see as a result of this hype. It must be appreciated that prisons and prison populations are not popular in the wider community and do not win votes or rate highly in the stake for public money. The community may find it disturbing to know that a section of our community whose numbers are increasing, who are unwell and who will

probably end up offending against the community as a result of their illness and lack of access to appropriate treatment, can be so marginalised by the criminal justice process. They may find it unsettling that doctors, nurses, other health and correctional staff are left to 'just cope' with these populations. Participants (prisoners and staff) talked about the many different paths they explored to try to get themselves treatment, to get a patient treatment, to effect some change on their or another human being's life. Perhaps as a society we are becoming complacent as we are bombarded by messages of destruction, human rights abuses, natural disasters and wars, and are desensitised to the plights of others who seem far away (Tainter 1990; Toynbee 1934-1961). Perhaps we care but are so busy trying to manage our lives in a society obsessed by consumerism we do not have the time to take action for others (Elshtain 1996). If a society can be judged and measured by the way that society treats its most unfortunate (Dostoyevsky 1956; Mahoney 1998) then we have a lot to learn as we are sending our most disadvantaged to prison to be further disenfranchised. We need researchers to inform leaders to take evidenced based action and create change in our society.

Supportive Teams and Barriers to Improved Services

Despite the limited resources for mental health care and the frustration expressed by staff participants, this research found some encouraging results, and many individuals demonstrate a positive attitude towards their work. Over half of the staff participants reported mainly positive experiences when working with mentally ill prisoners, and the majority of all staff sampled (74.2%, n=89) responded they feel comfortable working with offenders diagnosed with mental illness. Staff reported that teamwork is paramount and they can depend on their team when managing challenging prisoners. This finding is supported by a staff survey undertaken by the Department in 2007 where DCS staff reported they enjoy working within their team and by the research literature where it is shown that practices are improved when staff engage and work in teams (Cruser and Diamond 2000; Winter 2008). It is reassuring that staff feel supported in some way as the participants in this research raised a number of challenges they face when providing care to mentally unwell prisoners. Specifically, participants discussed acute staffing shortages, their limited ability to transfer clients to secure psychiatric facilities, limited access to psychiatrists and specialist mental health staff, prisoner boredom, overcrowding, a lack of appropriate facilities, time

constraints, the treatment-custody conflict, and inadequate training to deal with complex issues.

Current psychiatric service provision was seen by many staff to be unsatisfactory and ineffective with numerous examples of improvements discussed. This finding was evident across both phases; in the Phase One interviews staff indicating they are 'just hanging on', that is, doing the best they can with what they have, but with many feeling disillusioned and frustrated by their inability to effect change. A comment in an interview in Phase One illustrates this point -

My overall experience is one of just managing day by day but not really knowing what to do with people with mental illness and wondering why they are here. This is a prison [not a psychiatric ward].

In Phase Two the majority (84.1%, n=101) of participants supported the Phase One finding that they are just doing the best they can with the facilities available, and 44.2% (n=53) of staff (mainly prison officers) reported not really knowing how to care for people with mental illness and confusion as to why they are in prison populations and not hospitals. This relates back to the over-representation issues raised above and the requirement for recognition of the experiences of nurses and prisons officers operating in these public institutions and also for action to rectify, modify or improve the circumstances. Staff have a perception that they are under-equipped with the necessary skills and resources to manage the issues, and an attitude that it takes a major incident (i.e., prisoner suicide or an Aboriginal person dying in the back of a van) before any action is taken.

A key area of concern for mental health nurses was the lack of staff (75%, n=90), strongly agreed or agreed that there are not enough mental health nurses to adequately deal with the number of mentally ill prisoners), particularly psychiatric staff in regional areas, and that many staff are not permanent employees of the Department. The findings on staffing shortages are not surprising and are supported by the Department's 2007 staff survey which found staff shortages are common. This is also supported by the literature where staff shortages, absenteeism and turn over in corrections is high (Garland and McCarty 2009). The over-representation of prisoners with mental illness, coupled with limited resources and staff shortages, creates significant difficulties for managing

vulnerable and sensitive populations; not only does it result in a stressful work life for staff, it means limited tangible treatment options for prisoner patients other than pharmacotherapies thus lessening the already limited capacity of prisons to operate as care facilities.

Due to these barriers to service provision (i.e., staff shortages, limited treatment sessions and 20 minute appointments with patients) staff reported they are crisis managing prisoners rather than providing treatment and meaningful interventions - *"you have to see the most serious first and unfortunately many people miss out on adequate services as you're crisis managing people much of the time."* The findings demonstrate that this is very difficult for staff, particularly health professionals, as the overwhelming majority of participants recognised the importance of taking the time to listen to prisoners who experience mental illness (90.8%, n=109, strongly agreed or agreed) and to explain the reasoning behind their decisions (88.3%, n=106, strongly agreed or agreed). Problems finding suitably qualified staff are highlighted in the literature, including the shortages of clinical and managerial supervision (Polczyk-Przybyla and Gourney 1999). The literature claims these shortages reduce staff morale and promote general dissatisfaction amongst staff who are already overworked in a high stress profession (Garland, William, McCarty and Zhao 2009).

Can Prison be a Care Institution?

The findings show there are considerable challenges in providing psychiatric services in prisons, and that staff struggle with the nature of the prison environment and the inherent treatment-custody conflict. Mental health facilities are essential in correctional units however the struggle for a therapeutic environment needs to be acknowledged by prison administrators. As one staff member stated in Phase One -

You have to factor in the security aspect because working in a prison people have to understand that top of the list is people's safety - clients and staff. Life threatening situations are top of the list, then it is security, and then it is health underneath that. Therefore, nurses working in the custodial environment have to get used to that. The security coming above everything is different from the community because in a hospital the health of clients comes before...this impacts on the service we provide. It is all to do with

time management. If we had freer access to the prisoners our time would be used more effectively, and we would be able to see more people. Obviously you have to learn to deal with this and work around that. It is still very frustrating at times.

This finding was supported by participants in Phase Two with 69.5% (n=83) claiming that prisons are overly punitive and there is a need to move clients into more therapeutic environments. Prisons by their very nature are harsh environments designed for incapacitation, deterrence, retribution, and reformation (Norris and Rothman, 1998). They are not treatment centres where individual needs can be catered for, and where staff can perform the necessary lengthy interventions (as stated above they are presently restricted to 20 minute appointment slots), and provide care and support in any meaningful way. The challenges noted here by staff (i.e., punishment versus therapy) are strongly supported in the research literature. This tension was noted early on by Clemmer (1940), and since the issue was first recognised it has become evident that there is no easy solution. More recent literature shows there are considerable challenges (i.e., client access, security, nature of the population, power structures) for therapeutic treatment in an environment where rules and procedures take precedence over individual needs, treatment and compassion (Hardest et al. 2007; Mason and Mercer 1998; Mullen 2001; Ricketts et al 2007). Fellner (2006) recently delineated the problems of managing prisoners with mental illness as “an inherent tension between the security mission of prisons and mental health considerations. The formal and informal rules and codes of conduct in prison reflect staff concerns about security, safety, power, and control. Coordinating the needs of the mentally ill with those rules and goals is nearly impossible” (391).

The findings of this research and the research literature show a notable tension between therapy and security in prisons. At present, this tension means that any form of treatment and rehabilitation is a difficult task. Prisons in Western Australia are not in a position to be a therapeutic community and it is debatable whether prison can service both punishment and therapeutic functions. These purposes are antithetical and it cannot be denied that at present the primary goal of incarceration is security (of the community) not individualised treatment. This conflict presents demands for correctional administrators and staff who work with prisoner patients. Moreover, most of the prisoners interviewed for this research

have long-term mental health and social problems that will require ongoing assistance and support. It is not easy to provide this support to prisoners who are cycling in and out of prison especially considering the limited through care, re-entry model and support in the community. There is a need to find solutions to balance the treatment needs of individuals whilst maintaining the security and order of the population. What is more, alternatives to punishment for prisoners who display behaviours that are beyond their control when they threaten the potential order of the prison need to be adopted; further punishing vulnerable people is not appropriate. One option here is designing and adopting a correctional model of health care; a framework and model that utilises multi-disciplinary teams and includes prison officers in the care team, in order to provide comprehensive mental health services to prisoners in specialised mental health units on prison grounds. Alternatively, the community needs to look at other options to reduce its overreliance on incarceration as a solution to social problems.

Adequate time for relationship building is important

The findings reveal that relationship building is essential for therapeutic intervention and holistic treatment. The findings strongly suggest that engagement in therapeutic relationships whilst in prison is paramount if prisoners are to have access to effective treatment and information, the ability to self manage their medication and ongoing access to community services and support when released. This finding is strongly supported in the literature where it is argued that “the relation and interplay among mental health staff, security staff, and inmate-patients can have significant influence on the effectiveness of treatment” (Appelbaum 2008).

The findings here demonstrate that those prisoners who reported feeling listened to and supported also reported higher levels of satisfaction with services, decreased rates of stress, and more positive outlooks for the future. It is possible that this in turn reduces the crisis associated with unpredictable behaviours in the prison. The research literature supports the above findings and shows that forming therapeutic relationships with clients are central for both patients and nurses, and that this relationship has positive treatment effects (Lindqvist and Skipworth 2000; Martin and Street 2003).

It can be seen that providing time to develop these relationships in prisons, or in any form of care, is central to treatment and understanding. A quote from a Phase One interview supports this point, "*...mainly we really need more trained and dedicated mental health nurses. It is important to be spending time with people to be able to treat them.*" Additionally, it is important for nursing and other staff to have the time, and therefore the ability, to not only provide prisoners with treatment but also with health education and counselling about their medication, side effects and other treatment options (Martin and Street 2003). In this research many prisoner patients reported wanting further input into their treatment and medication and that at present they do not have adequate access to information about psychiatric illnesses, medication and treatment, and other supportive documentation. This finding was supported across both phases of the inquiry and in Phase Two most staff agreed that prisoner patients need additional access to health information and education. In light of the anecdotal evidence from prison administrators of the high rate of mental health clients who stop taking their medication, and from the bullying and punishment findings discussed further below, this seems particularly important. Not only relationships with health professionals are significant, perhaps even more essential are constructive and healthy relationships with correctional staff as prisoners spend the majority of their time under the watchful eye of prisoner officers whilst imprisoned. In the absence of abolishing prisons (very unlikely considering we are building more at a rapid rate) a correctional model of health care could provide a range of professionals and staff who work in teams to provide round the clock care to prisoners. However, this would require a new philosophy of health care to be explored and adopted by prison administrators and the broader community.

Role Conflict

The findings of this research demonstrate that prison officers and other correctional staff face a number of challenges when working with prisoners who display complex behaviours. Correctional staff commented that prisoners with mental illness can be difficult and time consuming to supervise and in many instances these staff are not sure how to effectively manage what they call the 'bizarre' behaviours of some prisoners. Moreover, prison officers experience ethical and moral dilemmas when performing their role. Again, some of these findings strongly support the research literature. Bonner and Vandecreek (2006) noted staff face "ethical quandaries because of the need to balance the mental

health of offenders with control, security and the paramilitary structure of the prison system" (542).

The findings on this theme converged across both phases of this research. In Phase One prison officers discussed experiencing role conflict - *"some of us are more accommodating and we bend the rules to give them [mentally ill prisoners] what they want and we let them get away with more but it upsets the flow and order of things. This is a prison, not a psychiatric facility, and I am a prison officer not a psychiatrist or a nurse."* This research found unique and somewhat mixed findings in relation to the notion of responsibility and flexibility when managing prisoners who are perceived to be difficult. In Phase Two some prison officers were supportive of mental health services, expanding job roles and further training whilst other officers claimed that mental health was not their responsibility. In Phase Two, 80% (n=96) of participants disagreed or strongly disagreed with the statement - 'it is not prison officers' job to care for prisoners', implying that it is indeed within their role to be caregivers (note this does not necessarily specifically relate to prisoners with mental illness).

The findings were also varied for other questions that related to this theme. In Phase One a correctional staff member commented that prison officers do not have the time or the training 'to deal with them' - *"Officers don't have the time or training to deal with them [mentally ill prisoners] and we should not have to. Sometimes I think this place is a funny farm and it is very hard to manage."* In Phase Two, the sample had mixed responses to this statement with 40.8% (n=49) strongly agreeing or agreeing, 25.0% (n=30) being undecided and 34.2% (n=41) strongly disagreeing or disagreeing with the statement. The majority of prison officers agreed with, or were undecided about, this statement. It is true that officers do not have the necessary training and with current staff shortages an incident with one prisoner can take a lot of their time from other duties. However, what is interesting is that the underlying message to come out in many of these responses was that even if they had the time and the training correctional staff would not want to work with psychiatric prisoners. It appears that many prison officers in the sample are willing to be seen generally as caregivers but not specifically to persons with mental illness. The quote of another officer supports this view -

It really concerns me the mental health problem...after more than two decades in the service I have just seen an explosion of numbers, and it is very difficult for uniform staff in the prison environment to manage these people. Generally uniform staff receive no training whatsoever in the management and care of mental health patients and rightly so as it is not their job.

The findings indicate that these attitudes stem from staff concerns about their job description expanding and evolving, and therefore, creating increased responsibility and accountability. This could possibly relate to attitudes towards task increases without increased benefits/wages, and training concerns. It may also stem from a cynical attitude towards prisoners' motivations (i.e., that they are seeking medication and are not genuinely unwell). Adams and Ferrandino (2008) indicate that "these issues are part of a larger set of ethical concerns when professionals have multiple roles with potentially conflicting role responsibilities" (924). It would be interesting to research the motivations individuals have for choosing to become a prison officer and their expectations of the role. One would assume that most people have a fairly good idea they will be working with complex and troubled individuals whether they are diagnosed with a mental illness or not. Perhaps the actual work environment is more demanding than individuals initially thought and they then experience the added pressure of being understaffed and inadequately trained. Some staff are likely to become stressed, detached and punitive.

Respondents in the 2007 DCS staff survey indicated that staff *do* face conflicting demands in their job. This specifically related to workload and organisational fairness. Staff in Adult Custodial and OMPD (the Divisions of focus in this research) scored higher on this question than other areas indicating that they experience more role conflict and demands in their workplace. The findings of the staff survey are consistent with the present findings in that staff conflict and role specifications may be related to concerns over expanding workload.

The management style and coping mechanisms adopted by prison officers also varied, however the majority of prison officers recognised the importance of listening to prisoners with mental illness and explaining their reasoning for making decisions. Overall, prison officers were supportive of mental health in prisons but they were unsure of the role they had or should have in the future.

Prison officers play an important and central role in the prison environment and there is a substantial body of research looking at the change in corrections in the 20th century and the impact this has had on the role of prison officers (Paton et al 2002). The research shows that as prisons have become more complex so has the role of correctional staff, with the American Correctional Association claiming that the prison officer is responsible for custody and control which “requires extensive interpersonal skills, special training and educations” (60). Research further shows that prison officers can perceive their role in various ways and this has significant impacts on the population they are responsible for managing. In particular, they can experience role conflict when working with mentally unwell prisoners and prison officers often report that mental health is not really their primary area (Ben-David et al. 1996) of responsibility. The findings discussed above support the literature that prison officers experience significant role conflict when managing complex behaviours, and that the health concerns of prisoners will take a secondary role to the security of the prison.

Prison officers have an active role in prison power relations as they take responsibility for ensuring whether prisoners’ needs are regularly reviewed and met. The findings suggest that this is a particularly challenging position with the mainstream population, and even more so with vulnerable individuals. As we have seen earlier in the literature review and research setting chapters, prisoners who experience mental health problems are less able to cope with the prison ‘code’ and are therefore more likely to find themselves in trouble. Prison officers may relax the rules slightly and not instigate disciplinary action on prisoners or give them additional chances before writing them up (reporting them for punishment or loss of gratuities); these are decisions that can have a significant impact on the life and mental stability of prisoners. The findings indicate that prison officers’ behaviour is dependent on their underlying attitude, view of their role, and their ability to deal with complex individuals without losing the respect of other prisoners, or becoming overly punitive. These decisions present potential conflict for officers who are on the one hand responsible for the security and order of the population, and on the other hand the welfare of individual prisoners and their mental health needs. Correctional staff in this research indicated that there are times when the needs of prisoners must be secondary to the overall security of the population.

Research by Paton et al. (2002) looked at prison officers' experience of identifying and managing mental health problems. Paton et al's findings show that officers are able to identify mental health problems when the behaviour is overtly abnormal but they experience role conflict as they are not specially trained to deal with mental health issues. In this research officers expressed similar sentiments. When behaviour is 'overtly bizarre' (i.e., a prisoner is rubbing faeces in their cell or is displaying self harming behaviour) prison officers are able to identify it, however they are unsure what to do, and all staff expressed a need for training if they are to work with these prisoners. Moreover, correctional staff stated that the sharing of health related information amongst staff would improve their ability to help as they would be informed and prepared when dealing with prisoners. The findings show that the issue of information sharing should be cautiously negotiated by prisons. On the one hand is the need for correctional staff to be informed in order to provide the best care; on the other hand is the need for patient confidentiality. This was highlighted as a particular issue by prisoners in this research with many calling for their health information to be private and not available to prison officers. In a sensitive environment such as a prison this issue needs careful consideration. Information can be used to enhance care but also as a form of control and power over health professionals. An officer may use the information against a prisoner or staff member. For example, the officer may not bring a prisoner to the medical centre in a timely manner or they may punish a prisoner who has a good relationship with another staff member thus jeopardising the work the health professionals do with that prisoner (Mullen 2001).

Bullying and Control

The issue of information sharing relates to bullying, role conflict and training as prison officers may become overly punitive if they are unsure of how to manage prisoners with mental illness. As one prison officer stated in Phase One -

I don't think that you can doubt that they [mentally ill prisoners] are treated differently by staff and other prisoners overall. They may need more attention or a different kind of approach and that is where it gets difficult because in this environment, the environment in an institution, you cannot be seen to be favouring people or giving people special treatment. This makes it difficult because many of these people do need special care and treatment.

Mentally ill clients were perceived by staff to be very vulnerable and to have different needs to the rest of the prison population. Although staff did not report bullying to be widespread, victimisation was observed during the data collection for this research (as discussed above in the prisoner findings).

