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THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

**Hoping Against Hope:
The Prison-to-Community Transition Experience of Men With
Co-Occurring Severe Mental Illness and Substance Use Disorder**

Michelle Denton

Bachelor of Health Science (Nursing)

Master of Business Administration

A thesis submitted for the degree of Doctor of Philosophy at

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School of Social Work and Human Services

Abstract

This thesis explores the prison-to-community transition experience after short-term incarceration, from the perspective of men with co-occurring mental illness and substance use disorder in Queensland, Australia. A specific focus was to examine the impact of systems and structures on the individual experience of transition. Prior research has established that people with co-occurring mental illness and substance use are overrepresented in the Australian prisoner population. It is also known that transition from prison to community for the general custodial population is a time of vulnerability, with increased risk of substance use, homelessness, unemployment, reincarceration and post-release death. All of these risks are compounded for prisoners with co-occurring disorders who are also at risk of a range of poor criminal justice outcomes and losing contact with mental health services after release. Review of the literature indicates a tendency for research to focus on recidivism as an outcome and emphasise either individual risk behaviour or social and structural factors influencing prison-to-community transition. Interventions during transition for the current population have traditionally been based on the criminalisation hypothesis, with a focus on increased provision of mental health services in prison and an emphasis on continuity of care in the community. There is a growing recognition in the international literature that the issues are much broader than mental illness; however, there is a lack of clarity as to how to respond to the complex needs of this population. Research exploring the perspective of men with co-occurring severe mental illness and substance use disorder during their prison-to-community transition experience has rarely been undertaken.

The conceptual framework developed for this study shifts the emphasis away from recidivism towards recovery and wellbeing through a lens of individual action, but only in the context of the potential for systems and structures to impact on the ability of individuals to exercise agency. A qualitative method was used comprising repeat in-depth interviews with 18 men: within 1 month prior to leaving prison, within 2 weeks post-release and at 3 months post-release. Three themes characterised the transition experience of participants: “hoping against hope”; “adrift in freedom”; and “the slippery slope”. Participants reported leaving the predictable and routine life in prison where they hoped for a better life after release, to an uncertain, unstable and isolated environment in the community, eventually sliding into drug use, chaos and despair. The risk environment framework (Rhodes, 2009) and structuration theory (Giddens, 1984) were employed to understand how participants were caught in a complex dynamic between their individual risk behaviour and broader structural risk

environments. This thesis proposes that a web of interrelated factors contributed to participants in the study as “ambivalent agents” who were suspended between the two worlds of prison and community, with a sense of “non-belonging” in either world. They negotiated multiple and competing identities and were ultimately set up to fail in their hope for a normal life in the community by the “structuration” of risk during transition. The findings in this study support previous research that prison mental health services alone are inadequate to meet the needs of this population. There is a need for the review of parole practices for this population, with an emphasis on prevention of incarceration related to non-offending behaviour. In addition, a focus on the provision of comprehensive interventions during prison-to-community transition, such as supported accommodation, assisted employment and other individually tailored social supports, is indicated. These interventions, in combination with a focus on flow through integrated treatment services targeting the needs of short-term prisoners with co-occurring disorders may facilitate recovery and wellbeing in this population, improve continuity of mental health care on return to the community, as well as address criminal justice outcomes. These interventions should be planned as a whole of government response, framed by a mental health recovery approach that fosters belief in the individual for recovery, as well as utilising a collaborative focus on risk in terms of both “a risk” and “at risk” identities.

Declaration by author

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly authored works that I have included in my thesis.

I have clearly stated the contribution of others to my thesis as a whole, including statistical assistance, survey design, data analysis, significant technical procedures, professional editorial advice, and any other original research work used or reported in my thesis. The content of my thesis is the result of work I have carried out since the commencement of my research higher degree candidature and does not include a substantial part of work that has been submitted to qualify for the award of any other degree or diploma in any university or other tertiary institution. I have clearly stated which parts of my thesis, if any, have been submitted to qualify for another award.

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Publications during candidature

No publications

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Keywords

prison, transition, re-entry, reintegration, mental illness, substance use disorder, policy, qualitative, Queensland, Australia

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Chapter 1: Background, aim and overview

1.1 Background

Prison-to-community transition is emerging as a distinct field of study in the international literature where it has been identified as an important opportunity for intervention to help mitigate the challenging circumstances that typically face prisoners as they leave custody (Petersilia, 2000, 2003; Travis & Petersilia, 2001). The body of research in this area is growing rapidly; however, the field remains relatively new, particularly in Australia where there has been very little investigation of this topic. While there is no official data on the national rate of prison separations in Australia, it was estimated that approximately 50,400 people returned to the community from prison in 2007–08 (Martire & Larney, 2010), and there is a large and growing ex-prisoner population of approximately 385,000 (ABS, 2008). It has been firmly established that people with severe mental illness are overrepresented in this population (Butler, Indig, Allnutt, & Mamoon, 2011).

It has been well recognised for several decades that the majority of prisoners returning to the community face multiple and complex challenges. The general prisoner population are greatly at risk of social disadvantage and poor health outcomes, including a high risk of death during transition from prison (Kariminia, Law, Butler, Corben et al., 2007). Of immediate concern on release for most prisoners is the need for stable housing and to find and maintain employment (Baldry, McDonnell, Maplestone, & Peeters, 2006; Graffam, Shinkfield, & Hardcastle, 2008; Shinkfield & Graffam, 2009; Travis, Solomon, & Waul, 2001). People with mental illness, and particularly those with co-occurring substance use disorder, typically have all of these problems with the addition of complex health needs, often accompanied by limited coping strategies (Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005; Fisher, Silver, & Wolff, 2006). This population also frequently experience limited access to family and social support (Baillargeon, Hoge, & Penn, 2010) and are more likely to experience homelessness and unemployment (Baldry et al., 2006; Draine, Salzer, Culhane, & Hadley, 2002b; Solomon, Johnson, Travis, & McBride, 2004). They are also more likely to return to prison earlier than other ex-prisoners (Cloyes, Wong, Latimer, & Abarca, 2010), have a history of previous incarceration (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009) and to serve short sentences for misdemeanours (Lovell, Gagliardi, & Peterson, 2002). It has been suggested that people with severe mental illness can be caught in a “revolving door” (Baillargeon et al.,

2009; Howerton, Burnett, Byng, & Campbell, 2009) and that “mentally ill offenders are often trapped in a cycle of petty crime, incarceration, release, homelessness and reimprisonment” (Thompson, 2008, p. 103).

The focus of interventions for this population has traditionally been on the provision of mental health treatment in prison and on continuity of care into the community. It has been noted, however (Skeem, Manchak, & Peterson, 2011; Wolff, Frueh et al., 2013), that this approach is historically based in a common but erroneous belief in the criminalisation hypothesis (Abramson, 1972). This hypothesis was based on a series of assumptions that untreated mental illness was the main source of criminal behaviour, and that the overrepresentation of people with mental illness in prison was mainly as a result of deinstitutionalisation of psychiatric facilities followed by a lack of community mental health support, which led to an increased vulnerability to arrest (Skeem et al., 2011). The accepted solution in this discourse was that by identifying mental illness in prison and engaging the person in treatment, with a focus on linkages to community mental health, the overrepresentation of people in prison would decrease (Peterson, Skeem, Hart, Vidal, & Keith, 2010). This approach has been labelled the “first generation” of interventions in transition support (Hartwell, 2010; Wolff, Frueh et al., 2013). However, there is a growing consensus that the proportion of people with a mental illness that fit the criminalisation hypothesis is relatively small (Baillargeon et al., 2009; Peterson et al., 2010) and that the primary association is between mental illness and incarceration and not between mental illness and offending (Skeem et al., 2011). Coupled with this is a growing awareness from evaluation studies that the “first generation” approaches are showing only modest results and are not significantly reducing the overrepresentation of people with a mental illness in prison (Wright, Zhang, Farabee, & Braatz, 2014).

One of the issues in the United States, where most of the research on this population has been conducted, is that programs for this group are primarily funded and managed by the criminal justice system and have an emphasis on risk management and re-offending rather than programs with a therapeutic and recovery approach, led by the health sector (Wilson & Draine, 2006). Another issue is that while there are some comprehensive transition support programs for people with a mental illness leaving prison that have been shown to be effective they are extremely resource intensive (Hartwell et al., 2012). Many of the early transition support programs were developed using models based on support for people with a mental illness leaving hospital and adapted for use in the criminal justice system. Hartwell (2010)

suggests that more research is needed to assess whether these approaches are appropriate for people with a mental illness leaving prison and whether more cost effective approaches can be developed. Current models of transition coordination have been developed in Australia and Queensland without the availability of local research to facilitate an understanding of the particular needs and experience of the target population. Provision of support to this group is resource intensive in a climate of fiscal restraint and it is essential that scarce resources are directed towards effective models of service delivery. This research is based on an assumption that service models that are deeply responsive to the client experience is an important and necessary component of service design.