Bullying or power control tactics range from prison sanctioned overt bullying or surveillance such as cell searches, strip searches, drug testing, and segregation (i.e., sending prisoners to punishment cells), or more covert such as asserting control over prisoners' medical information (Goulding 2007, Kupers 1999). Prisoners in this research had concerns regarding the confidentiality of their medical information and this was mirrored by nursing staff who were apprehensive regarding prison officer access to private medical files. According to Goulding (2007) record keeping, such as an individual's medical history, prison movements, and family background is one example of covert surveillance. This is information available to staff but not prisoners and therefore creates a one-way flow of information where the observed is passively controlled (Goulding 2007). Other forms of covert observation include surveillance cameras, listening devices, metal detectors, and biometric identification technology which was introduced into Western Australian prisons in early 2009 (Goffman 1961; Goulding 2007). These forms of surveillance impact on prisoners' personal and emotional lives and came up in the current research as I noted the hesitation of many prisoners to speak about personal matters, or their fear that people 'were in their heads'. As stated previously, this research therefore reflects Goffman's (1961, 1969) findings in a modern context as it was found that control strategies impact on staff lives and prisoner health.

These forms of surveillance and segregation work to isolate prisoners and act as environmental stressors (i.e., prisoners feeling as though someone is 'in their head') which may worsen psychiatric disorders and any chances for long-term healing (Kupers 1999). These findings are strongly supported in the literature (Senate Committee on Mental Health in Australia (2006, 338), where it has been found that sanctioned bullying (disciplinary techniques) including segregation units and safe cells have been shown to induce insanity.

Training and Education

Role Conflict, Relationship Building and Training

As stated above, research shows that prison officers experience a high level of workplace stress that is linked to their adopted ideologies and relationships with prisoners (Long et al. 1986, Tewksbury and Mustaine 2008). Attitudes to prisoners have been found to change over time and are linked to positive or negative events in the prison environment. Negative attitudes are associated with concerns over the expanding role of prison officers (Bowen et al. 2005) and officers feeling like they have insufficient knowledge and training to manage prisoners under their care (Paton et al, 2002). Education and training have been shown to have significant effects on officers' attitudes to, and understanding of, personality disorders and other disorders, with officers stating in one research study that training gave them the necessary skills, confidence and patience to deal with difficult situations (Hogue 1993). These findings are supported by Lea, Auburn and Kibbelwhite (1999) where staff training was found to considerably influence the attitudes and understanding of staff and in turn create more positive experiences for these staff and the prisoners under their care (Appelbaum, Hickey and Packer 2001; Cruser and Diamond 2000). The literature has also found that an insufficient level of training for prison staff is common and that any available training often starts at a level too high for the officers (Paton et al, 2002). These findings are all supported by the current research, where the majority of officers reported they receive no or very little training to work with psychiatric patients.

Officer Training

The findings from Phase One demonstrated participants' concern regarding training and education. The following quotes illustrate staff experiences -

The initial prison officer training is seriously lacking and needs to be revised. It should be a comprehensive 8-10 weeks training course. Quite often they are so desperate for staff that the training is nothing. It needs to be completely revised. The content is not adequate. There then needs to be ongoing updating.

I have never done training on mental health. There was none in the initial training I did. It would be good to have some level of understanding of the different mental illnesses, the symptoms, what people are going through and how to manage them and to recognise what is going on.

These concerns were supported by participants in Phase Two where 96.7% (n=116) of staff responded that training is vitally important, and 92.5% (n=111) believed all staff require additional up-skilling in mental health related topics. The lack of training opportunities for staff are of real concern with a large percentage of participants (73.3%, n=88) in this research reporting having received no mental health training at all. Regional participants were more likely to report having received no training than metropolitan staff. In addition, just under half of the sample in Phase Two reported they do not believe that training and education are valued by the prison they work in. In light of these findings it is not surprising that prison officers find it difficult to cope with complex behaviours and would rather not manage individuals they do not understand. There is an important distinction to be made in the findings here. On one hand some staff wanted information about mental illness, symptoms, and skills or ways of managing challenging behaviours, however, other staff wanted access to patient files. Access to patient files is not training and although it may provide staff with additional information it will not provide them with a skill set to identify and manage challenging situations. Given the findings of Lea, Auburn and Kibbelwhite (1999) it can be assumed that hands on training will equip prison officers with the necessary information and skills that may influence their attitudes towards prisoners in a positive way. Prison officers in the current research were open to receiving training - they thought it was *vitally important*; this training may impact on the attitudes of those officers who do not see it as their job to care for prisoners with mental illness.

Similar findings were reported in the Department staff survey (2007) where a number of staff reported they had inadequate training to carry out their job, that it was not easy for them to be released for training, and that training and performance management were not linked to improve overall job performance. Specifically, the Department questionnaire stated - 'I have received sufficient training to carry out my job'. Although 48% of respondents agreed with this statement, 33% of staff disagreed and a further 20% weren't sure.

The findings of the current research demonstrate that in addition to many staff reporting having received no training, 66.7% (n=80) of participants reported that they do not feel adequately prepared to have persons with mental illness under their care, and in many cases they are going from one crisis to another. Moreover,

81.6% (n=98) of participants reported they do not feel that uniformed staff have a suitable level of training to be managing persons with mental illness. Prison officers accounted for 61.7% (n=74) of the current sample. As stated above, the literature illustrates this is problematic as prison officers find working with mentally ill prisoners challenging at the best of times, these prisoners are involved in a higher number of rule infractions, and take up considerably more time and effort than other prisoners (Toch and Adams 1989; Hodgins and Cote 1991). This finding is of genuine concern as prison officers are, at present, the primary caregivers across most prisons in Western countries. As one staff member commented in Phase One, "*at the end of the day the custodial staff are the care people and they need proper training*" to be able to deal with complex situations, to provide the best services to prisoners, to reduce the need for crisis management, and to reduce levels of work place stress. As shown in this research a number of staff reported significant problems and psychological stress. It is important that prisons provide adequate support to staff to reduce the effects of the workplace on stress levels.

The findings indicate an urgent need for additional training for correctional staff. If people with mental illness are to be housed in prison, which is the case at present, it makes sense for correctional staff to be involved in a multidisciplinary care team. Correctional staff spend 24 hours a day, 7 days a week providing care to prisoners, making them the first in line to notice unusual behaviours. Consequently, there is an opportunity for prison officers to alert mental health staff early, so interventions can begin. However, staff need to take the attitude that it is their responsibility to do so, and be given the skills and confidence to identify the symptoms of mental illness. These staff must share in a mutual understanding and support each other to make both security and health decisions a priority.

Any training to prison staff needs to consider the demography of current prison populations and should include comprehensive cultural and spiritual training (this is particularly relevant in the Western Australian context). The importance of cultural and spiritual awareness was raised by participants as was the need to tailor services in the 'Aboriginal' prisons. However, overall the services and needs of those with mental illness were reported to be similar regardless of race. It has been reported that prison officers generally do not understand or appreciate

Indigenous customs or culture (Mahoney 2005) and with one of the highest rates of imprisonment and the over-representation of Aboriginal people recognised as a significant issue in Western Australia (Ferrante 2005) it is imperative that culturally specific behaviours and the implication for mental health treatments are included in all staff training.

When staff were asked about the best way to deliver this training they reported that it should be delivered to prison officers in small groups of about 10 officers, and be taught by someone outside of the current prison staff who has appropriate and significant credentials. It was felt that otherwise prison officers would have little regard for the information.

Health Staff Training and Professional Development

Health professionals also reported inadequate access to training and ongoing professional development. Health staff stated that a real issue for them was that time off work was rarely given to attend training. This sentiment was supported by 60.9% (n=73) of the sample. Staff discussed that although the Department will pay for health staff to participate in training, staff feel that they should not have to use their holidays and time off, which they need to debrief from a stressful job, to undertake professional development. This was related to the issue of staffing shortages. If there were adequate nursing hours there would be staff to cover training and professional development. Participants also reported that the Prison Counselling Service should have access to, and have a need for, additional specialist mental health training. This research found that regional participants agreed more strongly with many of the statements related to education and training and felt as though they have limited access to training opportunities. This is not surprising given their geographical isolation and therefore limited access to professional conferences and training opportunities that are available in bigger cities.

Again, the findings here are supported by the Department's staff survey (2007), and the research literature. The literature shows that ongoing training is important for staff, and that positive changes in attitudes and perceptions are reported after ongoing training amongst nurses (Flanagan and Flanagan 2001; Miller and Davenport 1996). It is important that staff who work in corrections are provided with appropriate training budgets and time to participate in professional

development. As has been established elsewhere in this thesis corrections is a particularly challenging and evolving work environment and staff need to be at the cutting edge of their field and feel valued and supported in their work culture. The literature shows that substantial returns can be yielded from relatively small investments in training (Parker 2006), including enhanced operations, bringing prison officers on board as part of a multidisciplinary team, and improved overall functioning of prisoners with mental illness (Cruser and Diamond 2000; Adams and Ferrandino 2008).

Policy, Procedures and Staff Consultation

Procedural Awareness and Meaningful Consultation

The findings demonstrated that staff had limited knowledge of any procedures or policies within the Department that relate to managing difficult situations or complex prisoners. Specifically, the findings show that 37.5% (n=45) of the staff sample had never seen or heard of policies relating to managing prisoners with mental illness, and 24.2% (n=29) were undecided if they had ever seen any. In addition, 55.0% (n=66) strongly agreed or agreed that there were inadequate operational guidelines when faced with a psychiatric crisis. Furthermore, both health professionals and correctional staff reported that they are not consulted or listened to by their line manager or by upper management, and 65.0% (n=78) responded that there is an inappropriate level of consultation with people in the field regarding decisions that directly affect them. Moreover, staff indicated that in their experience there are inadequate levels of support from both prison and health management. The research literature shows that adequate contact, consultation and supervision from management staff is imperative and will improve staff attitudes and job satisfaction (Garland, McCarty and Zhao 2009; Glaser and Dean 1999).

Given that prison officers find managing mentally ill prisoners difficult, because they require more attention than other prisoners and they are over-represented in rule infractions, clear policies would help provide a framework for addressing any issues. Previous research has highlighted the importance of clear policy and management procedures for prison officers and other corrections staff so they do not resort to controlling or avoidance disciplinary procedures which may make vulnerable prisoners worse off (Sandall and Spurgeon 1993). The findings here illustrate that even if policies are in place the majority of prisons staff are not

aware of them. This relates back to the themes discussed concerning role responsibility and the need for training. The findings suggest that if staff feel uncertain with the changing demands of their role, experience a lack of consultation and support regarding key changes that affect their working environment, and have limited access to training to facilitate educating them about the people under their care, they will have little incentive to embrace formal policies and procedures. They may also feel that there are too many policies and guidelines to operate within thus limiting their ability to stay abreast of the policies. There is a possible catch twenty-two here as staff will not embrace policies and procedures without other factors in place, such as consultation, training and an understanding of the relevance of the procedures; however, implementing appropriate and well thought-out procedures will give correctional staff more control, insight and confidence to perform their role. These issues were particularly poignant throughout both phases of this research.

Top Down Versus Bottom Up

The findings of both phases exemplify that staff perceive a work environment where processes are top down rather than bottom up. As one staff member stated in Phase One *"the reality is that it is about people trying to impose things from the top down when it should be managed from the bottom up. If there is going to be consultation, the consultation must be meaningful..."* This statement was supported in Phase Two where 64.1% (n=77) of participants strongly agreed or agreed that they were never asked what they require and that people make decisions that affect their working environment with no consultation. A further 65.8% (n=79) of the sample strongly agreed or agreed that policy and practices are imposed from the top down rather than the bottom up. These findings raise alarm bells for the inclusion of staff in decisions about their working environment, for staff morale and retention rates, and work place stress. Interestingly, there was an age variation in the responses to this question. Older staff (50-59 age bracket) agreed more strongly that 'policies and practices are imposed from the top down rather than the bottom up' than younger staff (40-49 age bracket). This may be that older staff have worked in prisons for longer and do not feel that their considerable experience, knowledge and skills are valued or respected by management.

Similar findings were reported in the Department staff survey (2007) where 43% of participants stated they felt their contribution to the organisation was not recognised; this was particularly the case for staff from Adult Custodial and the operational divisions (the same groups who participated in this research). Furthermore, the findings indicated that for Adult Custodial, more staff *do not* feel that their line manager consults them before decisions affecting them are made.

These findings indicate that some staff feel particularly disenfranchised and uninspired. In contrast the majority of staff who took part in Phase One of this research were passionate about their position, their work with offenders and their ability to affect change within the system. It should be acknowledged that others appeared somewhat rigid and cynical in their views. This may reflect individuals feeling 'beaten down by the system' as their input is not valued. If this is the case one can begin to understand more deeply why staff do not want to spend considerable amounts of time helping difficult prisoners. These findings have far-reaching implications. If, as the results here suggest, there are increasing numbers of mentally ill prisoners, there is a lack of training, the role of prison officers is expanding, there are inadequate policies and procedures, limited consultation and staff support, and staff do not feel that their professional contribution is valued, it is not surprising that staff feel unsure about their role, and taking the initiative to learn more about how to better manage prisoners. If the culture is "everyone else thinks that they know better" and no-one is supportive, then staff may question why they should stick their neck out and be accountable, as they are likely to be told what they did was incorrect.

Interface between Health and Justice and a Correctional Health Model

Staff responded that there were a number of issues with the health and mental health policies and procedures, i.e., they were outdated and not responsive, and that there is a need for effective guidelines and policy that is not too general or overbearing. The findings in Phase One indicated that staff felt there were problems with the current health-justice structure. The majority of participants (77.5%, n=93) strongly agreed or agreed that there is a need for the interface between health and justice to be reviewed. Research focusing on mental health nursing shows that staff in forensic and prison mental health settings face clinical and managerial challenges, particularly problems with policies and practices that

are often described as 'confused and divisive' (Polczyk-Przybyla and Gourney 1999).

Research into staff attitudes and experiences shows that staff, and in particular nurses, experience difficulties working with prisoners diagnosed with personality disorders. The research has found that positive attitudes and experiences are attributed to working in organisations with clear goals and expectations that are seen to be achievable through an agreed set of actions (Bowers et al. 1998) and by means of strong management support (Paton 2002). This is an important point as the current research found that 38.3% (n=43) of staff strongly agreed or agreed that management support from upper levels of health is very poor and totally inadequate; and 70.8% (n=85) of staff reported that they find prison health services a very difficult area to operate within due to security always taking precedence over the health of prisoners.

Participants believed that effective guidelines are important and that the interface between health and justice needs to be reviewed. At present, the Department adopts a medical community model of service delivery. This community model uses treatment times/appointments and an overreliance on medication. This model is problematic in a number of ways and staff stated that treatment times (appointments) are an ineffective way of treating prisoners. This research has found that the current model needs to be reviewed; prisons are not in the community and a more integrated correctional health model needs to be devised that better meets the needs of staff and prisoner patients. The criminal justice, social work, psychology, health and psychiatric professions could collaborate to design a 'Health in Corrections Model' and forecast which field is best placed to provide health services to prisoners. The most pertinent issue is not who provides the services but that the correctional health model reflects the changing and fluid nature, the health and mental health problems, and the inherent security issues, of prison populations.

On a broader level this finding has far reaching implications for the nature of health service provision in correctional environments. A number of questions can be posed in relation to this finding: should correctional health services be administered by health divisions within corrective services? Should it be administered by health departments who have a contract with corrections? Could

additional support and treatment oriented services be established to holistically manage offenders (and their families) whilst in custody and on return to the community? What implications would each model have for service provision, the goals and underlying philosophy of services (particularly the therapeutic versus containment argument), staff arrangements and employment, funding and budgets, and other related matters? These are important questions to pose for all government agencies, whether national or international, who must endeavour to find the most suitable and cost effective way to provide effective medical care and treatment to contained populations. Thought also needs to go into improving mental health services in the community; it could be argued that a proportion of the participants in this research could have avoided jail (and their victim's trauma) if support and crisis intervention had been made available.

Future Needs and Services

This research demonstrates an overwhelming support for the improvement and extension of mental health and psychiatric services in prisons, and in the community. However, it needs to be recognised that the extension of these services will come at a cost, the cost of incarceration, and with this the many other negative implications of imprisonment (i.e., the loss of social connections and serial institutionalisation). It would, of course, be far better to provide these services in the community and avoid further disadvantaging the already disadvantaged.

If services are to be provided in prisons they require improvement. Participants expressed a strong desire for changes or additions to the current facilities provided to mentally ill prisoner patients across prisons in Western Australia, and their current experience is one of working in an under resourced and exigent context. There was a unanimous call for additional resources and funding with health professionals supporting many of the statements more avidly than other staff groups in this research. Some of the key themes raised by staff are presented below.

Limitations of the Medical Model

As stated above, mental health services in prisons, and in the community in Western Australia, are underpinned by a medical model which emphasises the

importance of drug treatment in the management of mental health symptoms (Morgan 1993). This model is effective in many ways, however it appears to operate to the exclusion of other treatment options in many correctional environments and in some cases it could be said that health services are more responsive to prison administration needs rather than prisoners' psychiatric needs. It would be beneficial for corrections to consider the development of treatment options that still recognise the importance and benefits of pharmacotherapy but that also utilise behavioural, counselling and program related therapies in the treatment of mental illness. The findings of this research suggest that a balance of needs (e.g., prisoners, families, communities) and a holistic treatment approach is the best way forward and this was emphasised in the experiences and voiced needs of prisoner patients. Some serious strategic planning is what is required to devise an overall framework of mental health service provision (i.e., an integrated correctional model), and to then fit the types of services and staff, to the goals and objectives of the health services model.

Holistic Intervention

The over-reliance on the medical model has meant that many other forms of treatment are not utilised in prisons in Western countries. This has, in some ways, limited the scope and provision of alternative treatment options for prisoners and was illustrated by the experiences and views of participants in this research. 61.7% (n=74) of the staff sample agreed or strongly agreed that prisoners need to have more input into their treatment. Moreover, they expressed that other treatment options such as art therapy, meditation, and prison therapeutic treatment programs should be made available to prisoners. In relation to programs, 82.5% (99) of participants rated this as particularly important. These alternative forms of treatment may also better accommodate the needs of Aboriginal and other cultural groups who are not as easily categorised by Western notions of medicine. However, no major differences were found according to ethnicity in this research. Painting, or art therapy, may be a particularly powerful form of expression for some Aboriginal people and other groups of prisoners. This is supported by the literature where results reflect significant decreases in depressive symptoms for prisoners who participate in art based therapy programs and prisoners express a desire for creative expression (Gussack 2004, 2006, 2007; Hanes 2005; Kornfeld 1997)

Additional Staff

Staffing shortages and a need for additional well qualified staff was raised as a significant issue throughout Phase One and Phase Two with this finding supported in the literature (Boothby and Clements 2000; Finn 1989; Glaser and Deane 1999; Santamour 1986). I will requote the figures presented in the above results section as they warrant a double reading. 94.2% (n=113) of the sample strongly agreed or agreed that there is an urgent need for additional mental health nurses; 90.8% (n=109) of the sample strongly agreed or agreed that additional psychiatrists are required, desperately in regional areas; 76.7% (n=92) of staff stated that additional psychologists are needed; and 60.8% (n=73) of participants responded that further social workers are necessary. In addition, 90.0% (n=108) of the sample strongly agreed or agreed that there is a need for other specialist mental health staff in prisons (this could include: occupational therapists; counsellors; meditation experts; dance teachers and art therapists).