The challenge for prison-to-community transition research is that there appears to be multiple factors other than mental illness contributing to the overrepresentation of people with mental illness in prison, and little is understood about the best approach to take in terms of prison-to-community transition support for this population (Hartwell, 2010; Wolff, Frueh et al., 2013). Hartwell et al. (2012) comment:

While there is widespread recognition of the fact that “something must be done” to ease the re-entry process of individuals with mental disorders, a design of the most efficacious and utilitarian approach remains elusive.... In fact there are no comprehensive evidence based interventions addressing the post release transition needs of prisoners with serious mental illness. (p. 462)

In response to these insights, a new body of work is emerging that has been called the “second generation” approach (Barrenger & Draine, 2013; Osher, 2012; Wolff et al., 2013). This work appears to be taking related but parallel pathways of development in the literature. One pathway appears to remain primarily grounded in an understanding of individual risk behaviour as the major contributing factor to offending and incarceration of the mentally ill (Epperson et al., 2011; Osher, 2012; Wolff, Frueh et al., 2013). The other pathway is primarily grounded in an understanding of prison-to-community transition as socially situated (Angell, Matthews, Barrenger, Watson, & Draine, 2014; Davis et al., 2013; Draine & Wolff, 2009). More recently, the “risk environment framework” (Rhodes, 2002; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005) previously utilised to understand drug-related harm and HIV transition, has been employed to understand prison-to-community transition for people with severe mental illness (Barrenger & Draine, 2013).

There are a small number of studies in Australia examining factors relevant to the transition of the general custodial population, discussed in Chapter 3 (Baldry & Maplestone, 2003;

Baldry, 2010; Borzycki, 2005; Borzycki & Baldry, 2003; Graffam, Shinkfield, Lavelle, & McPherson, 2005; Kinner, 2006; Shinkfield & Graffam, 2009; Walsh, 2004). However, there are no known published studies in the Australian setting looking specifically at the transition experience of men with mental illness leaving custody. In addition to a lack of statistical data on this population, very little is known or understood about the complex dynamics impacting on the transition experience from a qualitative perspective. Researchers in the field have suggested that the US focus is different than the Australian context for this population (Baldry, 2010) and that it often “seductive” to “fall into the trap” of translating US data into the Australian context (Pitts & Smith, 2007, p. 67). This is especially so when discussing the prison and health environments, which are different in each country (Sheehan, McIvor, & Trotter, 2010). Moreover, Borzycki (2005) argues that any research and evaluation in the Australian correctional setting is scarce and that while knowledge from the international literature can be useful, “there are unique features of our cultural mix, our history, our geography and our multi-jurisdictional justice and welfare systems that make local research essential” (2005, p. xvii).

Overall, prison-to-community transition appears to be under-studied and under-conceptualised, particularly in terms of the Australian context. While the literature available provides a foundation for this study, it generally lacks a theoretical analysis of the complex interactions and systems that may be impacting on the individual experience. Visher and Travis (2003), for example, stated that “the successful reintegration of prisoners into society is arguably one of the most important components of an effective criminal justice system, yet remarkably little is known about the pathways of prisoner re-entry” (2003, p. 1). In addition, Bahr, Harris, Fisher, and Armstrong (2010, p. 2) commented that “although there has been extensive research on recidivism, there has been much less study of the process inmates go through when they are released from prison” [and] “There is need for more theorising and research about how released prisoners are able to make the transition to the community and adjust to life outside of prison”. Prison-to-community transition for people with co-occurring severe mental illness and substance use disorders, despite their high prevalence, have been particularly neglected by the research community. Hartwell (2010) observed:

more knowledge and innovative research is needed on the experience of ex-inmates with psychiatric disabilities and social integration [and that] resources for cost effectiveness studies as well as long-term follow-up qualitative studies are necessary. (p. 264)

After more than a decade of conducting quantitative research on prison-to-community transition, mainly with people with severe mental illness, Hartwell (2010) has been calling for qualitative research to explore questions related to the specific needs of released prisoners with a severe mental illness in the transition phase that she acknowledges quantitative research has not been able to illuminate. Hartwell (2010) makes a number of statements about this, including: ... “multimethod approaches have the ability to provide more comprehensive knowledge, data, and subsequent improved program planning” (p. 278) and “Qualitative research and description that documents the local barriers and resources influencing community reintegration is needed to inform post-release planning and transition services for ex-inmates with psychiatric disabilities” (p. 280). Hartwell (2010) concludes: “As it stands, qualitative research studies on the experience of ex-inmates with psychiatric disabilities in the community are scarce” (p. 280) There is clearly a gap in the qualitative research on the current topic and a need to further delineate, analyse and theorise about the specific nature of the challenges of prison-to-community transition for people with severe mental illness, as well as for people with co-occurring disorders.

The current study takes a different approach to other known research that has been undertaken to understand the prison-to-community transition experience for people with severe mental illness in five important ways. First, the qualitative approach utilised in this study seeks to understand the complexity of the transition experience from the perspective of men who have been diagnosed with co-occurring disorders. Thus, it seeks to hear the voices of participants and what is meaningful and relevant to them in terms of their needs and challenges during this time through the use of in-depth interviews. There are a small number of qualitative studies on the transition experience of the general custodial population (Howerton et al., 2009), of youth (Halsey, 2007) on women leaving prison (Baldry, 2010; McHugh, 2013; O’Brien, 2001) and a study specifically examining factors potentially impacting on post-release death (Binswanger et al., 2011). However, no known qualitative studies with the specific focus of the transition experience of men with diagnosed severe mental illness and co-occurring substance use disorder were found. Second, the study design of repeat interviews was an attempt to capture the entire transition phase in order to facilitate a fuller understanding of the transition experience than would have been possible with a cross-sectional view. Third, this study specifically focusses on the impact of systems and structures on the individual experience of transition, which is a perspective that has rarely been taken in previous prison-to-community transition research. Fourth, the conceptual

framework utilised in the study shifted focus to recovery and wellbeing rather than recidivism, which has been central to much of the prior research on this topic. Moreover, while an analysis of the reciprocal relationship between individual agency and structural considerations in the context of risk environments employing Giddens' (1984) structuration theory has been utilised by Rhodes (2009) in research on drug-related harm and HIV transmission; this approach has not been previously applied to the current context in any other known studies. Finally, very little is known about the prison-to-community transition experience for people with diagnosed severe mental illness and substance use disorder in the Australian context and this is the first known study to be undertaken with that specific focus.

The topic of this research evolved as a result of involvement by the researcher in the design and development of services and programs for people with severe mental illness who are involved in the criminal justice system in Queensland. As a service manager in the forensic mental health field for over a decade, the researcher worked with a multidisciplinary team of clinicians to build an integrated network of services to provide assessment, diversion, treatment and transition support services for people with mental illness involved with the criminal justice service. The prison mental health component of the service was constrained by funding and policy decisions that restricted scope to the provision of psychiatric treatment inside prison and a limited focus on transition support that was primarily aimed at improving continuity of mental health care by linking consumers to mental health services in the community. The commitment to this research developed through the experience over 10 years of working with colleagues who continue to provide mental health services in prisons in less than ideal conditions and with limited capacity to provide comprehensive support for transition back to the community.

This is the first known study to use an in-depth, repeat interview research design to explore the perspective of men with co-occurring disorders in the Australian context. As the policy focus on the transition needs of people with a mental illness leaving custody grows, it is important that the gaps in existing knowledge are filled by hearing the voices of mentally ill prisoners and their experience of transition. This research adds to the understanding of the complexity of the prison-to-community transition experience and assists in identifying factors that may facilitate successful transition, in order to inform policy and program development that is responsive to the needs of this target group.

1.2 Research aims

The aims of the study were to:

1. Explore the experience of men with co-occurring severe mental illness and substance use disorder leaving prison in Queensland;
2. Enhance understanding of the needs and challenges of this population during prison-to-community transition;
3. Examine the impact of systems and structures on the individual during prison-to-community transition;
4. Identify policy and applied implications of this research that is responsive to the needs of the target group.

1.3 Overview of the thesis

Having outlined the rationale, significance and scope of this study, the data and literature on the prisoner and ex-prisoner populations and the complex problems they are known to face as they return to the community are reviewed in Chapter 2. The international and local policy context is also outlined in this chapter. Previous research on the transition experience is reviewed in Chapter 3 and a thematic and historical map of the literature specifically relevant to understanding the transition experience for the population being studied is presented and discussed. In Chapter 4, the conceptual framework underpinning this research is explained. The conceptual framework recognises the lived experience of research participants as the subject of enquiry, acknowledges individual agency as one key element influencing the transition experience, and shifts the focus away from recidivism towards recovery and wellbeing as an important aspect of the prison-to-community transition experience. Rhodes' (2009) "risk environment" framework combined with the National Institute for Health and Clinical Excellence's (NICE) conceptual framework for understanding public health (Kelly et al., 2009) were utilised to develop the four surrounding structural elements of the political/economic risk environment, the social/cultural risk environment, the prison/post-prison risk environment and the policy/organisational risk environment. Giddens' (1984) structuration theory was employed to understand the reciprocal relationships between individuals and risk environments as they interact and how environments can "structure" individual risk behaviour. The methodology is discussed in Chapter 5 and some of methodological challenges encountered in the research are described.