Improvement and Extension of Services - Community and Corrections

Secure Psychiatric Facilities

The literature review revealed the prevalence of violence exhibited by some, but certainly not all, persons with mental illness who are untreated to be four to ten times greater than the general population (Mouzous 1999). This is supported by other researchers where those with a history of psychiatric illness are more likely to have been convicted of criminal offences (Hollin 2001, 1993; Mullen 2000; Ly and Forster 2005), to re-offend (Belfrage 1996), and in many cases these are violent offences against individuals not previously known to the offender (Boker 1982; Mullen 2000). These statistics should act as powerful motivators for the suitable treatment of offenders with mental illness, many of whom will be released back into the community, and the improvement of both community and prison based service provision in order to reduce recidivism rates of violent and other offences by this demographic.

Staff raised many frustrations and difficulties in trying to have acute prisoners transferred to a secure psychiatric hospital unit off the grounds of the prison. In some cases it was anecdotally discussed that prisoners have been transported from prison cells to the grounds of Graylands Hospital where they have received involuntary treatment only to be turned around and taken straight back to prison. This signifies an urgent need to address the shortage of bed numbers and access to

secure psychiatric facilities for those who require this kind of service. Several decades post deinstitutionalisation it must be recognised that there is always going to be a need for acute intervention services and some long-term stay facilities. There is a serious shortage of facilities to treat acutely unwell individuals as in-patients. Many staff claimed this is an abuse of human rights; these prisoners may go on to harm themselves or others in the absence of secure hospitalisation.

Additional Unit/Facility for Mental Health Clients/Suicide and Self-Harm Prevention

The experiences and attitudes of all participants in this research demonstrate the vulnerability of prisoner patients who are incarcerated. This finding was consistent across both phases. Phase One found that many prisoner patients feel vulnerable and isolated in prison and this was supported by the staff results. Phase Two confirmed this finding across a broader sample of prisoners, staff, and prison locations and this is also strongly supported by the research literature. The literature clearly shows that mentally ill prisoners are victimised in prison populations and often over-represented in rule infractions, self-harming behaviours and as victims of sexual assault (Hayes and Craddock 1992; Ivanoff 1992; Langford 2005). 90.8% (n=109) of the staff sample responded that there is a need for a special facility to be established to accommodate the special needs of prisoners with mental illness and those at risk of suicide and self-harm.

This thesis has established that prisons struggle to act as care institutions due to the antithetical nature of its functions. The findings suggest that staff support providing a treatment facility for prisoners who will not cope in mainstream prison populations. This is not to imply that all mentally ill prisoners need to be segregated from the rest of the prison population as this will only work to perpetuate the social stereotypes of mental illness in our community. However, there is a need to step back and recognise that some individuals are unable to function, let alone to the best of their ability, in mainstream prison populations and will require a therapeutic community at different times.

There was also the hint of a suggestion by some correctional staff and prison administrators that changes be made to the existing legislation so that all mental health clients can be treated under the Mental Health Act in prisons. Prison by its

very nature does not support the implementation of this and the topic raises many human rights issues; it would mean that involuntary treatment of mentally prisoners would be sanctioned across all prisons. If a suggestion of such magnitude was to ever receive consideration it would warrant further research attention.

Extend Services into the Regions

This research indicates that staff believe there is a need to extend regional mental health services both in prisons and the community (however, as discussed above prisoners were the most satisfied at one regional prison site). That is, 87.5% (105) of the sample strongly agreed or agreed that there is an immediate need to extend mental health service provision in the regions. As expected, regional staff agreed more strongly with these statements than metropolitan participants. These statements related to the general extension of regional services, additional mental health nurses, psychiatrists, psychologists, social workers and other specialist staff, and programs for mentally ill prisoner patients. Staffing shortages and inappropriate facilities were raised by all staff and at present staff feel these issues are not being addressed. As discussed in the research setting chapter, Aboriginal people are significantly over-represented in Australian prison populations and in Western Australia a number of the regional prisons are considered 'Aboriginal Prisons'. Therefore, to address these issues adequately there is a requirement to assess issues relating to the over-representation of Aboriginal people in prison populations and in mental health statistics, and of the need for services to be mindful of Aboriginal culture and spirituality. Although the need for different services according to ethnicity was not a major finding of this research, some staff and prisoners were aware of the overly Westernised notions of mental illness. It is important that any services, programs, and treatment options are considerate of the demographic features of the clients they are designed to treat, whether male, female or Aboriginal.

Dangerous and Severe Personality Disorders - A Treatment Resistant Population?

Many staff expressed strong opinions on the subject of services to prisoners diagnosed with personality disorders. Some staff felt that the improvement of services for this group was essential; others felt that this was a political stunt and completely unnecessary at the ground level; and still others did not feel that individuals with personality disorders are worthy of treatment. This is interesting

and may warrant further attention from the Department of Corrective Services especially in light of the research findings outlined in the literature review. That is, that at any one time the Western Australian prison system could be managing up to 100 prisoners with dangerous and severe personality disorders. Research by Fazel and Danesh (2002) shows that in Western countries, 65% of the prison population could be diagnosed with personality disorder, including 47% with antisocial personality disorder, however, we also saw the limited reliability of assessments and screening in the literature review so perhaps these figures should be read with caution.

The literature does show that those with personality or adjustment disorders are more likely to commit violent offences and are generally prone to higher levels of violence (Jamieson and Taylor 2004). Consideration needs to be given to the treatment of these disorders with claims that personality disorders are resistant to treatment and that when treated with other individuals they upset and disturb the progress of others (Cawthra and Gibb 1998). The issue of how to manage and treat those with personality disorders and dangerous and severe personality disorders is hotly debated and will require considerable attention by Government, the Department, and health services in Western Australia in the near future. In relation to this is the need for contemplation in regard to possible changes in legislation; whether we want a system that can detain treatment resistant people against their will for indefinite periods of time. Under special circumstances prisoners can be held at the discretion of the Attorney General after their sentence has expired. Whether or not mentally ill people, and whether those with personality disorders are defined as mentally ill, should come under these provisions is debatable.

Closer linkages with community services

Many mental health patients end up in the criminal justice system due to a lack of structured support systems that can assist this group to move out of substance abuse, homelessness, other social welfare issues (Borum et al 1997; Drake et al. 1993; Lamberti et al. 2001; Monahan 1995; Rachbeisel, Scott and Dixon 1999; Steadman et al. 1998; Swartz et al. 1998; Williams 2007), and to be compliant with treatment programs. It is important that support networks provide a holistic community environment for those with mental illness (Lamberti et al. 2001). The improvement of community services, supported accommodation, re-entry

services, community linkages and the need for additional hospital-like services was highlighted as an important area by staff across both phases of this research. 71.7% (n=86) of the sample strongly agreed or agreed that there is a need to create enhanced linkages with community mental health services; and 69.2% (n=83) of the sample strongly agreed or agreed that supported accommodation and additional services in community settings are a priority. These findings support the research literature where it is claimed by many that prisoners would be better treated in hospitals and community based programs rather than in the criminal justice system (Weedon 2005). This could take the form of supported accommodation or half-way houses to help prisoners get back on their feet.

The findings of this thesis support the use of extending community mental health services for prisoners, in particular re-entry services. At present many people with mental illness are diverted to health treatment through the criminal justice system where it is argued that they are at least getting some treatment. There is some merit in this; however, this argument is suspicious and people should not have to face the debilitating effects of imprisonment in order to receive treatment for their mental illness. Of course prisoners should receive good health and social care whilst imprisoned but sending the mentally ill to prison to receive care is bordering on crazy. There is a need to recognise that prisons in their current capacity are unable to provide the kinds of services necessary to all prisoners. The increased use of diversion and community mental health services will help to alleviate the rising number mentally ill people on our prisons.

Additional Resources

None of the services suggested can be implemented without adequate funding and resources from the State government; a tall order when policy agenda shifts in response to media headlines. One of the most prominent features of the lack of funding was the limited range of programs on offer in prisons, specifically specialist programs for the mentally ill, including programs aimed at dual diagnosis clients. The limited funding for programs creates additional problems as it was previously noted in the literature review that offenders with mental illness are more likely to reoffend than other prisoners and are also given longer sentences (Fields 2006). Without programs targeted to their needs it is unlikely that prisoner patients will be able to access parole in Western Australia.

All this suggests that the shortfalls in mental health service provision are widely recognised. Staff and prisoners have some practical and solution focused ideas and many of these individuals would like to be a part of the change process. This research shows that Australia could lead the way with holistic and creative services that treat and manage the mentally ill, help people get back on their feet, and work at the grass roots to reduce the number of mental health clients coming into contact with the justice system.

Chapter Summary

This chapter discusses the prisoner patient and staff findings across both phases of this research in the light of existing literature. The research provides insight into the experiences of service providers and users, and demonstrates that prisons are complex environments which present many challenges to the effective delivery of multi-faceted, individualised and comprehensive mental health services. This thesis confirms findings elsewhere in the literature that there are considerable shortcomings in the services provided in prisons today; the situation is not dissimilar in Western Australia. It shows that staff and prisoners have a perception that we have seen a shift from psychiatric institutionalised care to institutionalised prison care. Moreover, the results show that prisons are very difficult environments for prisoners living with mental illness to negotiate and survive within. With regards to the mixed methods considerations the findings show a high level of support and correlation across both the staff and prisoner findings and across the qualitative and quantitative phases. The use of the sequential mixed method and pragmatic stance were an insightful way to explore the topic and enhanced the scope and quality of this research.

It has been demonstrated that the incarceration of the mentally ill is influenced by a host of complex factors and there are a number of issues facing prison staff, correctional officers and health professionals, when working with prisoners who experience mental illness. Staff who choose to work in prisons must contend with an environment that is perceived as the dumping ground for individuals with mental illness in addition to the practical issues of staffing shortages; management problems; inappropriate facilities and infrastructure; an overreliance on medication and limited treatment options; insufficient or nonexistent training for prison officers and limited access to professional development for health professionals; and problems relating to the inherent nature of the prison context

such as bullying. Staff had strong attitudes towards their work and the current services provided to prisoners. Many staff discussed doing the best they can with the services and resources available to them and health professionals have a perception that they are crisis managing prisoners rather than providing effective treatment. Moreover, health professionals struggle to strike a balance between therapy and security and correctional staff experience role confusion due to the need to balance the mental health of offenders with the security and control of the prison and to also manage the expanding and changing nature of their role.

Prisoner patients were somewhat undecided about current service provision and had mixed attitudes towards prison officers. However, they held generally positive attitudes towards nurses who were seen as helpful and understanding. Prisoners specifically raised the importance of having increased access to nursing staff, psychiatrists and specialist staff and programs in prisons. This access could have an impact on and improve therapeutic relationships; increase prisoners' understanding of their illness; provide them with behavioural modification and coping skills in addition to their medication; reduce prisoner boredom by providing an outlet; develop a sense of achievement (i.e., art therapy); improve staff morale and sense of success/achievement with these clients; decrease the number of challenging incidents and the need to place prisoners in punishment for non-compliance; and therefore make these prisoners easier to manage and return to the community with a degree of confidence that there is improvement, insight and stability. The notion of relationship building needs to be more widely recognised and embraced in corrections health services. This is important, particularly as it correlates with improved attitudes to the services received and will likely have positive outcomes for offenders. However, several issues need to be taken into account and it must be realised that health staff have limited access to prisoners due to security routines; they are understaffed and are therefore seeing those most in need; and the current community model of care means treatment times are limited to 20 minutes. These barriers hamper the development of relationships in most prisons.

The experiences of prisoners are complex and multifaceted. The majority of prisoners find living in prison with a mental illness difficult and there is some evidence that prison contributes to the mortification of self and the normalising of prison life. Some prisoners have support networks, are stable on medication and

are more able to cope with their incarceration. Others are vulnerable, lonely and isolated and experience their imprisonment as a series of high stress situations that produce fear and distress. These prisoners are desperate and cannot understand how they have ended up living in prison with their illness. Prisoners in this sample were the targets of bullying and harassment and are over-represented in rule infractions. Prisoners' experiences and attitudes provide an interesting insight into how best to improve and provide mental health services that are responsive to individual needs. The findings illustrate that in most cases prisoners have insight into their illness and circumstances and have ideas for improving services that are realistic, practical and achievable.

CHAPTER EIGHT: CONCLUSION

“The key point is that correctional institutions are reservoirs of physical and mental illness, which constantly spill back into the community. If these diseases are to be treated properly, transmission interrupted, and the health of the general public [and those incarcerated] optimized, then effective treatment and education must be provided in the jail system. These conditions are public health problems that demand effective management and close coordination among correctional health, community health, public health, and mental health facilities” (Pomerantz 2003, 21).

There are limited resources and insufficient infrastructure in Western Australia to provide the necessary care for people who experience psychiatric illness and mental health problems in prisons. Moreover, the cultures of both staff and prisoners show that in some instances change would be embraced and in others any change to staffing roles or services to prisoners would not be welcomed. Overall, the results of this research lend support to a rethinking of the current model of health service provision. Some serious strategic planning is what is required to devise an overall framework for mental health service provision (i.e., an integrated correctional model), and to then fit the types of services and staff, to the goals and objectives of the correctional health services model. It is important for any course of action to be strategically thought out and purposeful, taking into account where the system, staff culture, inmate culture and services currently sit and knowing what direction the system and services need to reach. This type of planning will allow for any change to be embraced in an environment that is commonly change resistant. Any plan must include a vision and goals that health professionals and correctional staff can relate to and aspire towards. And any change to mental health services, or indeed any change to prison culture, will take time and strong leadership to empower others to participate in the change process. If the staff culture across prisons is improved, along with services, one would expect an improvement in the inmate culture and the mental health of the population.

This research used a mixed methodology design to explore and provide a ‘snapshot’ of mental health experiences in the offender population and to gain a

deeper understanding of the experiences of prisoners and staff in the prison environment. The combining of methods allowed for an enhanced scope, depth and exploration of findings creating both measurable and quantifiable data and data that gave precedence to insight and reflection based on individual experiences. This two-phase sequential research consisting of qualitative (semi-structured interviews and participant observation, n=17) and quantitative (survey questionnaire, n=168) Phases provided the means to gather data and many interesting and insightful findings emerged from the research.

A general observation throughout the interviewing phase of this research was the striking openness and self awareness of the participants. They invariably demonstrated a good understanding of their circumstances, mental illness and the impact of their lifestyle and they are taking responsibility for their (offending) behaviour and the consequences thereof. They have also shown a constructive willingness to participate in this research, and have expressed relatively balanced opinions about prison life. This experience supports the methodological choice and philosophical stance made at the beginning of this research process, and emphasises the value of self-reporting as a means for understanding and planning. It also supports the choice of the sampling method, in that, the balanced findings show there was not a bias on the part of nursing staff to choose prisoners who would report only 'positive' attitudes to health services. A good cross section of participants was selected through the use of a purposive sampling method. These men are experts on their own lives as can be seen in their construction of their problems (Goulding 2007).

The probability of a person with mental illness being arrested and imprisoned appears to be high from previous literature findings (Belfrage 1996; Hollins 1993; Ly and Forster 2005; Mullen 2000) and there is no doubt that there are increasing numbers of the mentally ill in prison populations. With the shift to deinstitutionalisation from psychiatric institutions and an increase in psychiatric drug treatment, current government ideology and policies put those who are identified with mental illness into the community resulting in many inadvertently become involved in the criminal justice system. This community care initially reduces the cost of supporting those so affected but the cost to society and the individual has been much greater and has remained hidden; in the long term the cost of crime and the cost of prison-based care is dear as are the numerous

personal and emotional costs of incarceration. It is ironic that many individuals with mental illness have to be locked in prison to get some form of psychiatric treatment. It would appear that this is an abdication of responsibility and there is a need for a shift in thinking to provide funding to improve service provision in a multifaceted and creative way as unfortunately, "the criminal justice system has largely taken the place of the state hospitals in becoming the system that can't say no" (Lamb and Bachrach, 2001, 1042).

Overall, there was unity in the staff and prisoner results from both phases of this research. The findings in Phase One were organised into four overarching themes; resources and funding; education and training; management, consultation, and context; and current service provision. There was generally overwhelming consensus from participants on the survey questions, and even though some were statistically significant and others were not, the findings still indicated that the difference was generally between those who strongly agreed and those who agreed in most cases. In some cases health/clinical professionals agreed more strongly and in other cases prison/senior officers agreed more strongly but overwhelmingly the findings were complementary of each other regardless of age, staff position, prison location (although Albany can be regarded as an outlier) or race. This cohesiveness of the QUAL and QUAN findings shows that staff report similar experiences and attitudes. However, despite the 'majority' responses there was also a pattern of 'undecided' responses in Phase Two with approximately 20% of the sample being unsure. These responses provided an opportunity to wonder why (i.e., fear, unable to imagine alternatives, insufficient training about mental illness) participants responded in this way, however, it is difficult to determine without additional research. In retrospect it may have been good to use a 4 or 6 point Likert Scale to remove the opportunity for the sample to be undecided on an issue.

The findings are unique, insightful and important and this research raised many questions in relation to responsibility and duty of care; treatment approaches; staff training and prisoner access to health information; the confidentiality of information; levels of staffing; resourcing; service delivery and the future of prison or hospital based care (or a mixture of both); bullying and vulnerability in the prison environment; conceptual/operative models and tension with issues regarding custodial/containment versus clinical/therapeutic care practices;

administrative systems and policy related issues; and has highlighted the experiences and issues faced by staff who work with, and prisoners who experience, mental illness.

Specifically, the findings illustrate that staff are feeling overwhelmed in an under-resourced and challenging working environment for which they are neither trained nor supported. Staff have a critical role to play in a person's care and treatment in prison and indeed throughout each prisoner's journey in the criminal justice system. It is crucial that staff feel supported, have strong leadership, and that prison and health procedures ensure that people with a mental illness are properly cared for in an ethical manner. There is no doubt that this is a difficult undertaking in the prison context and observations from this research, and the literature in the field, highlight the complexities of interactions between therapeutic treatment and security management. By their very nature prisons do not exist to provide mental health treatment; the prison exists to provide security and safety to the community. Prison is the revolving door that is tasked with punitive, deterrent, protective and rehabilitative functions - functions that are counterintuitive - and many of which, would be better addressed in a community setting. Therefore, it is imperative to be realistic about what can be achieved in the prison context; however this should not be used as a barrier to avoid issues that need to be tackled. What the findings from this research show is that staff are shouting for prison reform, however to date little improvement has been achieved, resulting in staff feeling that their voice is not heard.