Following the outline of the contextual, conceptual and methodological underpinnings of the thesis, Chapters 6 to 8 present the analysis of the qualitative data collected from 18 men with severe mental illness and co-occurring substance use disorder who were recruited through the Queensland Prison Mental Health Service and interviewed three times during their transition from prison to community. Chapter 6, “Hoping against hope”, captures the complex tension pre-release between participants’ strong hopes for the future to lead a normal life in the community and their ambivalence about leaving their friends in prison and the routine and predictability of prison life. Chapter 7, “Adrift in freedom”, examines the vulnerability participants experienced on return to the community without the anchors of stable housing, meaningful activity and family support. “The slippery slope” explored in Chapter 8 represents the struggle against the gradual slide back into drug use, crime and despair. Chapter 9 draws together and reflects on the analysis of the experience of the research participants in light of the context and theory, finally discussing implications for policy and practice in the provision of transition support for this population, the limitations of the study and future research.

Appendix A provides a copy of the participant information sheet. Appendix B provides a copy of the information given to clinicians involved in recruiting for the study, Appendix C provides a copy of the consent form, Appendix D provides a copy of the semi-structured interview guide, and Appendix E provides a copy of the ethics approval.

Chapter 2: The prisoner population and the transition context

2.1 Introduction

This chapter outlines the criminal justice, health, social and policy context of prison-to-community transition for men with severe mental illness and co-occurring substance use disorder. The population being studied are overrepresented in the criminal justice system and are known to experience complex health, psychological and social problems during prison-to-community transition. They are predominantly a young population who experience repeated short-term returns to prison, with extreme risk of death post-release. There is considerable debate in the literature as to why this population are overrepresented in prison, and this discussion has important implications for understanding prison-to-community transition. The policy environment in the United States, the United Kingdom and Australia is relevant to this study and is compared and contrasted across these jurisdictions to review where the Australian policy context is situated within the international context.

2.2 Prisoner and released prisoner populations

In the last 25 years the number of persons incarcerated in the developed world has increased dramatically and the world's prison population is currently estimated to be 9.8 million (Walmsley, 2009). The United States has the highest incarceration rate in the world, with 730 people incarcerated per 100,000 adults in the community (Glaze & Parks, 2011). The US data is in stark contrast to other industrialised countries such as Sweden, Denmark, Switzerland, Germany and Japan, which all have prison populations of less than 85 prisoners per 100,000 of their adult population (Walmsley, 2009). The phenomenon in the United States of a total of seven million people incarcerated or under supervision in the community (Wakai, Shelton, Trestman, & Kesten, 2009) has been described as "mass incarceration" (Travis & Visher, 2005) and is causing widespread attention and concern by community members and policy makers (Greenberg et al., 2011).

The prisoner population in Australia sits in between the rates of the United Kingdom at 154/100,000 and New Zealand at 190/100,000. In Australia, as of June 30, 2013, there were 30,775 people in prison, reflecting a rate of 170 people incarcerated per 100,000 adults compared to 165/100 in 2012 (Australian Bureau of Statistics [ABS], 2013). Of these, 20% or 6,076 people were in prison in Queensland, the second largest prison population in Australia (ABS, 2013). There is great variation in prisoner numbers between states in Australia.

Northern Territory's imprisonment rate is over four times higher per head of population than for New South Wales; five times higher than for Queensland; and seven times higher than for Victoria. The prison population in Australia increased by approximately 37% from 2000 to 2010, including an increase in female prisoners by 60% (ABS, 2010). This rate of growth in prisoners is above the rate of population growth and has been attributed largely to sentencing policy and practices (Brown, 2013).

Of those people incarcerated in Australia in 2012, the vast majority (92%) were male and over a quarter (27%) of the prison population identified as Indigenous Australians (ABS, 2013). The incarceration rates for Indigenous people were 14 times those of non-Indigenous people (6974/100,000), despite making up less than 3% of the Australian population (Heffernan, Andersen, Dev, & Kinner, 2012). It is a relatively young population in prison in Australia, with just under 77% of the people in custody aged between 20 and 44 years and the median age of all prisoners at 33.9 years (ABS, 2013).

Similar to other western jurisdictions, most prisoners are spending short periods of time incarcerated. Prisoners in Australia were sentenced in 2012 to a median sentence length of 3 years and 3 months with a median of expected time to serve of 2 years. Almost one quarter (24%) of all prisoners were on remand (unsentenced), with a median time spent in prison of 2.8 months (ABS, 2013). Over half (58%) of all prisoners in Australia on June 30, 2013 had served a sentence in an adult prison prior to their current incarceration, with 63% of sentenced prisoners having served a prior sentence (ABS, 2013). Of all sentenced prisoners, only 5% were serving a life term or other indeterminate sentence. It is clear that while many prisoners will return to prison in relatively short periods of time, 95% will be released back into the community within several years (Petersilia, 2003).

While it has been reported that there is no official data on the annual national rate of prison separations in Australia, it was recently estimated that approximately 50,400 people returned to the community from prison in 2007–08 (Martire & Larney, 2010), which has grown from estimates of 43,000 in 2001 (Baldry et al., 2006). Calculations were made by Martire and Larney (2010) from the available data representing 62% of known prison separations in three states, excluding Queensland where data were not available. It has been estimated that there is a large and growing ex-prisoner population in Australia of 385,000 people, representing 1.8% of Australia's population (ABS, 2008). There are strong calls in the literature for routine collection of prison separations in order to provide adequate information for policy

and planning (Kinner, 2006; Kinner, Burford, van Dooren, Gill, & Gallagher, 2013; Kinner, George, Campbell, & Degenhardt, 2009; Martire & Larney, 2010). It has been suggested that the lack of data on prison separations in Australia attests to the marginalised nature of this population and “is sound testimony to the politico-social envisioning of this population as deservedly and fundamentally “other” (Halsey, 2010, p. 553).

2.3 Health and social problems of prisoners and released prisoners

There is substantial evidence that people in prison have significant mental health and substance use problems in comparison to the general community, and that people with a severe mental illness are overrepresented within the criminal justice system. It has been estimated that men with a mental illness are four times more likely, and women eight times more likely, than the general population to be incarcerated (Butler, Allnut, Cain, Owens, & Muller, 2005; Butler et al., 2006; Butler & Milner, 2003; Fazel & Danesh, 2002; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1990).

While the figures vary somewhat between countries, it has generally been reported that 8–14% of people in prison in Australia have a psychotic illness such as schizophrenia, with up to 40–60% experiencing some mental disorder such as anxiety, depression or post-traumatic stress disorder (Butler et al., 2006; Butler & Milner, 2003). It is possible, however, that these data do not accurately reflect the prevalence of psychotic illness in Australian prisoners, with one US study recently reporting rates of psychosis in jails of 15% for males and 30% for females (Steadman et al., 2009). There is consensus in the literature that the true prevalence of mental illness in prisoners and released prisoners is unknown because of a lack of available, comprehensive and consistent data (Butler et al., 2005; Lurigio, 2011). It is clear, however, that women, Indigenous people and remand populations are all overrepresented in the mentally ill cohort in Australia (Butler et al., 2006; Heffernan et al., 2012; Tye & Mullen, 2006). While there are no comparable Australian data, findings of up to 19% prevalence of psychotic illness have been found in the community corrections population in the United States (Lurigio, Swartz, Johnson, Graf, & Pickup, 2003). This contrasts markedly with the estimated 12 months prevalence of psychotic illness in the general community in Australia, of less than 1% of the population (Morgan et al., 2011).

Prisoners in general experience markedly higher rates of chronic and communicable diseases than their community counterparts, particularly HIV, hepatitis C and hepatitis B (Butler & Dolan, 1997; Hammett, Roberts, & Kennedy, 2001). People with a severe mental illness die

up to 30 years earlier than the general community population, mostly because of physical illness and chronic disease (De Hert et al., 2011). The risk of mortality for people with severe mental illness from chronic disease such as cardiovascular, cancer and chronic lung disease is 10 times that of the risk of suicide (Lawrence & Kisely, 2010; Leucht, Burkard, Henderson, Maj, & Sartorius, 2007). Likewise, people with severe mental illness in prison are a particularly disadvantaged group and are substantially more likely to report poor physical health than the general custodial population (Butler, Allnutt, & Yang, 2007). Rates of physical victimisation in prison are higher for prisoners with mental illness (Blitz, Wolfe, & Shi, 2008), as are rates of sexual assault in prison (Wolff, Blitz, & Shi, 2007). People with a mental illness are also more likely to commit suicide while they are in prison (Baillargeon et al., 2009).

People with cognitive disability are also known to be overrepresented in prison and while the exact prevalence is unknown, estimates have been as high as 30% of people involved with the criminal justice system (Borzycki, 2005; Petersilia, 2005). In a large data linkage study conducted in Sydney, NSW, involving the criminal justice and social service pathways of 2,731 individuals with known mental health or cognitive disorder diagnosis, Baldry et al. (2012) found that the 1463 people with known cognitive disability had multiple and complex co-morbidities, poorer criminal justice outcomes and higher need for support to live in the community.