The same complementarities could be said for the prisoner patient findings although more variability was recorded in terms of prisoners' experiences of treatment, services and the overall prison environment. Some prisoners reported satisfaction with their current treatment, and others were calling for something to be done to improve their situation. An important conclusion is that the men interviewed generally saw themselves as damaged and unwell people; they have significant insight into some facets of their lives. Although the findings lend support to Goffman and Bourdieu's ideas they also show that prisoners are able to maintain some sense of self identity whilst incarcerated. Prisoners strong views point to the maintaining of a self-image and their own opinions beyond prison values. However, as stated in the discussion chapter perhaps these views are simply self-preservation of a kind. Goffman claims that in institutionalised settings

an individual maintains an 'underlife' - the reserving of something of oneself from the clutch of an institution that is not an incidental mechanism of defence but an essential constitute of the self (1961, 305). The interviews in this study may have provided prisoners with an interaction or arrangement where they felt some sense of control, where they were not denied respect and regard for their views, and where they were therefore able to freely express their feelings, attitudes and opinions.

The majority of prisoners in this sample presented patterns of extensive mental distress living in prison and most of these men are victims of the system in many ways. At the same time, they seem to have very limited knowledge and access to any kind of facility that might provide genuine help or support. They are also limited in their own coping skills, mainly enduring the situation until it gets too bad and they go into crisis. This understanding returns the researcher to one of the initial points this research began with and focused on in the literature review chapter. These men represent a gestalt of problems and issues, and therefore holistic, multiple agency, long-term programmes of care and treatment are likely to be the most suitable response. To address just one problem (e.g. mental illness, drug use, trauma, social isolation, family breakdown, or abuse) is to ignore the co-morbidity between the different issues that dominate these men's lives (Goulding 2007).

There is evidence of some people with mental illness being victimised and disadvantaged in prison populations and this raises questions regarding society's duty of care to provide safe environments and treatment in prisons that are equal to that in the community (although given the limited standard of community care one could question the relevance of this comparison). The critical question of whether people with a mental illness suffer disadvantage in prisons purely because they have a mental illness is difficult to determine as it is likely that many individuals suffer in harsh and over populated prison populations, not just the mentally ill. Instead, apparent bullying and differential treatment may relate to a lack of understanding, knowledge and education of mental illness by other prisoners, staff and indeed the community at large and an inability to manage mental illness in prisons due to limited resources. It no doubt also relates to the inherent power struggles evident in prison culture as prisoners assert some control in order to survive. Further research concentrating on public perceptions of the

mentally ill, the mentally ill in institutions, and how these perceptions have changed and are changing over time would provide further insights into these issues. Moreover, the relationship between mental impairment and the disciplinary process is an important area in need of further research as this PhD study found that prison management are using disciplinary action to control and force prisoners to take medication in an environment that does not have the legislative power to involuntarily treat. This raises a number of human rights issues.

It needs to be remembered that prisons are dealing with and treating individuals, not just 'prisoners'. These individuals have a right to access voluntary rather than coercive treatment during their incarceration. Voluntary treatment (i.e., not reliant on bullying and segregation) can be made possible via the enhancement of the relationship between correctional staff, health professionals and prisoner patients; essentially an improvement in the prison cultures of these groups is required. There is a need to have sufficient and well informed staff who are able to manage the risks of this environment whilst capitalising on the opportunity to treat mental illness. Adams and Ferrandino (2008, 25) put this best when they said there is:

"a need to see treatment and behaviour management as compatible rather than as conflicting...appropriate and effective treatment serves a behaviour management function that can enhance the overall operation of the institution. Likewise, effective behaviour management can facilitate treatment...thus, we need to create more 'special' milieus so that inmates can locate settings that let them effectively function or, better yet, let them thrive."

This will be particularly important when prisoners are released into the community and the prison support networks are gone. A firm understanding of their illness, medication, effects on behaviour, behaviour management techniques and relationship building, will be crucial if people are to have a chance at re-integrating and living or 'thriving' as well as possible in the community, and not re-offending and repeating the cycle.

An inability to effectively manage prisoners with mental illness was systemic across prisons in this research sample and although some prisoner participants reported positive experiences of mental health care they did not have adequate treatment options or sufficient access to mental health professionals. Moreover, the findings suggest that some prisoners experience a mortification of self identity and a normalising of prison life; prisoners have little point of service comparison as many had very limited access to community care prior to their imprisonment or are institutionalised.

Staff reported that prisoners with mental health problems are over-represented in rule infractions and can take up a considerable amount of staff time and resources. It is a very encouraging finding that, despite staff desperation, many prisoners reported feeling adequately cared for in relation to their mental health. This was related to the personality of staff and the ability of staff members to form constructive, healthy, relationships with prisoners so that prisoners feel supported and involved in their treatment.

The findings of this research demonstrate that those prisoners who reported feeling listened to and supported also reported higher levels of satisfaction with services, decreased rates of stress, and more positive outlooks for the future. In order for these relationships to be fostered and for prisoner patients to trust in health professionals and correctional staff, it is important that there is a sufficient number of staff in each prison, that staff have plenty of access to prisoners, and that adequate amounts of time are provided for relationship building and therapeutic intervention. In the current community model situation, with 20 minute medical appointment times, participants felt that healthy treatment relationships were difficult to foster in an environment that is untrustworthy by its very nature. This was further illustrated by staff who felt like they were only crisis-managing prisoners, particularly in busy metropolitan prisons with large and demanding caseloads. The research literature supports the above findings and shows that forming therapeutic relationships with clients is central for both patients and nurses, and that this relationship has positive treatment effects (Martin and Street 2003). This care will ultimately increase trust between staff and prisoners with psychiatric illness and may reduce the number of behavioural incidents from prisoners as they do not feel so isolated. This thesis demonstrates a need for holistic mental health treatment based on expanded therapeutic options,

broader role definitions and appropriate training for correctional staff in order to reduce role conflict, improved access to training and education for health professionals, and a reduction in the current overreliance on the medical model as this does nothing to foster healthy relationships amongst prisoner patients and staff; one of the main driving forces behind successful mental health treatment.

Providing training to staff, and enhancing staff morale, is one of the preferred approaches to improve service provision in prisons. There is a need for a firmer commitment to modify and rethink the paradigm of corrections and change correctional staff attitudes from entirely security focused to care and treatment focused. If prisons are, as it appears, to be the 'new age' institution, taking the place of the 'dark age' psychiatric hospital, this role needs to be embraced. It does appear that prisons have been forced to adopt this role with little planning, discussion or agreement. That is, there has been little discussion and agreement of this arrangement at the society level; prisoners are being warehoused in prisons due to the failing of other services. It should be recognised that the point of incarceration provides an opportunity to assess, identify, diagnose, inform, educate, and treat the mentally ill. All staff in this environment will need to play an active role with this goal in mind. Giving prison officers the role as quasi-mental health agents, having them work closely with health professionals, and better managing the security-therapeutic tension, will vastly improve prison administrators' ability to achieve appropriate standards of care. However, it needs to be acknowledged that not all treatment can be provided in prison, that prison has other detrimental consequences, and that there will also need to be an improvement in community based services to reduce the overreliance on prison mental health treatment and the damaging effects of prison on the individual. At present, an assumption cannot be made that this service provision will be adequately provided or that people will be directed to the mental health system through the criminal justice system; these systems, and their roles, are blurred when it comes to mental health. These issues will become even more entrenched as the pressure on beds for patients, and cells for prisoners increases, and the demands for the provision of better and more encompassing services for people within the criminal justice system who have a mental illness increases.

The needs of offenders with mental illness are complex and will require a committed response spanning legislative, administrative, policy, and funding

initiatives. However, the needs of mentally ill prisoner patients are also practical and achievable in an effective system of service delivery. There is a clear need for safe and secure treatment; for a collaborative health/justice system and service models where there is a sharing of responsibility and expertise between relevant government (and, where appropriate, non-government) agencies; for a review of the interaction and model of care; access and early intervention in the community to reduce the numbers of mentally ill individuals in prisons; improved integration, re-entry and linkages with the community; increases in staff numbers and staff knowledge and training, including improved attitudes and skills; improvements in individual care so that it is of a high standard either in prison or psychiatric facilities; the need for new facilities to be provided; consistency of service provision and care across prisons and regions; strong governance, policy and procedures; improved accountability and performance management; and ongoing research and evaluation. The findings suggest that a team approach to treatment could improve outcomes. Individuals who work in the corrections field need to: feel empowered to undertake their job; have conviction in the decisions they make; be supported by management and have strong leadership; model sympathetic, understanding and caring behaviour; and be responsible and accountable, before prisoners can change, adopt healthy attitudes and lifestyles, and better manage their mental illness.

Ongoing research and evaluation is needed, in particular research on treatment outcomes and long-term follow up of prisoners released from prison and into the community looking at criminal, clinical and psychosocial variables. The use of quality of life measures and indicators may be of benefit in evaluating the goals and outcomes of mental health services and changes in the future. Research focusing on the experiences and needs of women in relation to mental health, and the experiences of juveniles who first enter the justice system, would also provide improved understandings. The findings of this research can be used as a benchmark of current experiences. This will allow for future research into prisoner and staff attitudes when services improve in Western Australia. Research in corrections settings is challenging and it is important for research to provide meaningful data and information that will assist in offering better services and interventions to meet the needs of prison populations.

Meeting the needs of disadvantaged populations will require innovative research and thinking. It would seem that society has reached a point where there is a need for a re-conceptualisation of the nature of prisons, punishment, security, rehabilitation and treatment. Prisons as they currently stand do not work to deter crime or to rehabilitate offenders. Furthermore, they currently do not have the capacity or philosophical underpinnings to adequately treat psychiatric illness. This is evidenced from the findings of this research, from the literature, and from the recidivism rates of those with mental illness and other offenders. Prisons merely remove 'unwanted', 'undesirable' and the most disadvantaged people from the community. This is not to say that prisons (or treatment centres, or education and training schools, or hospitals, or places of spiritual and emotional healing) could not do all of these things and are not required in some capacity. This thesis does not have all the answers and perhaps poses more questions. However, what is required is a change in thinking and action; a re-conceptualisation about how we 'treat' and care for people and the very nature and purpose of incarceration. This not only relates to prisoners with mental illness, but indigenous offenders, ageing prisoners, women in custody (and their children) and juveniles in detention. As society becomes more multifarious, these prison populations become more complex; as there is growing recognition and understanding of people's needs and individual human rights, prisons will in turn need to become more comprehensive treatment centres; or, other alternatives to incarceration will have to be developed.

The needs of prisoners with psychiatric illness and mental health problems are multifaceted and will require a committed response from corrections, social and community services and governments. Overall, this research has demonstrated that prisoners and staff have a great deal of insight into their experiences and their needs; we just need to catch up, listen to them, give them a voice in research and through consultation, and get on with offering the kinds of responsive services that should be readily available. According to Soderstrom (2008, 14) "it is imperative that jail and prison officials embrace the treatment mandate before them." According to the prisoners in this research it is imperative that we *"stand up and do something for the mentally ill, not just talk about it..."*

There is an urgent need to support staff with additional training and appropriate administrative systems and to improve holistic service delivery to prisoners with

mental illness. The main challenge will be how these services are implemented in an environment that is inherently challenging, with primary caregivers (prison officers) who are not health professionals, to prisoners who are institutionalised by disciplinary power. Strategies and solutions to address the current shortcomings must be holistic, take a team care multi-disciplinary approach, and be as personalised as possible. These are all services that should be currently available in both prisons and the community, that is, in a well thought out and multi-faceted model of mental health service delivery. The expressed experiences of prisoners and staff confirm that this approach is not presently available but that it is certainly achievable via a well designed correctional model of health care delivery.

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Additional Resources

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“We are mad, not only individually, but nationally. We check isolated manslaughters and murders; but what of war, the much - esteemed crime of slaughtering whole peoples?”
Seneca, Epistles, 95, 30.

APPENDICIES

Appendices A - The 2005 Media Focus on Mental Health in Australia

“We are only one headline away from a policy crisis”

Issues related to community mental illness, the prevalence of mental illness in prisons and the ways in which prisoners were handled have been the focus of a number of articles published in newspapers and magazines, and the focus of documentaries in recent years. There have also been significant events in the area of mental health policy. Below is a sample of the material that was in the media and policy that took place during the course of the research. This is not an exhaustive list but provides an example of the many recent developments and climate of rapid change in the area of mental health.

In April, June and July (2005) the West Australian published these articles:

- ❖ “Prisons warehouse mental cases: parole board chief” - prisoners who shouldn’t be there are being warehoused in prisons are there is nowhere else for them to go. Many of these people should be in hospital but there are no places for them. The parole board in Western Australia finds it very difficult to have people placed outside of the prison in secure facilities with adequate supervision. This is a common dilemma for the parole board.
- ❖ “New unit for mentally ill defendants” - about 26% of Western Australia’s 3500 prisoners have a diagnosed mental health condition. Many of these individuals are kept warehoused in Western Australian jails for years at a time with the prospect of never being released. Current attention and focus on cases has prompted consistent calls for a dedicated facility to care for individuals.
- ❖ “Western Australia ‘worst’ for mental services” - the human rights commissioner slams Western Australia’s mental services in the South West of Australia as the worst in Australia. Country services in Western Australia are seriously lacking and when crisis occurs many patients have to be driven by police to Perth.

In July of 2005, The Weekend Australian published a number of articles with issues relevant to mental health. The articles included:

- ❖ The release of a paranoid schizophrenic prisoner without medication or direction to seek help from Risdon Prison in Hobart. The apparent lack of post-release services in the community meant that many mentally ill prisoners were forced to manage in the community for long periods of time before accessing mental health clinics.
- ❖ A 22 year old prisoner was released from Long Bay Prison in Sydney after many periods of imprisonment. He later stole a vehicle and drove himself to the police station asking officers to lock him up again. He was held for a while, released on bail and then committed suicide.
- ❖ In 1983 the Richmond Report was released that proposed progressively shutting down large psychiatric hospitals in NSW. The author, David Richmond, was quoted saying that a new model is needed “Fundamentally the planning and precepts of the 1980s were for a different kind of community.” De-institutionalisation was not counterbalanced with community based care and has led to prisons doing the job of the psychiatric hospitals that emptied following this report (Breen, 2005).
- ❖ Issues of budgeting were raised in Queensland with comments that the prison system provided significant funding for incarceration but very little on post release services. Guaranteeing post release services can reduce the rate of recidivism, drug overdose and suicide (Breen, 2005).
- ❖ In NSW a proportional increase in prisoner population coincided with the deinstitutionalisation of many of the mentally ill. The call to re-open secure psychiatric wards has been accompanied with demand for secure hospital facilities and acute and sub-acute beds. A 1996 Corrections Health found that half the women and one third of the men in prison in NSW said they have been diagnosed with a mental illness at some time in their lives. These prisoners often end up being untreated in the general prison population (The Weekend Australian, 2005).
- ❖ Also in on the 14th July 2005 the ‘Palmer Report’ was released: this was an inquiry into the circumstances of the Immigration Detention of Cornelia Rau, which raised concerns about mental health care in prisons and in immigration detention.

In September (2005) the ABC's Four Corners program showed a documentary called 'Asylum' looking at the nature of institutionalisation.

In October (2005) the West Australian published two articles (amongst others) including:

- ❖ "Our Mentally Ill are Missing Out on Help" - The mentally ill are missing out on help due to the under-funding of services. This under-funding of the system puts psychiatric patients at serious risk. Those who get involved with services in Western Australia have serious mental illness, such as schizophrenia, bipolar disorder, or major depression. Ten per cent of sufferers of all of these illnesses will ultimately die of suicide (Dr Paul Skerritt, 2005).
- ❖ Care of Mentally Ill Failing: MP - Call for a return to a system of mental institutions to get psychiatric patients out of community care that has failed to meet their needs. MLA Janet Woollard made this claim and stated that long-term mental illness is best cared for in an institutional-style setting rather than by families, who often struggle to cope (Dr Paul Skerritt, 2005).

In October (2005) the Insight program on SBS looked the issues surrounding mental health in Australia.

On the 19th October 2005 the *Not for Service* report was released. This was a project of the Mental Health Council of Australia, the Human Rights and Equal Opportunity Commission and the Brain and Mind Research Institute.

On a positive note on 19 October a statement was released showing that 'Western Australia leads the nation in mental health funding'.

On the 21st December 2005 the National Mental Health Report 2005 was released which provided a ten year view of trends across the First and Second National Mental Health Plans.

On the 10th February 2006 there was a discussion of mental health reform at the Council of Australian Governments (CoAG) meeting in Canberra.

In April of 2006 the Federal Government announced that it will commit 1.6 Billion dollars to mental health reform over five years.

Appendices B - Definitions

The Australian National Mental Health Plan 2003-2008

The National Mental Health Plan 2003-2008 defines mental health as a:

“state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential” (5)

and that:

“Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities” (5).

Mental Illness (or mental disorder) is described in the Plan as:

“a clinically diagnosable disorder that significantly interferes with an individuals cognitive, emotional or social abilities” (5).

Diagnostic and Statistical Manual of Mental Disorders

The term mental disorder is defined in the DSM-IV. A mental disorder “is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual” (56).

DSM-IV consists of five groups of diagnostic categories called “axes.” Axis I includes the major psychiatric disorders and diagnoses, such as the psychoses, mood disorders, etc. Formally, Axis 1 is the group of categories for coding Clinical Disorders and Other Conditions, which may be a focus of clinical attention (e.g., family/vocational problem). Axis II is for Personality Disorders and Mental Retardation exclusively; Axis III is for General Medical Conditions. Axis IV is for Psychosocial and Environmental Problems (i.e., stressors related to Axes I and II) and Axis V is for Global Assessment of Functioning.

Substance use disorders are part of Axis I and is the term that refers to a habitual pattern of alcohol or illicit drug use that results in significant problems related to aspects of life, such as work, relationships, physical health, financial well-being, etc. There are two mutually exclusive sub-categories - substance *abuse* and substance *dependence*. In some cases, substance *use* (as distinct from abuse or dependence) negatively affects people with mental health problems.

Based on DSM-IV classification, concurrent disorders refers to a substance use disorder in combination with an Axis I or Axis II mental health disorder. Using a system like DSM-IV as the basis for the definition of concurrent disorders may at times seem like an overly medical and psychiatric approach. However, this approach for classifying concurrent disorders is the most widely used in the research literature, and has been used in previous attempts to define best practices in this area. This practice is continued because appropriate treatment and support in the mental health field, including drug therapies, comes after accurate assessment and diagnosis. It follows then that the same holds true for people with concurrent mental health and substance abuse problems; a mental health diagnosis can be established by non-medical professionals, such as registered psychologists; a broad psychosocial rehabilitation approach is now widely regarded as essential for effective care and support of people with severe mental illness. In the same view, the treatment and support of people with concurrent disorders goes well beyond strictly medical/psychiatric interventions.

This Study focused on all disorders in Axis I and personality Disorders in the Axis II range.

High and Low Prevalence

Another way to talk about mental illnesses is to refer to high prevalence and low prevalence disorders. The most widely known high prevalence disorders are depression and anxiety disorders while the most widely known low prevalence disorders are schizophrenia and bipolar disorder. High prevalence disorders are experienced by about 20 percent of the population for depression and 10 percent of the population for anxiety disorders. Low prevalence disorders may affect about one percent of the population for schizophrenia and two percent of the population for bipolar disorder (SANE 2002).

Corrective Services

People with cognitive impairment are “identified as those as having either a psychiatric disorder (e.g., psychosis, neurosis, personality or behaviour disorders), an organic impairment (e.g., dementia), or a developmental disorder (e.g., mental retardation) that affects cognitive or emotional functions to the extent that capacity for judgment and reasoning...is somewhat diminished” (Grudzinskas 2003, 6). For this study only those who have an identified mental illness (e.g. psychiatric disorder, including bi-polar disorder, depression and self-harming behaviour) will be included in the research¹⁴. This will not include individuals with developmental disorder or intellectual disability, however, it will include individuals with personality disorders and in some instances may include individuals with co-morbidity.

Terms used in Western Australia

The terms decision-making disability, mental illness, and dangerous and severe personality disorder (DSPD) are defined and applied in Western Australia by various government bodies (notably the Department of Corrective Services). The term decision-making disability is an overarching term that refers to people who lack the capacity to make reasoned decisions, and includes people with a mental illness, acquired brain injury, and intellectual disability. Lacking capacity for decision-making means a person is unable to:

- Understand the context of the decision to be made;
- Understand the options available;
- Consider the likely consequences of each option and make a decision consistent with his or her values; and
- Communicate his or her decision in some way.

The term mental illness describes a group of illnesses that are diagnosable mental disorders¹⁵ caused by dysfunction of the brain, characterized by alterations in thinking, mood, and/or behaviour. Mental illnesses are generally associated with distress and/or impaired functioning.

¹⁴ That is, those flagged on the Total Management System (TOMS) as having a history of mental illness (psychiatric alert) and referred by Department of Corrective Services Health Services. TOMS is one of the Departments computer based recording information technology systems for storing prisoner information, prisoner movements and other prison related information, including health and psychiatric alerts.

¹⁵ Mental disorder is a psychiatric term, and is the definition preferred in most of the international literature. This term will be used interchangeably with mental illness and mental health problem in this paper.

The term dangerous and severe personality disorder (DSPD) is used to describe a subset of personality-disordered people who display symptoms of one or more of the following categories of personality disorder:

- Cluster A (the odd and eccentric types): paranoid, schizoid, and schizotypal.
- Cluster B (the dramatic, emotional or erratic types): histrionic, narcissistic, antisocial, and borderline personality disorders.
- Cluster C (the anxious and fearful types): obsessive-compulsive, avoidant, and dependent.

(Source: Department of Corrective Services, 2006).

Mental Illness and Intellectual Disability

It is important to distinguish between mental illness and what is usually referred to as intellectual disability. The two conditions are very different, contrary to views of many people in the community (McAfee and Gural 1988). Ellis and Luckasson (1985) express the distinction in this way:

“Mentally ill people encounter disturbances in their thought processes and emotions; mentally retarded people have limited abilities to learn...Most mentally retarded people are free of mental illness” (424).

They stress the fact that mental illness is frequently temporary, cyclical or episodic, whereas an intellectual disability remains relatively constant through life.

Criminology Terminology

For this research, prisoners/inmates/offenders are defined as “any individual confined or detained in a penal institution...individuals sentenced to such institution under criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures [as]...alternatives to criminal prosecution or incarceration...and individuals detained pending arraignment, trial, or sentencing” (Grudzinskas 2003, 8). These words are used in the literature interchangeably depending on the country of the research. In Western Australia, the Department of Corrective Services uses the word prisoner to refer to an offender who is incarcerated in a state prison. The Department of Health Services uses the word patient or prisoner patient to refer to a prisoner who experiences

health related problems. The word client is also used by some professionals in the prison context.

As this research falls within the health, social work, psychology and criminology fields I felt that it was appropriate to use the terms 'prisoner', 'inmate', 'offender', 'patient', 'client' and 'prisoner patient' interchangeably.

Forensic - a forensic patient is defined by the legislation and the WA Act and is generally an individual housed in a State Psychiatric facility. This individual may also be in prison or be transferred back to forth between facilities. The majority of the prisoners in this study were mainstream prisoners who have mental health disorders. When this thesis uses the word forensic is generally refers to forensic psychiatric mental health services.

Appendices C - Mullen, 2001

Mental Health Services (this whole section taken or adapted from Mullen, 2001. For a complete overview refer to *Mental Health in the Criminal Justice System - A Review of the Relationship between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services*).

Assessment and Acute Intervention Service

All prisoners should have a comprehensive assessment and acute intervention service which enables prisoners with mental health concerns to be seen at any stage of their incarceration. This service should have inbuilt mechanisms for self referrals, referrals to be made by custodial staff and health staff or to be seen following representations by relatives, friends or fellow prisoners. This process should take the form of an initial screening with a qualified mental health nurse with subsequent referral to a psychiatrist if needed (Weisman, 1998).

Assessment and Acute Care Unit

At the least, prisoners should have easy and rapid transfer and access to a psychiatric care unit within the prison which allows prisoner patients further assessment and short-term treatment. Ideally this should be staffed 24 hours a day by professional and specialist mental health staff and in this context there is also always the presence of custodial staff. Psychiatrists, clinical psychologists, social workers, nurses and mental health nurses should all have regular input into the unit and have opportunities to develop the skills and knowledge of custodial staff in more sensitive and effective ways of managing distressed and disturbed prisoners under their care. If patients show signs of improvement after short-term stay they can exit from this unit into the mainstream prison setting with a well established on-going care plan, however, for those prisoner patients who do not improve timely transfer should be made to an outside specialist hospital (Mullen, 2001).

Medium Stay Units

Medium stay units are designed to care for prisoner patients for periods of around 3-6 months and allow for initial treatment and stabilisation and some level of rehabilitation of the patient's disorder. These units have a history of accruing vulnerable individuals who have chronic psychotic disorders or who are self

harming individuals with ongoing concerns of suicidal and self damaging behaviour (Mullen, 2001). It is essential that these units have an avenue for prisoner patients to be transferred to long-term mental health care and hospitalisation in order to best cater for their needs which is doubtful that the prison environment will be able to provide.

Long Term Care Units

Long-term stay units are designed to take care and manage prisoners with chronic mental disorders, brain damaged and those with intellectual disability. These units have ongoing occupational therapy and educational facilities and mental health facilities run like a community outreach program. Patients usually require on-going care and are required to stay on a long-term basis. The exit from this unit may, under special circumstances, be back into the mainstream prison population or into a more intensively staffed mental health ward (Mullen, 2001).

Special Units for Severe and Dangerous Personality Disorder

Prisoners who are described as having dangerous and severe personality disorder (DSPD) are difficult to manage and treat. How to treat and manage these prisoners is receiving attention in both England, where a considerable amount of developmental work is taking place, and also in Australia. There is no specific treatment or management regime for personality disorders prisoners in Western Australia; however, it is a current focal point due to media focus and attention. The State Government is looking at establishing special units for managing these offenders.

Suicide Minimisation Program

These units are designed to allow for the monitoring, identification and intervention with prisoner patients who pose a considerable risk to their own safety. The suicide minimisation program usually runs separately from other mental health services in order to emphasise its role and the importance of suicide prevention in the prison environment and prison administration. Suicide prevention should be an ongoing responsibility of the whole prison system not just mental health services (Mullen, 2001).

Hospital Support outside Prison

Secure and medium forensic mental beds need to be available to prisoner patients who require transfer to more intensive psychiatric care hospitals outside of the

prison. "Prison mental health services are equivalent of community based outpatient services, not equivalent of a specialised inpatient psychiatric units" (Mullen, 2001, 40). These units should be available as part of an all encompassing mental health service and should have adequate space and allow for the ongoing hospitalisation of mentally disordered prisoners requiring acute hospital care. Of the nature of these units Mullen (2001) states "in my views just as with inpatient medical treatment such units should be placed alongside other inpatient mental health facilities not continuous to correctional facilities"...he goes on to state that the "transition from prison to community is critical and mental health services in prison need to establish the appropriate links to community services to provide as clear and speedy transfer of care for the prisoner as is practical. It is here that so many care plans come adrift. In an ideal world prisoners with serious mental disorders, like schizophrenia, should serve the last part of their sentences in local general psychiatric units or forensic units preparing for their return to the community" (40).

Through care in the Community

This section is outside of the scope of the present Phase Two it is necessary to touch on it briefly as it is important that those prisoners who are returned to the community have adequate access to services once outside of prison. This includes access to any medications they were taking whilst in prison, community links with GP's and services to help them appropriately manage their mental illness. It is here that many systems fall down and long waiting lists for community care prevent patients from having appropriate access to treatment and medications and often sees their mental state decline increasing the likelihood of re-offending.

There is a well established debate around; who has responsibility for community care of those who are mentally disordered with a history of offending? Many community organisations are undecided as to who has responsibility for mentally disordered offenders. Do general mental health services fulfill this function or should separate and parallel services be established for those who are both mentally disordered and have a history of offending? (for further information refer to - Gunn, 1977; Gallwey, 1990; Muller-Isberner, 1996; Whittle and Scally, 1998; Heilbran and Griffin, 1998). Very often, as with much of this area, the argument comes down to cost.

Appendices D - Phase One Staff Qualitative Research Guide



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Qualitative Research Question Guide (Staff)

Note: These questions have been designed to act as a guide only. At no time will they be given to participants. The interviews will be semi-structured and the questions will act as a template and prompt for the researcher of topics to cover. Additional topics may be added or removed to the question list as issues become pertinent to the researcher.

Topic: Mental Health/Psychiatric Illness in Western Australian Prisons: A Study of Staff and Male Prisoner Patients Experiences.

Demographics:

Time:

Location:

Interviewer's name and position: Kate Hancock – Principal Researcher

Interviewee's name and position:

Summary of Study: The core aim of this study is to collect informative information on staff and prisoners experiences in Western Australian prisons.

Research Objective: To gain a greater understanding of the issues facing prison staff when working with mentally ill prisoners.

- To gain a greater insight into the attitudes of staff in relation to current services, treatment and facilities.

Interview Areas to Explore

<p>Prompt Questions What role do you see yourself as having in relation to assessing and/or diagnosing and/or treating of</p>	
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<p>prisoners (patients) who have/or are suspected of having mental illness?</p> <p>Can you explain the process that takes place when someone is diagnosed or thought to be suffering from a mental illness? What are your thoughts of/on this process?</p> <p>Do you think the reception/orientation process needs to be sensitive to the individual mental health prisoner's issues as they come into prison?</p> <p>What do you feel is the most effective way of treating people suffering from various disorders in the prison environment? (Personality, anxiety, psychotic and mood disorders).</p> <p><i>(Notes for interviewer -By?</i> <i>Drugs</i> <i>Segregation from other prisoners</i> <i>Isolation units</i> <i>Programs</i> <i>Counselling</i> <i>Therapeutic intervention</i> <i>Being transferred to a secure hospital unit</i> <i>Other)</i></p> <p>How do you feel (what are your attitudes?) about the current treatment of prisoners with mental illness?</p> <p>What are your feelings/attitudes (what do you think about) towards mental health offenders in custody?</p> <p><i>(Notes for interviewer - Easy or hard to work with?</i> <i>Have complex issues?</i> <i>Demanding and time consuming?)</i></p> <p>What problems, if any, do you experience with the assessing and/or diagnosing and/or treating of prisoners (patients) who have/or are</p>	
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suspected of having mental illness?

Do you think it is important to make time to listen to prisoners who experience mental health issues?

Do you think it is appropriate/necessary to explain reasons for decisions to mentally ill prisoners?

Do you think prisoners who experience mental health problems are treated differently by staff and other prisoners?

If so, in what way?

Why do you think this happens?

What are your attitudes/thoughts on the current level of services provided for the assessment, diagnosis and treatment of mental illness in the prison/s you work in?

What, if any, other services would you like to see implemented/provided in the prison/s you work in for people with mental illness and staff?

How would this improve the level of service you provide and patients receive?

From your experience what currently works well in the service you provide to those with mental health problems?

How do you feel the overall mental health of the prison population can be improved?

In your experience, what mental health disorders are the most prevalent in the prison you work in?

From your experience do you think that the numbers of prisoners with psychiatric issues is increasing/has increased in the time you have worked in prisons?

(Notes for interviewer - If yes, why

<p><i>do you think this is the case?</i> <i>Improved screening and awareness?</i> <i>Larger prison population?</i> <i>Increases in illegal drug use?</i> <i>De-institutionalisation of psychiatric wards?</i> <i>Other...?)</i></p> <p>How do you make decisions about priorities when there is limited access to services and resources?</p> <p>Do you feel that you have adequate support when faced with mental health/psychiatric crisis issues? What kind of support would you ideally like to have when faced with a crisis situation? If yes, what kind of support do you and why does it work well?</p> <p>Have you adopted/adapted your own attitudes and approach/actions to dealing with prisoners who experience and are diagnosed with mental illness? Can you share these attitudes and this approach/action with me?</p> <p>Do you feel that the approach you adopt impacts/contributes to the stability and wellbeing of the prisoner under your care?</p> <p>Do you feel there are adequate operational guidelines (are there guidelines/policy?) for you to operate within when dealing with prisoners who experience mental illness?</p> <p>Do you feel you have adequate training or access to training to have persons with mental illness under your care? What type of training do you think would be useful for you to undertake?</p> <p>What are your experiences of dealing/interacting with prisoners who experience mental illness?</p>	
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<p>Can you think of any specific situations you have encountered and can tell me about?</p> <p>Do you think that prisoners with mental illness have different needs to the rest of the prison population? If so, what are these needs?</p> <p>Do you feel that mentally ill prisoners need to be managed differently from other prisoners? In what way?</p> <p>Do you think that metropolitan and regional prisons have different needs in relation to the way they treat and manage offenders with mental illness?</p> <p>Do you feel comfortable (job satisfaction) working with prisoners who experience mental health/psychiatric issues?</p> <p>What topics do you think are important to study in the prison environment in relation to prisoners with mental illness?</p> <p>Are there any things that you think it is important for me to ask staff and patients (prisoners) in relation to mental illness and mental health in the prison environment?</p> <p>Do you have any thing else you would like to add that is related to the topic?</p>	
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Template adapted from Creswell (1998, p.127, Figure 7.5: Sample Interview protocol)



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Qualitative Research Question Guide (Prisoner/patients)

Note: These questions have been designed to act as a guide only. At no time will they be given to participants. The interviews will be semi-structured and the questions will act as a template and prompt for the researcher of topics to cover. Additional topics may be added or removed to the question list as issues become pertinent to the researcher.

Topic: Mental Health/Psychiatric Illness in Western Australian Prisons: A Study of Staff and Male Prisoner Patients Experiences.

Demographics:

Time:

Location:

Interviewer’s name and position: Kate Hancock – Principal Researcher.

Interviewee’s name and position:

Summary of Study: The core aim of this study is to collect informative information on staff and prisoners experiences in Western Australian prisons.

Research Objective: To develop a greater understanding of the issues, experiences and needs of prisoners who experience mental health problems and psychiatric illness in custody in Western Australia.

Interview Areas to Explore

Prompt Questions	
<p>Have you had problems that have affected your mental/psychiatric health?</p> <p>Have you seen a doctor or has a doctor advised you about this? Have you ever had a previous assessment for your mental illness? Did your GP or someone else in the past pick it</p>	

up/diagnose it? (*Note for Interviewer - do you think you have a mental health problem?*).

What has it meant for you having this problem/illness and living in prison? How have you found it adjusting to prison life?

What kind of problem/illness do you have (identified by the doctor that you have?) (think you have)?

Was your mental health/psychiatric illness picked up upon entry into the prison system through the initial prison assessment or were you later diagnosed?

How was it discovered that you had a mental health problem/illness and by whom?

Once it was discovered that you had a mental illness what happened?

Who were you referred to?

How long did you have to wait to be seen?

What treatment were you recommended? What kind of treatment are you receiving now? Are you happy with this treatment/is it working for you?

Do you feel that you have adequate access to care, services and treatment in relation to your mental health/psychiatric needs?

If so, what works well for you and why does it work well?

If not, what could be done to immediately improve things for you (besides being let out on the street).

What could be done on a long term basis to improve things for you?

Who would you like to provide these services? (Doctors, nurses, social workers, psychologists, program workers, others?). Why?

What do you feel are your short term and long term needs in relation to your mental health problem?

What level of comfort (*Note to researcher - trust*) do you have in the prison health system?

<p>Do you feel like the services are compromised because the ‘prison system’ has access to information about your health?</p> <p>Do you feel supported by health staff to be on your side or do you feel like the staff can not be trusted?</p> <p>Do you feel you are treated differently by other prisoners and staff because you have a mental illness? If so, in what way and how does this make you feel?</p> <p>Can you describe what it is like to live in prison with a mental health problem/psychiatric illness?</p> <p>Have you ever been placed in isolation/segregation on disciplinary action? How did this make you feel?</p> <p>What topics do you think are important to study in the prison environment in relation to prisoners with mental illness?</p> <p>Are there any things that you think it is important for me to ask staff and patients (prisoners) in relation to mental illness and mental health in the prison environment?</p> <p>Do you have any thing else you would like to add that is related to the topic?</p>	
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Template adapted from Creswell (1998, p.127, Figure 7.5: Sample Interview protocol)

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Cricos Provider Code 00301J

Information Sheet

Mental Health/Psychiatric Illness in Western Australian Prisons

My name is Kate Hancock. I am a PhD research student at Curtin University and an employee at the Department of Corrective Services. I am working on a project looking at mental health and psychiatric illness in the prison environment as part of my studies at Curtin. I am contacting a number of staff and prisoners about their experiences of mental illness and mental health services in prison. This research has been approved by the Department's Research Committee. You have been chosen because of your experience and knowledge.

What will I have to do if I take part?

If you agreed to take part, you will be asked to answer some questions in an interview. There are no right or wrong answers – I am just interested in your experience. The interview should take about an hour to complete and will contain questions relating to your experiences of working with prisoners who experience mental health/psychiatric issues in prison and what services are available for prisoners. The interviews will be audio recorded and you will be required to give consent for me to tape record the interview. It is important that the interviews are tape recorded in order for me to accurately reflect your thoughts. Unfortunately it will not be possible to participate if you do not give consent for the interview to be recorded.