While there is a lack of precise information particularly in Australia, there are strong indications that those people with severe mental illness who are leaving prison are more disadvantaged than both released prisoners with no mental illness and people with mental illness but no criminal justice involvement. A Queensland-based study comparing 61 men with a psychotic disorder incarcerated on remand, with 123 men with psychosis from the surrounding community with no criminal justice involvement, found that that the offender group reported more childhood abuse, increased history of self-harm, fewer educational qualifications, significantly greater levels of substance dependence, as well as higher levels of homelessness in the previous year (White, Chant, & Whiteford, 2006). Social issues such as low education levels, unemployment and lack of stable housing have been widely reported in ex-prisoners (Borzycki, 2005; Graffam et al., 2005; Petersilia, 2003; Shinkfield & Graffam, 2009). There is very little detailed knowledge, however, of the health and wellbeing of prisoners post-release in Australia. It has been suggested that “information on the health of

prisoners as they re-enter the community is almost non-existent [and] is urgently needed” (Belcher & Al Yaman, 2007).

There is extensive literature discussing the difficulties people being released from prison have in finding suitable accommodation. There is a growing consensus that there is a strong association between homelessness and incarceration and that these factors increase the risk of each other, often complicated by mental illness and substance use (Greenberg et al., 2011; Tsai, Mares, & Rosenheck, 2012). In the first major study on the housing status of released prisoners in Australia, Baldry et al. (2006) found a significant association between homelessness and reincarceration in released prisoners. The 50% of participants in the study ($n = 238$) who moved accommodation more than twice in the first 9 months post-release were up to eight times more likely to be re-incarcerated during that time. Moving often, lack of family and professional support, lack of employment and worsening drug use were all associated with poor housing and return to prison (2006, pp. 6–7). Baldry’s study did not measure the impact of mental illness; however, there is growing evidence that people with a mental illness are particularly vulnerable to homelessness. In the second Australian survey of psychosis ($n = 1,825$), approximately 12% of people living with psychosis reported having been homeless in the previous 12 months (Harvey, Killackey, Groves, & Herrman, 2012). The combination of severe mental illness and being recently released from prison is likely to compound the disadvantage in terms of stable housing. Tsai et al. (2012) call for more research into the specific housing support needs of people who have been incarcerated and are chronically homeless.

People who are leaving prison with or without severe mental illness have consistently been found to have high rates of unemployment and experience difficulty in finding a job compared to their counterparts in the community. It has been well established that if ex-prisoners remain unemployed they are at a higher risk of returning to prison (Graffam et al., 2008; Latessa, 2012; Shinkfield & Graffam, 2009; Tripodi, Kim, & Bender, 2009; Uggen, 2000). Even with a history of previous employment, having a criminal history has been shown to hinder job search. Furthermore, practical issues such as not owning work attire have been found to impede employment opportunities (La Vigne, Shollenberger, & Debus, 2009). Lack of family support has also been shown to impede job success, because of the reliance on a network of family and friends to vouch for the person looking for a job (La Vigne et al., 2009). In a survey of 424 prisoners about to be released from prison in Ohio (Visher, Baer, & Naser, 2006), 90% of participants thought that a job on release would help them stay out of

prison, only 22% had a job organised, and 89% felt that that would need *some help* or *a lot of help* finding a job. Of the participants in this survey, 31% identified “finding a job or not getting a job because of their criminal record” as their greatest worry about life after prison (2006, p. 6).

Employment alone will not necessarily improve the transition experience for the population being studied. Unemployment is a known risk factor for offending and incarceration; however, whether employment is protective against re-incarceration for released prisoners is contested in the literature (Latessa, 2012; Tripodi et al., 2009). It would appear that the positive impact of employment on offending, when it does occur, is relatively short term and is related to a complexity of factors, including the level of support that is received from family and support agencies. Research has found that there is a relationship between unstable housing and unemployment that appears to increase the risk of each other, which in turn can increase the risk of offending and re-incarceration (La Vigne et al., 2009). There also appears to be a relationship between employment and substance use, with those people who avoid substance use post-release more likely to find employment and less likely to return to prison (Brucker, 2006; La Vigne et al., 2009). All of these associations in relation to employment appear to apply equally to people with and without mental illness. Frounfelker, Teachout, Bond, and Drake (2011), for example, found no difference between the positive impact of employment outcomes for a group of people with severe mental illness and no criminal justice involvement and a comparison group of people with severe mental illness and offending behaviour, and concluded that employment support would be equally appropriate for both groups.