Do I have to take part?

No, **taking part is voluntary**. If you don't want to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind. If you want to participate but change your mind later, you can withdraw from the Phase One at any time without having to give any reasons.

If I agreed to take part what happens to what I say?

All the information you give me **will be confidential** and used for the purposes of this study only. The data and interview notes will be collected and stored for 5 years in locked filing cabinets and computer hardware that requires passwords to be

accessed and will be disposed of in a secure manner. All tape recordings will be wiped once the interview material is typed up into notes. The information will be used in a way that will not allow you to be identified individually and pseudonyms will be established for all participants to help maintain confidentiality. The interview material will be typed up by the researcher. The results of this study may be published in reports and research journals, however you will not be able to be identified in these publications.

What do I do now?

Please think about the information on this sheet, and ask me if you are not sure about anything. If you would like to take part, you can contact me on the number below and we can organise a time for me to come and meet you and do the interview. You will also sign a consent form. The consent form will not be used to identify you. It will be filed separately from all other information. If, after the discussion, you want any more information about the study contact me directly during business hours.

My contact details are:

Kate Hancock
 Work Number: 08 9264 1848
 Email: kate.hancock@student.curtin.edu.au
 Postal Address: PO BOX 87 Mundaring, WESTERN AUSTRALIA, 6073

Best wishes

Kate Hancock

THANK YOU VERY MUCH FOR YOUR HELP!

This study has been approved by the Curtin University Human Research Ethics Committee. HREC Approval Number HR 134/2005 If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Informed Consent

Mental Health/Psychiatric Illness in Western Australian Prisons

*This form is to be completed independently by the participant

Name:.....

Prison:.....

Position (e.g. Officer, Nurse, Social Worker):.....

	Yes	No
1. I understand the attached information sheet and have had the opportunity to ask questions.		
2. I understand that I can withdraw from the Phase One at any time without having to give any reasons.		
3. I am aware of, and consent to the tape recording of my discussion with I.		
4. I am aware of, and consent to I taking notes during the course of the discussion.		
5. I understand the results of this study may be published in reports and research journals and that I will not be able to be identified in these publications.		
6. I give consent that I would like to be involved in this research project.		

Signature of Participant:.....

Date:.....

Signature of Researcher:.....

Date:.....

Should you need to contact me my contact details are:

Kate Hancock
 Work Number: 08 9264 1848
 Email: kate.hancock@student.curtin.edu.au
 Postal Address: PO Box 87 Mundaring, WESTERN AUSTRALIA, 6073

This study has been approved by the Curtin University Human Research Ethics Committee. HREC Approval Number HR 134/2005 If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Appendices G - Phase One Prisoner Patient Information Sheet and Consent Form



Faculty of Education, Language Studies and Social Work

Information Sheet

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Cricos Provider Code 00301J

Mental Health/Psychiatric Illness in Western Australian Prisons

My name is Kate Hancock. I am a PhD research student at Curtin University and an employee at the Department of Corrective Services. I am working on a project looking at mental health/psychiatric illness in the prison environment as part of my studies at Curtin. I am contacting a number of prisoners about their experiences of mental illness and mental health services in prison. The research findings will be used to help improve outcomes for prisoners and to improve service provision. You have been chosen because of your experience and knowledge.

What will I have to do if I take part?

If you agreed to take part, you will be asked to answer some questions. There aren't any right or wrong answers – I am just interested in your views and experiences. The interview should take about an hour to complete and will contain questions relating to your experiences in prison. The interviews will be audio recorded and you will be required to give consent for me to tape record the interview. It is important that the interviews are tape recorded in order for me to accurately reflect your thoughts. Unfortunately it will not be possible to participate if you do not give consent for the interview to be recorded.

Do I have to take part?

No, **taking part is voluntary**. If you don't want to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind. You can pull out of the discussion at any time without prejudice. If you want to participate but change your mind later, you can withdraw from the Phase One at any time without having to give any reasons.

If I agreed to take part what happens to what I say?

All the information you give me **will be confidential** and used for the purposes of this study only. However, I must inform management if something leads me to believe that either your or another inmate's health and safety is at immediate risk. The data and interview notes will be collected and stored for 5 years in locked filing cabinets and computer hardware that requires passwords only known to me and will be disposed of in a secure manner. All tape recordings will be wiped once the interview material is typed into notes. The information will be used in a way that will not allow you to be identified individually. Prison authorities or other prisoners will not be able to link any information provided by you and pseudonyms (made-up names) will be established for all participants. The interview material will be typed

up by a professional typist who will sign a guarantee of confidentiality. The results of this study may be published in reports and research journals, however you will not be able to be identified in these publications.

What do I do now?

Think about the information on this sheet, and ask me if you are not sure about anything. If you agreed to take part, you should notify the prison contact person on this sheet and I will come out to visit you to do the interview. You will also sign a consent form. The consent form will not be used to identify you. It will be filed separately from all other information. If, after the discussion, you want any more information about the study, tell the prison contact person, who will contact me or you can contact me directly during business hours on the number below or have a staff member call me and I will call you back promptly if you do not have access to the telephone.

My contact details are:

Kate Hancock
Work Number: 08 9264 1848
Email: kate.hancock@student.curtin.edu.au
Postal Address: Po Box 87 Mundaring, WESTERN AUSTRALIA, 6073

Best wishes

Kate Hancock

If you feel upset after the discussion and need help dealing with your feelings, it is very important that you talk to someone right away.

The contact details for the person to talk to are:

.....
.....
.....

THANK YOU VERY MUCH FOR YOUR HELP!

This study has been approved by the Curtin University Human Research Ethics Committee. HREC Approval Number HR 134/2005. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Informed Consent

Mental Health/Psychiatric Illness in Western Australian Prisons

*This form is to be completed independently by the participant

Name:.....

Prison:.....

	Yes	No
1. I understand the attached information sheet and have had the opportunity to ask questions.		
2. I understand that I can withdraw from the Phase One at any time without having to give any reasons.		
3. I understand that withdrawing from the study will not affect my parole or length of prison service.		
4. I am aware of, and consent to the tape recording of my discussion with I.		
5. I am aware of, and consent to I taking notes during the course of the discussion.		
6. I understand the results of this study may be published in reports and research journals and that I will not be able to be identified in these publications.		
7. I understand that everything I say is confidential. However, I must inform management if: Something leads I to believe that either I or another inmate’s health and safety is at immediate risk.		
8. I give consent that I would like to be involved in this research project.		

Signature of Participant:.....

Date:.....

Signature of Researcher:.....

Date:.....

Should you need to contact me my contact details are:

Kate Hancock

Work Number: 08 9264 1848

Email: kate.hancock@student.edu.au

Postal Address: Po Box 87 Mundaring, WESTERN AUSTRALIA, 6073

This study has been approved by the Curtin University Human Research Ethics Committee. HREC Approval Number HR 134/2005. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Appendices H - Phase Two Prisoner Patient Information Sheet and Consent Form



Department of Education

Department of Languages
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Intercultural Education

Information Sheet

**Mental Health/Psychiatric Illness in
Western Australian Prisons**

Department of Social Work
and Social Policy
GPO Box U1987
Perth WESTERN
AUSTRALIA 6845

Tel: +618 9266 7617
Fax: +618 9266 3186

My name is Kate Hancock. I am a PhD research student at Curtin University and an employee at the Department of Justice. I am working on a project looking at mental illness in the prison environment as part of my studies at Curtin. I am contacting a number of prisoners about their experiences of mental illness and mental health services in prison. The research findings will be used to help improve outcomes for prisoners and to improve service provision. You have been chosen because of your experience and knowledge.

What will I have to do if I take part?

If you agreed to take part, you will be asked to answer some questions. There aren't any right or wrong answers - I am just interested in your views. The questionnaire should take about half an hour to complete and will contain questions relating to your experiences in prison. I will come and meet you and we will fill in the questionnaire together.

Do I have to take part?

No, **taking part is voluntary**. If you don't want to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind. You can pull out of the discussion at any time without prejudice. If you want to participate but change your mind later, you can withdraw from the Phase Two at any time without having to give any reasons.

If I agreed to take part what happens to what I say?

All the information you give me **will be confidential** and used for the purposes of this study only. However, I must inform management if something leads me to believe that either your or another inmate's safety is at immediate risk. The data will be collected and stored for 5 years in locked filing cabinets and computer hardware that requires passwords only known to me and will be disposed of in a secure manner. The information will be used in a way that will not allow you to be identified individually. Prison authorities will not be able to link any information provided by you. The results of this study may be published in reports and research journals, however you will not be able to be identified in these publications.

What do I do now?

Think about the information on this sheet, and ask me if you are not sure about anything. If you agreed to take part, you should notify the health staff member who asked if you would like to participate and I will come out to visit you to fill out the questionnaire. You will also sign a consent form. The consent form will not

be used to identify you. It will be filed separately from all other information. If, after the discussion, you want any more information about the study, tell the prison contact person, who will contact me or you can contact me directly during business hours.

Should you need to contact me my contact details are:

Kate Hancock
 Work Number: 08 9264 1848
 Email: kate.hancock@student.curtin.edu.au
 Postal Address: Post office box to be advised

The person to contact at your prison if you wish to participate is:

Best wishes

Kate Hancock

If you feel upset after the discussion and need help dealing with your feelings, it is very important that you talk to someone right away.

The contact details for the person to talk to are:.....

THANK YOU VERY MUCH FOR YOUR HELP!

This study has been approved by the Curtin University Human Research Ethics Committee. HREC Approval Number HR 134/2005. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Informed Consent

Mental Health/Psychiatric Illness in Western Australian Prisons

*This form is to be completed independently by the participant

Name:.....

Prison:.....

	Yes	No
--	-----	----

1. I understand the attached information sheet and have had the opportunity to ask questions.		
2. I understand that I can withdraw from the Phase Two at any time without having to give any reasons.		
3. I understand that withdrawing from the study will not affect my parole or length of prison service.		
4. I am aware of, and consent to I taking notes during the course of the discussion.		
5. I understand the results of this study may be published in reports and research journals and that I will not be able to be identified in these publications.		
6. I understand that everything I say is confidential. However, I must inform management if: Something leads I to believe that either I or another inmate's safety is at immediate risk.		
7. I give consent that I would like to be involved in this research project.		

Signature of Participant:.....

Date:.....

Signature of Researcher (if present):.....

Date:.....

Should you need to contact me my contact details are:

Kate Hancock

Work Number: 08 9264 1848

Email: kate.hancock@student.curtin.edu.au

Postal Address: Po Box 87 Mundaring, WESTERN AUSTRALIA, 6073

This study has been approved by the Curtin University Human Research Ethics Committee. HREC Approval Number HR 134/2005. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Appendices I - Phase Two Prisoner Patient Questionnaire

** please note – there are some formatting errors in this version of the questionnaire in the thesis that could not be corrected due to the set thesis margin sizes*

QUESTION 1: Please provide some basic information.

	1	2	3	4	5	6
1A: Which age bracket do you fit	18-29	30-39	40-49	50-59	60-69	70+

1B: Which prison do you live in?	Hakea	Casuarina	Eastern Goldfields	Albany		
1C: What illness or disorder do you have?	Schizophrenia	Bi- Polar	Personality Disorder	Depression	Anxiety Disorder	Other (Please Specify).....
1D: Do you identify with a cultural or ethnic group? Please specify.....						

Current Service Provision Questions
Issues, Attitudes and Experiences

QUESTION 2: The following statements/quotes are about issues you may face in the prison, your attitudes or experiences and issues that may arise for you. For each statement, please circle the response which most reflects your feelings about the statement.

Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
2A: "I find it hard living in prison with a mental illness"	1	2	3	4	5
2B: "No-one in prison understands what I am going through"	1	2	3	4	5
2C: "Some days are good and other days are bad"	1	2	3	4	5
2D: "My mental health is a very spiritual thing for me"	1	2	3	4	5
2E: "I got seen by the medical staff right away when I came to prison"	1	2	3	4	5
2F: "I do not feel that I have adequate access to care, services and treatment"	1	2	3	4	5
2G: "I think that the mental health service and treatment is really good"	1	2	3	4	5
2H: "For people who are unwell the system is failing. People have to wait too long to get care and many are placed in CCU which is not ideal. It takes a long time to get people stable on medication and even then lots of people should not be in prison. They should go to a special ward or something"	1	2	3	4	5
Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
2I: "Prison is becoming the new kind of institution for people with mental illness"	1	2	3	4	5
2J: "I feel very isolated and alone"	1	2	3	4	5
2K: "You cannot confide in people here, officers, health staff or prisoners as they share the information with other people"	1	2	3	4	5

2L: “My health information should be private and only available to medical staff”	1	2	3	4	5
2M: “The mental health staff are good, helpful and understanding”	1	2	3	4	5
2N: “The officers treat you differently because you have a mental illness. They talk behind your back and call you names”	1	2	3	4	5
2O: “Many of the prisoners are vulnerable, especially the guys with mental illness”	1	2	3	4	5
2P: “The officers don’t care and prison is about discipline not treatment”	1	2	3	4	5
2Q: “The other prisoners treat you differently and think you should not be taking all the medication”	1	2	3	4	5
2R: “I find that sometimes being in prison is a help as you get looked after and have better treatment than you would in the community”	1	2	3	4	5
2S: “The prison should not use disciplinary action to force us to take our medication”	1	2	3	4	5
2T: “The psychiatrist’s are very helpful and I have enough access to see them”	1	2	3	4	5
2U: “I feel that the staff listen to me and that I have people who I can talk too”	1	2	3	4	5
2V: “It is very negative in prison and it makes it hard to build the spirit back up”	1	2	3	4	5
2W: “The peer support team is a real help”	1	2	3	4	5
2X: “The prison counselling service is very helpful”	1	2	3	4	5
2Y: “I don’t think that prison officers should be looking after us as they are not qualified medical staff”	1	2	3	4	5

Education and Training Questions

QUESTION 3: Do you feel that the Uniform Staff (Prison Officers) adequately care for you?

Strongly Agree 1 2 3 4 5 Strongly Disagree

3A: If not why?

1: Because they do not have enough training?

2: Because of the personality of the officers?

3: Because they have low awareness of mental health?

4: All of the above?

5: Other.....?

QUESTION 4: Do you feel that the Prison Counselling Staff provide you with adequate care and services?

Strongly Agree 1 2 3 4 5 Strongly Disagree

QUESTION 5: Do you feel that the Nurses adequately care for you?

Strongly Agree 1 2 3 4 5 Strongly Disagree

QUESTION 6: Do you think that all the prison staff need more training in mental health?

Strongly Agree 1 2 3 4 5 Strongly Disagree

QUESTION 7: Do you feel that prisoners have adequate information and education about mental illness, medication, how to manage their own illness, how to ask for help and how to understand the behaviours of other prisoners?

Strongly Agree 1 2 3 4 5 Strongly Disagree

Question 8: The following are statements/quotes that relate to training and education within the prison. Can you please indicate whether you strongly agree, agree, are undecided, disagree or strongly disagree with the statements below:

	1	2	3	4	5
Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
8A: "Training in mental health is vitally important"	1	2	3	4	5
8B: "All prison staff need more training in mental health"	1	2	3	4	5
8C: "Most other prisoners have no idea what a mental illness/disorder is and it would good for people to have a better understanding"	1	2	3	4	5
8D: "Only trained medical staff should be allowed to work with people who have mental illness/disorder"	1	2	3	4	5
8E: "ARMS, risk prevention and self harm training are really important"	1	2	3	4	5

8F: “The officers have no idea what mental health is and are not properly trained to help us”	1	2	3	4	5
8G: “There should be pamphlets and information available at the medical centre so people understand better”	1	2	3	4	5
8H: “Staff need to be very well trained to care for prisoners with mental illness/disorders”	1	2	3	4	5
8I: “People need to be educated about mental health”	1	2	3	4	5
8J: “Prisoners need to be educated about their own mental health”	1	2	3	4	5
8K: “Prisons should have special programs for mental health clients”	1	2	3	4	5
8L: “There is plenty of information available on mental health in the prison”	1	2	3	4	5
8M: “Peer support is really good. They should get extra training and have a specialist mental health peer support team”	1	2	3	4	5
8N: “Members of the Prison Counselling Service need additional specialist mental health training”	1	2	3	4	5
8O: “Officers who work in the CCU and places like that should be specially trained in mental health”	1	2	3	4	5

Resources, Funding and Additional Services Questions

QUESTION 9: The following items/quotes seek your opinions on what additional resources and services you would you like to see established for the treatment and on-going care of prisoners who experience mental illness? For each statement, please circle the response which most closely reflects your views about the statement.

Statement	1	2	3	4	5
	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
9A: “I would like to have more regular visits by the mental health staff and greater access to staff”	1	2	3	4	5
9B: “There needs to be a greater range of staff”	1	2	3	4	5
9C: “I would like more input into my treatment and medication”	1	2	3	4	5
9D: “It would be good to have more counselling services and art therapy rather than just having to take drugs all of the time”	1	2	3	4	5
9E: “We need more services in regional areas”	1	2	3	4	5
9F: “They need more staff to help us out. There are not enough and it means we do not get proper care”	1	2	3	4	5
9G: “They should build a special unit for people with Personality Disorders”	1	2	3	4	5

9H: “I would like to have greater access to the psychiatrists”	1	2	3	4	5
9I: “Prison is a hell hole and mental health people do not belong here. We need a medical place”	1	2	3	4	5
9J: “We need to be in a medical environment and a special unit that is staffed by medical people where we will get looked after properly”	1	2	3	4	5
9K: “I think they should build another place like Graylands that can have way more people”	1	2	3	4	5
9L: “When you are unwell you want to be looked after but you need to be able to be outside and walk around in open spaces”	1	2	3	4	5
9M: “People need to be somewhere therapeutic and the government has to do something about it”	1	2	3	4	5
9N: “I am happy to stay in prison and receive treatment from the medical staff”	1	2	3	4	5
9O: “I would not want to go to a Psychiatric hospital. I have a mental illness but I am stable and able to manage in prison”	1	2	3	4	5
9P: “It is a disgrace that people with mental illness have ended up in prison we really need care and support”	1	2	3	4	5
9Q: “It would be good to have mental health programs for mental health clients”	1	2	3	4	5

QUESTION 10: My experiences of living in prison with a mental illness are generally?

Very Positive 1 2 3 4 5 Very Negative

QUESTION 11: From your experience do you think that the numbers of prisoners with mental health issues is increasing/has increased in the time you have lived in prison?

Increased	1
3B No3 Decreased	2
Stasu3C: Stayed the same	3

QUESTION 12

If yes, why do you think this is the case?

Improved screening and awareness at the prisons	1
Increases in illegal drug use	2
De-institutionalisation	3

Larger prison populations	4
Other (please specify).....	5

Now I'd like to get your specific views on the following questions. Please write your answers in the spaces provided.

QUESTION 13: Issues

What are the key issues/problems that arise for you living in prison with a mental illness/disorder?

QUESTION 14: How do you feel (what are your attitudes) about the current level of treatment, services and facilities for prisoners with mental health issues in the prison you live in and prisons in Western Australia?

QUESTION 15: What are your main experiences of living in prison with a mental illness/disorder?

QUESTION 16: As someone living in prison with a mental illness/disorder what are your short-term and long-term needs?

**THANK YOU FOR YOUR PARTICIPATION
IT IS GREATLY APPRECIATED!**

Appendices J - Phase Two Staff Information Sheet and Consent Form



Faculty of Education, Language Studies and Social Work

Department of Education
Department of Languages
and Intercultural Education
Department of Social Work
and Social Policy

GPO Box U1987
Perth WESTERN
AUSTRALIA 6045
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Fax: +618 9266 3186

Information Sheet

Mental Health/Psychiatric Illness in Western Australian Prisons

My name is Kate Hancock. I am a PhD research student at Curtin University and an employee at the Department of Corrective Services. I am working on a project looking at mental illness in the prison environment as part of my studies at Curtin. I am contacting a number of staff and prisoners about their experiences of mental illness and mental health services in prison. This research has been approved by the Department's Research Committee. You have been chosen because of your experience and knowledge.

What will I have to do if I take part?

If you agreed to take part, you will be required to complete the enclosed questionnaire and consent form. There are no right or wrong answers - I am just interested in your experience. The questionnaire should take about half an hour to complete and will contain questions relating to your experiences of mental health in prison. **Taking part is voluntary.** If you don't want to take part, you do not have to give a reason and no pressure will be put on you to try and change your mind.

If I agreed to take part what happens to what I say?

All the information you give me **will be confidential** and used for the purposes of this study only. The data will be collected and stored for 5 years in locked filing cabinets and computer hardware that requires passwords to be accessed and will be disposed of in a secure manner. The information will be used in a way that will not allow you to be identified individually. The results of this study may be published in reports and research journals, however you will not be able to be identified in these publications.

What do I do now?

Think about the information on this sheet, and ask me if you are not sure about anything. If you agreed to take part you should read and sign the consent form, fill in the enclosed questionnaire, put it in a sealed envelop and return it to one of the contacts in the prison your work in. Alternatively you can post it to direct to me. The consent form will not be used to identify you. It will be filed separately from all other information. If you do not want to complete the consent form, return the completed survey to me and this will be taken as your consent to participate. If, after completing the questionnaire, you want any more information about the study please contact me.

My contact details are: Kate Hancock
1297
Email: kate.hancock@student.curtin.edu.au
87 Mundaring WESTERN AUSTRALIA 6073

Work Number: 08 9264

Postal Address: PO Box

Best wishes

Kate Hancock

THANK YOU VERY MUCH FOR YOUR HELP!

This study has been approved by the Curtin University Human Research Ethics Committee. HREC Approval Number HR 134/2005. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.

Informed Consent

Mental Health/Psychiatric Illness in Western Australian Prisons

*This form is to be completed independently by the participant

Name:.....

Prison:.....

Position (e.g. Officer, Nurse, Social Worker):.....

	Yes	No
1. I understand the attached information sheet and have had the opportunity to ask questions.		
2. I understand that I can withdraw from the Phase Two at any time without having to give any reasons.		
3. I understand the results of this study may be published in reports and research journals and that I will not be able to be identified in these publications.		
4. I give consent that I would like to be involved in this research project.		

Signature of Participant:.....

Date:.....

Signature of Researcher:.....

Date:.....

My contact details are:

Kate Hancock

Work Number: 08 9264 1297

Email: kate.hancock@student.curtin.edu.au

Postal Address: Po Box 87 Mundaring, WESTERN AUSTRALIA, 6073

Appendices K - Phase Two Staff Questionnaire

** please note – there are some formatting errors in this version of the questionnaire in the thesis that could not be corrected due to the set thesis margin sizes*

QUESTION 1: Please provide some basic information.

	1	2	3	4	5	6	7	8
1A: Which age bracket do you fit	18-29	30-39	40-49	50-59	60-69	70+		

Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
3A: “It is important to make time to listen to prisoners who experience mental illness”	1	2	3	4	5
3B: “It is important that the initial assessment is sensitive to mental health issues”	1	2	3	4	5
3C: “Crisis care has become like a pseudo psychiatric wing”	1	2	3	4	5
3D: “My overall experience is one of just managing day to day but not really knowing what to do with people with mental illness and wondering why they are here. This is a prison”	1	2	3	4	5
3E: “There are not enough mental health nurses to adequately deal with the numbers of mental health clients”	1	2	3	4	5
3F: “We do not have the appropriate facilities to manage people with mental illness”	1	2	3	4	5
3G: “The initial assessment is only as good as the nurse administering it”	1	2	3	4	5
3H: “Officers don’t have the time or the training to deal with them and they should not have too. Sometimes I think this place is a funny farm and it is very hard to manage”	1	2	3	4	5
3I: “We have very limited access to the psychiatrist and this is problematic for us”	1	2	3	4	5
3J: “The GP we have is limited and not trained in mental health”	1	2	3	4	5
3K: “Mental health prisoners are very vulnerable and I just don’t understand why they are here”	1	2	3	4	5
3L: “It is important to take the time to explain reasons for decisions to prisoners”	1	2	3	4	5
3M: “Prisoners with mental illness have different needs to the rest of the prison population”	1	2	3	4	5
3N: “I don’t feel comfortable working with prisoners who experience mental health issues”	1	2	3	4	5
Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
3O: “Prisons are very punitive and mental health clients need to be in a more therapeutic environment”	1	2	3	4	5
3P: “Mentally ill prisoners are very vulnerable”	1	2	3	4	5
3Q: “Aboriginal prisoners have different needs to other prisoners”	1	2	3	4	5
3R: “Regional Prisons have much the same needs as other prisons”	1	2	3	4	5

3S: “Mental health prisoners have committed a crime like anyone else and should be in prison”	1	2	3	4	5
3T: “The human rights of many mentally ill prisoners is in question”	1	2	3	4	5
3U: “You just do the best with what you have”	1	2	3	4	5
3V: “It is not prison officers job to care for prisoners”	1	2	3	4	5
3W: “Prison is becoming the new kind of institution for people with mental illness”	1	2	3	4	5

QUESTION 4: From your experience what currently works well in the service you provide? Please rate the following statements from one to five.

4A) “We have great staff who work well as a team”

Strongly Agree 1 2 3 4 5 Strongly Disagree

4B) “In prison you have a captive audience so clients get some treatment”

Strongly Agree 1 2 3 4 5 Strongly Disagree

4C) “We get to know the clients and their needs really well which creates a positive environment”

Strongly Agree 1 2 3 4 5 Strongly Disagree

4D) “We have enough time to manage people well rather than just crisis managing people”

Strongly Agree 1 2 3 4 5 Strongly Disagree

4E) “We have a good relationship with Prison Counselling Service”

Strongly Agree 1 2 3 4 5 Strongly Disagree

4F) “Peer support is a real benefit”

Strongly Agree 1 2 3 4 5 Strongly Disagree

**4G) Other (Please specify.....
...)**

Strongly Agree 1 2 3 4 5 Strongly Disagree

Education and Training Questions

QUESTION 5: Have you received any training to have people with mental illness under your care?

Yes	1
3B No3 No	2

QUESTION 6: Do you feel you have adequate training or access to training to have persons with mental illness under your care?

Strongly Agree 1 2 3 4 5 Strongly Disagree

QUESTION 7: Do you feel that uniform staff have a suitable level of training to be managing patients with mental illness?

Strongly Agree 1 2 3 4 5 Strongly Disagree

QUESTION 8: Do you feel that prisoners have adequate information and education about mental illness, medication, how to manage their own illness, how to ask for help and how to understand the behaviours of other prisoners?

Strongly Agree 1 2 3 4 5 Strongly Disagree

Question 9: The following are statements/quotes that relate to training and education within the prison. Can you please indicate whether you strongly agree, agree, are undecided, disagree or strongly disagree with the statements below:

	1	2	3	4	5
Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
9A: "Training is vitally important"	1	2	3	4	5
9B: "All staff need more training in mental	1	2	3	4	5

health”					
9C: “I have adequate training in mental health”	1	2	3	4	5
9D: “There is a lack of training for uniform staff in prisons”	1	2	3	4	5
9E: “ARMS, risk prevention and self harm training are really important”	1	2	3	4	5
9F: “I have never done any training in mental health”	1	2	3	4	5
9G: “Time off work is never given for mental health training”	1	2	3	4	5
9H: “Staff need to be very well trained to care for prisoners with mental illness”	1	2	3	4	5
9I: “People need to be educated about mental health”	1	2	3	4	5
9J: “Prisoners need to be educated about their own mental health”	1	2	3	4	5
9K: “Prisons should have special programs for mental health clients”	1	2	3	4	5
9L: “There is plenty of information available on mental health”	1	2	3	4	5
9M: “Training and education are valued in the prison I work in”	1	2	3	4	5
9N: “Members of the Prison Counselling Service need additional specialist mental health training”	1	2	3	4	5

Management and Consultation Questions

QUESTION 10: The following are statements/quotes that relate to management, consultation and policy within the prisons. For each statement, please circle the response which most closely reflects your views about the statement.

	1	2	3	4	5
Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
10A: “There is inadequate management support when	1	2	3	4	5

faced with mental health crisis issues”					
10B: “There are inadequate operational guidelines and policy to operate within when dealing with prisoners who experience mental illness”	1	2	3	4	5
10C: “There is an appropriate level of consultation with people in the field about mental health”	1	2	3	4	5
10D: “The policy and guidelines need revising in relation to the role of mental health and what happens on the ground”	1	2	3	4	5
10E: “There is a total lack of health management support for mental health”	1	2	3	4	5
10F: “There is a total lack of prisons management support for mental health”	1	2	3	4	5
10G: “I have never seen or heard of any policies relating to mental health”	1	2	3	4	5
10H: “Management support from upper levels of health is very poor and totally inadequate”	1	2	3	4	5
10I: “Policy and practices are imposed from the top down rather than the bottom up”	1	2	3	4	5
10J: “You get callous working in prisons because everybody who is outside of the prison thinks that they know how to do the job better”	1	2	3	4	5
10K: “Quite often things get imposed on us that are ineffective and do not work on the ground”	1	2	3	4	5
10L: “We are never asked what we need and why we need it, people just make decisions that affect us with no consultation”	1	2	3	4	5
10M: “Health is a difficult area because in the prison security always comes before peoples health”	1	2	3	4	5
10N: “We need effective guidelines and policy that are not to general or overbearing”	1	2	3	4	5
10O: “The interface between health and justice needs to be reviewed”	1	2	3	4	5

Resources, Funding and Additional Services Questions

QUESTION 11: The following item seek your opinions on what additional resources and services you would you like to see established for the treatment and on-going care of prisoners who experience mental illness? For each statement, please circle the response which most closely reflects your views about the statement.

	1	2	3	4	5
Statement	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
I would most like to see:					

11A: The number of beds at the Frankland Unit extended	1	2	3	4	5
11B: A special facility set up at each prison for mental health clients	1	2	3	4	5
11C: A special facility built off the grounds of the prisons for mental health prisoners	1	2	3	4	5
11D: Group and art therapy for prisoners	1	2	3	4	5
11E: The extension of regional services	1	2	3	4	5
11F: A state facility for mental health at Casuarina	1	2	3	4	5
11G: A state facility for mental health at Hakea	1	2	3	4	5
11H: A special mental health service for courts clients so they are not transferred to Frankland	1	2	3	4	5
11I: A unit for people with personality disorders	1	2	3	4	5
11J: A psychiatric hospital for prisoners	1	2	3	4	5
11K: Closer linkages with community services	1	2	3	4	5
11L: Supported accommodation and services in the community	1	2	3	4	5
11M: Extension of crisis care facilities to cater for mental health clients	1	2	3	4	5
11N: Additional mental health nurses	1	2	3	4	5
11O: Additional psychiatrists	1	2	3	4	5
11P: Additional psychologists	1	2	3	4	5
11Q: Additional social workers	1	2	3	4	5
11R: Specialist people in the prison to work with mental health prisoners	1	2	3	4	5
11S: Programs for mental health clients	1	2	3	4	5
11T: “There needs to be a facility that accommodates mental health patients that can be managed according to their requirements and needs”	1	2	3	4	5
11U: other please specify.....	1	2	3	4	5

QUESTION 12: My experiences with mental health prisoners are generally?

Very Positive 1 2 3 4 5 Very Negative

QUESTION 13: From your experience do you think that the numbers of prisoners with mental health issues is increasing/has increased in the time you have worked in prisons?

Increased	1
------------------	---

3B No3	Decreased	2
Stasu3C:	Stayed the same	3

QUESTION 14: If yes, why do you think this is the case?

Improved screening and awareness	1
Increases in illegal drug use	2
De-institutionalisation	3
Larger prison populations	4
Other (please specify).....	5

Now I'd like to get your specific views on the following questions. Please write your answers in the spaces provided.

QUESTION 15: Issues

What are the key issues/problems that arise for you when working with prisoners who experience mental illness?

QUESTION 16: Attitudes

What are your feelings/attitudes/thoughts about the placement of mental health patients in Prison?

Metropolitan participants ($Mdn = 2.00$) agreed more strongly with the statement than regional participants ($Mdn = 2.00$), $U = 188.000$, $p < .05$, $r = -.29$

I would like to have more input into my treatment and medication

Metropolitan participants ($Mdn = 2.00$) agreed more strongly with the statement than regional participants ($Mdn = 2.00$), $U = 171.500$, $p < .05$, $r = -.33$

People need to be somewhere therapeutic and the government has to do something about it

Metropolitan participants ($Mdn = 2.00$) agreed more strongly with the statement than regional participants ($Mdn = 2.00$), $U = 182.000$, $p < .05$, $r = -.29$

I am happy to stay in prison and receive treatment from the medical staff

Metropolitan participants ($Mdn = 2.00$) agreed more strongly with the statement than regional participants ($Mdn = 2.00$), $U = 176.500$, $p < .05$, $r = -.30$

Staff Results

Question Nine - Metropolitan and Regional Differences

A special facility set up off the grounds of the prisons for mental health clients

On average, regional participants reported a stronger level of agreement with the above statement ($M = 2.29$, $SD = 1.145$), than metropolitan staff ($M = 2.81$, $SD = 1.200$). This difference was significant [$t(118) = 2.381$, $p < .05$] at the .05 level.

The extension of regional services

On average, regional participants reported a stronger level of agreement with the statement above ($M = 1.65$, $SD = .721$), than metropolitan staff ($M = 2.07$, $SD = .828$). This difference was significant [$t(118) = 2.902$, $p < .05$] at the .05 level.

Additional mental health nurses

On average, regional participants reported a stronger level of agreement with the statement above ($M = 1.51$, $SD = .576$), than metropolitan staff ($M = 1.95$, $SD = .872$). This difference was significant [$t(118) = 3.374$, $p < .05$] at the .05 level.

Additional psychiatrists

On average, regional staff reported a stronger level of agreement with the statement above ($M = 1.61$, $SD = .691$), than metropolitan participants ($M = 1.91$,

$SD = .691$). This difference was significant [$t(118) = 2.150, p < .05$] at the .05 level.

Additional psychologists

On average, regional participants reported a stronger level of agreement with the statement above ($M = 1.78, SD = .805$), than metropolitan staff ($M = 2.42, SD = 1.096$). This difference was significant [$t(67.713) = 3.353, p < .05$] at the .05 level.

Additional social workers

On average, regional participants reported a stronger level of agreement with the above statement ($M = 2.14, SD = 1.073$), than metropolitan staff ($M = 2.63, SD = 1.196$). This difference was significant [$t(118) = 2.279, p < .05$] at the .05 level.

Specialist people in the prison to work with mental health prisoners

On average, regional staff reported a stronger level of agreement with the statement above ($M = 1.60, SD = .712$), than metropolitan participants ($M = 2.07, SD = 1.055$). This difference was significant [$t(118) = 2.918, p < .05$] at the .05 level.

Programs for mental health clients

On average, regional participants reported a stronger level of agreement with the statement above ($M = 1.77, SD = .759$), than metropolitan staff participants ($M = 2.21, SD = .879$). This difference was significant [$t(118) = 2.288, p < .05$] at the .05 level.

Question Nine - Prison Staff Group/Occupation

A one-way Analysis of Variance, Pearson Chi-Square Test and Krustall-Wallis Test were chosen to analyse the interaction between prison staff group/position (*health/clinical, prison/senior officers, education/programs and other staff*) and the statements in Q11. The assumptions of the Chi-Square and ANOVA tests were violated as the number of cases (expected frequencies not greater than 5) in each cell was not sufficient, the sample size was not large enough, and the data was skewed. However, as the results of the Chi-Square and ANOVA support each other,

and are further supported by the Kruskal-Wallis Tests the significant ANOVA results are presented. These results are broken down as they appear in the questionnaire and are therefore easier to interpret. The results that revealed a significant relationship are presented below.

Group and Art therapy

There was a significant difference across staff group for Q11d: "group and art therapy" [$F(3, 116) = 8.501, p < .05$]. Health/clinical participants had a mean score of ($M=1.81, SD.780$), prison/senior officers had a mean score of ($M=2.58, SD.922$), education/programs had a mean score of ($M=1.33, SD.577$), and other staff had a mean score of ($M=1.73, SD.905$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers and between prison/senior officers and other staff. Health/clinical and other staff agreed more strongly with the statement than prison/senior officer staff do.

Extension of regional services

There was a significant difference across staff group for Q11e: "the extension of regional services" [$F(3, 116) = 3.972, p < .05$]. Health/clinical participants had a mean score of ($M=1.50, SD.508$), prison/senior officers had a mean score of ($M=1.99, SD.852$), education/programs had a mean score of ($M=1.33, SD.577$), and other staff had a mean score of ($M=1.55, SD.688$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff agreed more strongly with the statement than prison/senior officer staff do.

Closer linkages with community services

There was a significant difference across staff group for Q11k: "closer linkages with community services" [$F(3, 116) = 10.994, p < .05$]. Health/clinical participants had a mean score of ($M=1.53, SD.567$), prison/senior officers had a mean score of ($M=2.45, SD.953$), education/programs had a mean score of ($M=1.33, SD.577$), and other staff had a mean score of ($M=1.73, SD.467$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers and between prison/senior officers

and other staff. Health/clinical and other staff agreed more strongly with the statement than prison/senior officer staff do.

Supported accommodation and services in the community

There was a significant difference across staff group for Q11i: “supported accommodation and services in the community” [$F(3, 116) = 9.966, p < .05$]. Health/clinical participants had a mean score of ($M=1.53, SD.718$), prison/senior officers had a mean score of ($M=2.49, SD1.010$), education/programs had a mean score of ($M=1.33, SD.577$), and other staff had a mean score of ($M=1.73, SD.647$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical agreed more strongly with the statement than prison/senior officer staff do.

Extension of crisis care facilities to cater for mental health clients

There was a significant difference across staff group for Q11m: “extension of crisis care facilities to cater for mental health clients” [$F(3, 116) = 4.047, p < .05$]. Health/clinical participants had a mean score of ($M=1.78, SD.751$), prison/senior officers had a mean score of ($M=2.50, SD1.219$), education/programs had a mean score of ($M=1.33, SD.577$), and other staff had a mean score of ($M=2.55, SD1.293$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical and other staff agreed more strongly with the statement than prison/senior officer staff do.

Programs for mental health clients

There was a significant difference across staff group for Q11s: “programs for mental health clients” [$F(3, 116) = 5.860, p < .05$]. Health/clinical participants had a mean score of ($M=1.50, SD.622$), prison/senior officers had a mean score of ($M=2.12, SD.859$), education/programs had a mean score of ($M=1.33, SD.577$), and other staff had a mean score of ($M=1.64, SD.505$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical and other staff agreed more strongly with the statement than prison/senior officer staff do.

Appendices M - Phase Two Results and Additional Data - Education and Training Construct

Prisoner Patient Results

Metropolitan/Regional Differences

All prison staff need more training in mental health

On average, metropolitan prisoners reported a higher level of agreement with the above statement ($M = 1.67$, $SD = .606$), than regional prisoners ($M = 2.17$, $SD = .786$). This difference was significant [$t(46) = -2.47$, $p < .05$] at the .05 level.

There should be pamphlets and information available in the medical centre so people understand better

On average, metropolitan prisoners reported a higher level of agreement with the above statement ($M = 1.77$, $SD = .504$), than regional prisoner patients ($M = 2.22$, $SD = .786$). This difference was significant [$t(46) = -2.55$, $p < .05$] at the .05 level.

Staff need to be very well trained to care for prisoners with mental illness/disorder

On average, metropolitan prisons participants reported a higher level of agreement with the statement above ($M = 1.73$, $SD = .450$), than regional prisoners ($M = 2.28$, $SD = .752$). This difference was significant [$t(46) = -3.14$, $p < .05$] at the .05 level.

Staff Results

Metropolitan/Regional Differences

Training in mental health is vitally important

On average, regional participants reported a stronger level of agreement with the above statement ($M = 1.29$, $SD = .535$), than metropolitan staff participants ($M = 1.67$, $SD = .680$). This difference was significant [$t(71.264) = 3.231$, $p < .05$] at the .05 level.

All staff need more training in mental health

On average, regional participants reported a stronger level of agreement with the above statement ($M = 1.43$, $SD = .733$), than metropolitan staff ($M = 1.81$, $SD = .764$). This difference was significant [$t(118) = 2.720$, $p < .05$] at the .05 level.

ARMS, risk prevention and self-harm training are really important

On average, regional participants reported a stronger level of agreement with the above statement ($M = 1.49$, $SD = .641$), than metropolitan staff participants ($M = 1.95$, $SD = 1.022$). This difference was significant [$t(118) = 3.028$, $p < .05$] at the .05 level.

Time off work is never given for mental health training

On average, regional participants reported a stronger level of agreement with the above statement ($M = 2.10$, $SD = 1.107$), than metropolitan staff ($M = 2.60$, $SD = 1.116$). This difference was significant [$t(118) = 2.369$, $p < .05$] at the .05 level.

Prison Group/Occupation

I have adequate training in mental health

There was a significant difference across staff groups for statement 9c above [$F(3, 116) = 26.105$, $p < .05$]. Health/clinical participants had a mean score of ($M=2.63$, $SD1.212$), prison/senior officers had a mean score of ($M=4.28$, $SD.7785$), education/programs had a mean score of ($M=3.00$, $SD1.000$), and other staff had a mean score of ($M=4.00$, $SD.447$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers and between health/clinical staff and other staff. Health/clinical staff agreed more strongly with the statement than prison/senior officer staff who disagreed leaning towards strongly disagreed and other staff who disagreed with the statement.

I have never done any mental health training (reversed means)

There was a significant difference across staff group for statement 9f above [$F(3, 116) = 23.520$, $p < .05$]. Health/clinical participants had a mean score of ($M=1.69$, $SD1.030$), prison/senior officers had a mean score of ($M=3.69$, $SD1.249$), education/programs had a mean score of ($M=2.00$, $SD1.732$), and other staff had a mean score of ($M=3.82$, $SD.982$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers and between health/clinical staff and other staff. Health/clinical staff disagreed more strongly with the statement than prison/senior officer and other staff groups.

Time off work is never given for mental health training

There was a significant difference across staff group for Q9g: "time off work is never given for mental health training" [$F(3, 116) = 10.240$, $p < .05$]. Health/clinical participants had a mean score of ($M=3.13$, $SD1.264$), prison/senior

officers had a mean score of ($M=1.93$, $SD.926$), education/programs had a mean score of ($M=2.33$, $SD.577$), and other staff had a mean score of ($M=2.18$, $SD.974$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between prison/senior officers and health/clinical staff. Prison/senior officer staff agreed with the statement more strongly than health/clinical staff who are undecided that time off work is never given for mental health training.

People need to be educated about mental health

There was a significant difference across staff group for statement 9i above [$F(3, 116) = 3.330$, $p < .05$]. Health/clinical participants had a mean score of ($M=1.34$, $SD.483$), prison/senior officers had a mean score of ($M=1.81$, $SD.839$), education/programs had a mean score of ($M=1.33$, $SD.577$), and other staff had a mean score of ($M=1.55$, $SD.522$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff disagreed more strongly with the statement than prison/senior officers do.

There is plenty of information available on mental health

There was a significant difference across staff group for statement 9l [$F(3, 116) = 3.976$, $p < .05$]. Health/clinical participants had a mean score of ($M=3.25$, $SD1.047$), prison/senior officers had a mean score of ($M=3.89$, $SD.853$), education/programs had a mean score of ($M=3.67$, $SD.577$), and other staff had a mean score of ($M=3.36$, $SD1.120$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff are undecided about the statement in comparison to prison/senior officers who disagreed with the statement.

Appendices N - Phase Two Results and Additional Data - Current Mental Health/Psychiatric Service Provision Construct

Prisoner Patient Results

Metropolitan/Regional Differences

I do not feel that I have adequate access to care, services and treatment (reversed means)

On average, metropolitan prisoners reported a higher level of agreement with the above statement ($M = 3.30$, $SD = 1.29$), than regional prisoners ($M = 2.22$, $SD = 1.00$). This difference was significant [$t(42.789) = 3.229$, $p < .05$] at the .05 level.

You cannot confide in people here, officers, health staff or prisoners as they share the information with other people

On average, metropolitan prisoners agreed with the above statement more strongly ($M = 2.27$, $SD = 1.14$), than regional prisoners ($M = 3.22$, $SD = 1.06$) who tended to be undecided. This difference was significant [$t(46) = -2.88$, $p < .05$] at the .05 level.

The officers treat you differently because you have a mental illness. They talk behind your back and call you names

On average, metropolitan prisoners reported a higher level of agreement with the above statement ($M = 2.70$, $SD = 1.44$), than regional prisoners ($M = 3.56$, $SD = 1.09$) who tended to disagree. This difference was significant [$t(43.269) = -2.32$, $p < .05$] at the .05 level.

The other prisoners treat you differently and think you should not be taking all of the medication

On average, metropolitan prisoners reported a higher level of agreement with the above statement ($M = 2.33$, $SD = .994$), than regional prisoners ($M = 3.06$, $SD = 1.16$) who were undecided. This difference was significant [$t(46) = -2.28$, $p < .05$] at the .05 level.

It is very negative in prison and it makes it hard to build the spirit back up

On average, metropolitan prisoners reported a higher level of agreement with the above statement ($M = 1.93$, $SD = 1.08$), than regional prisoners ($M = 2.78$, $SD = 1.06$) who leaned towards undecided. This difference was significant [$t(46) = -2.63$, $p < .05$] at the .05 level.

The peer support team is a real help

On average, regional prisoners reported a higher level of agreement, although leaning towards undecided, with the above statement ($M = 2.44$, $SD = 1.04$), than metropolitan prisoners who were undecided, leaning towards disagreed ($M = 3.17$, $SD = 1.39$). This difference was significant [$t(43.599) = 2.04$, $p < .05$] at the .05 level.

I don't think prison officers should be looking after us as they are not qualified medical staff (reversed mean)

The t-test results did not show a statistically significant finding for this statement, although it was very close. However, the Mann-Whitney and the Wilcoxon tests did find statistically significant results. Metropolitan participants ($Mdn = 4.00$) attitudes differ in relation to the statement (more in agreement) than regional participants (less in agreement) ($Mdn = 2.50$), $U = 178.500$, $p < .05$, $r = -.40$.

Staff Results

Metropolitan/Regional Differences

There are not enough mental health nurses to adequately deal with the numbers of mental health clients

On average, regional prisons reported a higher level of agreement with the above the statement ($M = 1.70$, $SD = .689$), than metropolitan staff participants ($M = 2.44$, $SD = 1.00$). This difference was significant [$t(64.422) = 4.293$, $p < .05$] at the .05 level.

We do not have the appropriate facilities to manage people with mental illness

On average, regional prisons participants reported a stronger level of agreement with the above statement ($M = 1.48$, $SD = .641$), than metropolitan staff participants ($M = 1.86$, $SD = .833$). This difference was significant [$t(118) = 2.790$, $p < .05$] at the .05 level.

We have very limited access to the psychiatrist and this is problematic for us

On average, regional prisons reported a stronger level of agreement with the above statement ($M = 1.87$, $SD = .937$), than metropolitan staff ($M = 2.47$, $SD = .797$). This difference was significant [$t(118) = 3.513$, $p < .05$] at the .05 level.

It is important to take time to explain reasons for decisions to prisoners

On average, regional participants reported a stronger level of agreement with the above statement ($M = 1.65$, $SD = .580$), than metropolitan participants ($M = 2.09$, $SD = .947$). This difference was significant [$t(59.979) = 2.795$, $p < .05$] at the .05 level.

You just do the best with what you have

On average, regional prisons staff participants reported a stronger level of agreement with the above statement ($M = 1.97$, $SD = .743$), than metropolitan staff participants ($M = 2.33$, $SD = .808$). This difference was significant [$t(81.011) = 2.351$, $p < .05$] at the .05 level.

It is not officer's job to care for prisoners

On average, regional prisons strongly disagreed with the above statement ($M = 4.14$, $SD = .983$), compared to metropolitan staff participants who disagreed ($M = 3.72$, $SD = 1.14$). This difference was significant [$t(118) = -2.127$, $p < .05$] at the .05 level.

Prison Staff Group/Occupation*It is important to make time to listen to prisoners who experience mental illness*

There was a very significant difference between staff groups for statement 3a above [$F(3, 116) = 17.380$, $p < .05$]. Health/clinical participants had a mean score of ($M=1.09$, $SD=.296$), prison/senior officers had a mean score of ($M=1.89$, $SD=.632$), education/programs staff had a mean score of ($M=1.00$, $SD=0.00$), and other staff had a mean score of ($M=1.55$, $SD=.522$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison officers, and between education/programs staff and prison officers. Health/clinical staff and education/programs staff agreed more strongly than prison officers, who also agreed.

It is important that the initial assessment is sensitive to mental health issues

A significant difference was noted between staff groups for statement 3b above [$F(3, 116) = 13.135$, $p < .05$]. Health/clinical participants had a mean score of ($M=1.16$, $SD=.369$), prison/senior officers had a mean score of ($M=1.82$, $SD=.605$),

education/programs staff had a mean score of ($M=1.00$, $SD0.00$), and other staff had a mean score of ($M=1.73$, $SD.467$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison officers, and between health/clinical staff and other staff. Health/clinical staff agreed more strongly than other groups.

My overall experience is one of just managing day to day but not really knowing what to do with people with mental illness and wondering what they are doing here. This is a prison.

There was a very significant difference between staff groups for statement 3d above [$F(3,116) = 8.582$, $p < .05$]. Health/clinical participants had a mean score of ($M=3.72$, $SD.924$), prison/senior officers had a mean score of ($M=2.53$, $SD1.219$), education/programs staff had a mean score of ($M=3.00$, $SD1.732$), and other staff had a mean score of ($M=2.45$, $SD1.036$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison officers, and health/clinical staff and other staff. Health/clinical staff disagreed more strongly than other staff and prison/senior officers.

It is important to take time to explain reasons for decisions to prisoners

A significant difference between staff groups was recorded for statement 3l above [$F(3,116) = 4.684$, $p < .05$]. Health/clinical participants had a mean score of ($M=1.47$, $SD.507$), prison/senior officers had a mean score of ($M=2.00$, $SD.828$), education/programs staff had a mean score of ($M=1.33$, $SD.577$), and other staff had a mean score of ($M=1.64$, $SD.505$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff agreed more strongly that it is important to explain reasons for decisions.

Prisoners with mental illness have different needs to the rest of the prison population

There was a very significant difference between staff groups for statement 3m above [$F(3,116) = 3.425$, $p < .05$]. Health/clinical participants had a mean score

of ($M=1.53$, $SD.671$), prison/senior officers had a mean score of ($M=2.08$, $SD.888$), education/programs staff had a mean score of ($M=2.33$, $SD1.155$), and other staff had a mean score of ($M=2.09$, $SD1.044$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff agreed more strongly than prison/senior officers that prisoners with mental illness have different needs to the rest of the population.

I don't feel comfortable working with prisoners who experience mental health issues (means reversed)

There was a very significant difference between staff groups for statement 3n above [$F(3,116) = 8.694$, $p < .05$]. Health/clinical participants had a mean score of ($M=1.50$, $SD.781$), prison/senior officers had a mean score of ($M=2.53$, $SD1.076$), education/programs staff had a mean score of ($M=1.67$, $SD1.155$), and other staff had a mean score of ($M=2.18$, $SD.751$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff disagreed more strongly than prison/senior officers who leaned towards undecided regarding how comfortable they feel working with prisoners who experience mental illness.

Aboriginal prisoners have different needs to other prisoners

A significant difference between staff groups was found for statement 3q above [$F(3,116) = 3.882$, $p < .05$]. Health/clinical participants had a mean score of ($M=2.16$, $SD.987$), prison/senior officers had a mean score of ($M=2.88$, $SD1.170$), education/programs staff had a mean score of ($M=2.00$, $SD1.000$), and other staff had a mean score of ($M=2.27$, $SD1.009$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers, and health/clinical staff and other staff. Health/clinical staff agreed more strongly than prison/senior officers and other staff that aboriginal prisoners have different needs.

Regional prisons have much the same needs as other prisons

There was a significant difference between staff groups for statement 3r above [$F(3,116) = 3.087, p < .05$]. Health/clinical participants had a mean score of ($M=3.28, SD1.170$), prison/senior officers had a mean score of ($M=2.97, SD1.098$), education/programs staff had a mean score of ($M=3.33, SD1.155$), and other staff had a mean score of ($M=2.09, SD1.300$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and other staff. Health/clinical staff were undecided leaning towards disagreeing compared to other participants that were in agreement with the statement.

The human rights of many mental health prisoners is in question

There was a very significant difference between staff groups for statement 3t above [$F(3,116) = 7.290, p < .05$]. Health/clinical participants had a mean score of ($M=2.28, SD.991$), prison/senior officers had a mean score of ($M=3.22, SD.911$), education/programs staff had a mean score of ($M=2.67, SD1.528$), and other staff had a mean score of ($M=2.82, SD.982$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff agreed, slightly leaning towards undecided, compared to prison/senior officers who are undecided leaning towards disagreeing with the statement.

You just do the best with what you have

A significant difference between staff groups was found for statement 3u above [$F(3,116) = 7.757, p < .05$]. Health/clinical participants had a mean score of ($M=2.63, SD.942$), prison/senior officers had a mean score of ($M=1.89, SD.538$), education/programs staff had a mean score of ($M=2.00, SD1.732$), and other staff had a mean score of ($M=2.00, SD.775$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Prison/senior officers agreed more strongly than health/clinical staff who tended towards undecided about the statement.

Prisoners with mental illness have different needs to the rest of the prison population

There was a very significant difference between staff groups for statement 3m above [$F(3,116) = 3.425, p < .05$]. Health/clinical participants had a mean score of ($M=1.53, SD.671$), prison/senior officers had a mean score of ($M=2.08, SD.888$), education/programs staff had a mean score of ($M=2.33, SD1.155$), and other staff had a mean score of ($M=2.09, SD1.044$).

Multiple comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Health/clinical staff agreed more strongly than prison/senior officers that prisoners with mental illness have different needs to the rest of the prison population.

Appendices O - Phase Two Results and Additional Data - Management, Consultation and Context Construct

Staff Results

Metropolitan/Regional Differences

There is a total lack of health management support for mental health

On average, regional participants report a stronger level of agreement with the statement “there is a total lack of health management support for mental health” ($M = 2.91$, $SD = .978$), than metropolitan staff participants ($M = 3.28$, $SD = .882$). This difference was significant [$t(118) = 2.060$, $p < .05$] at the .05 level.

Staff Group/Occupation

I have never seen or heard of any policies relating to mental health

There was a significant difference across staff for Q10g: “I have never seen or heard of any policies relating to mental health” [$F(3, 116) = 2.830$, $p < .05$]. Health/clinical participants had a mean score of ($M=3.44$, $SD1.045$), prison/senior officers had a mean score of ($M=2.85$, $SD.961$), education/programs staff had a mean score of ($M=2.67$, $SD1.155$), and other staff participants had a mean score of ($M=2.82$, $SD1.079$).

Multiple Comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Prison/senior officers agreed, leaning towards undecided and health/clinical staff disagreed that they have never seen or heard of any policies relating to mental health.

You get callous working in prisons because everybody who is outside of the prison thinks that they know how to do the job better

There was a significant difference across staff for Q10j: “you get callous working in prisons because everybody who is outside of the prison thinks that they know how to do the job better” [$F(3, 116) = 6.784$, $p < .05$]. Health/clinical participants had a mean score of ($M=3.78$, $SD1.008$), prison/senior officers had a mean score of ($M=2.78$, $SD1.126$), education/programs staff had a mean score of ($M=4.00$, $SD.000$), and other staff participants had a mean score of ($M=2.91$, $SD1.375$).

Multiple Comparisons revealed a significant mean difference ($p < .05$) between health/clinical staff and prison/senior officers. Prison/senior officers agreed, leaning towards undecided and health/clinical staff disagreed with the statement above.