2.4 Short-term prisoners and the “revolving door” of incarceration

A “revolving door” phenomenon, with repeated cycles in and out of short-term incarceration, has been clearly identified in the literature (Baillargeon et al., 2009; Howerton et al., 2009; Padfield & Maruna, 2006). People who have severe mental illness, and those who are released on parole with conditions attached, have been found to be particularly vulnerable to short-term incarceration and the revolving door phenomena (Baillargeon et al., 2009; Haimowitz, 2004). Short-term prisoners have been termed “the forgotten majority” as they form a dominant group in the prisoner population but receive less attention and services than higher risk long-term prisoners (Howerton et al., 2009). Hartwell (2003) found that there was

a tendency for people with a long history of mental illness to be reincarcerated more quickly than their non-mentally ill counterparts and for predominantly misdemeanour offences.

There are a number of compounding and interrelated reasons why short-term prisoners are more vulnerable to the revolving door phenomenon. Short-term stay does not allow time for pre-release preparation and short-term prisoners are often not eligible for programs such as drug and alcohol education (Lewis, Maguire, Raynor, Vanstone, & Vennard, 2007). In addition, it has been found that 30–40% short term prisoners lose their housing while in prison (Teague, 2000), and repeated short-term incarcerations make it more difficult to secure and maintain employment. Moreover, health and mental health problems are likely to be overlooked in short prison stays (Howerton et al., 2009).

It is known that short-term prisoners include many people who have breached their parole conditions due to a technical violation. People on parole with severe mental illness have been found to be more vulnerable to this occurring than their counterparts in the general custodial population (Baillargeon et al., 2009; Howerton et al., 2009; Padfield & Maruna, 2006). For example, a violation can occur because of a failure to present to the parole office for a scheduled appointment, failure to notify of a new address, failure to attend a treatment program, failure to take prescribed medication or for drugs found in the urine (Pryor, 2010). High expectations placed on parolees have been reported, such as to attain full-time employment, attend weekly drug tests during office hours, attend outpatient drug treatment appointments as well as attend Alcoholic Anonymous and Narcotics Anonymous meetings in the evenings (Pryor, 2010). Fulfilling these sorts of expectations is likely to require high level planning and organising skills and may disadvantage people with a severe mental illness.

Research in the United Kingdom found that recalls to prison have been rising rapidly over the last decade and that only 16% of recalls from parole in 2004 were as a result of committing a new offence (Padfield & Maruna, 2006). A similar trend has been identified in the United States, where up to 50% of recalls were identified as being for technical violations (Travis & Petersilia, 2001). Up to one third of California's prison population consists of recalled parolees, costing the state \$500 million dollars per year (Padfield & Maruna, 2006). It has been suggested that the increase in recalls is as a result of more stringent rules and regulations surrounding parole, rather than parolees' behaviour on release, and that this reflects a "new penology" in sentencing and parole practices (Simon, 1996). These developments have also been described as reflecting "a discourse emphasising risk rather than reformation or justice"

that is politically motivated in part by governments wanting to promote a “tough image” on crime (Padfield & Maruna, 2006, p. 339).

Tighter restrictions on parolees have been described as not only costly, but discriminatory, because the process of recall from parole in the United States, United Kingdom and Australia is administrative rather than judicial and therefore open to bias against people with certain characteristics, such as a history of mental illness (Padfield & Maruna, 2006). There is an inherent tension apparent in research findings related to parole practices for people with severe mental illness. That is, when testing effectiveness of practices such as greater parole supervision to address issues that arise post-release, such as minor drug use or failure to attend appointments, results show that greater supervision leads to greater surveillance, in turn leading to increased levels of recall for parole violations for people with mental illness (Osher, 2012). Alternative approaches, such as referral to treatment programs for post-release drug or alcohol use, and supportive accommodation for parolees who have difficulty attending parole appointments due to chaotic lifestyles resulting from homelessness or mental illness, are consistently suggested in the literature (Epperson et al., 2011; Lurigio, 2001; Petersilia, 2005).

People with severe mental illness and co-occurring substance use disorder are overrepresented in short-term prisoners. It is ironic that short-term prisoners not only form the majority of people in prison; it is possible that they have the greatest needs in relation to continuity of mental health care, alcohol and drug treatment, housing, employment and education (Howerton et al., 2009). However, it is this group who receive less attention in terms of access to rehabilitation services and transition support than those people leaving prison who are considered to be of higher risk (Baldry, Dowse, Snoyman, Clarence, & Webster, 2008)

2.5 Post-release mortality

The immediate post-release period — for up to 1 year — is a time of marked vulnerability for ex-prisoner mortality, whether or not they have an identified mental illness (Biles, Harding, & Walker, 1999; Coffey, Veit, Wolfe, Cini, & Patton, 2003; Kariminia, Law, Butler, Corben et al., 2007; Kariminia, Law, Butler, Levy et al., 2007; Kinner et al., 2011). The risk of death from substance abuse, suicide or accident in the first 2 weeks post-release has been found to be up to 17 times higher than in the general population (Kariminia et al., 2006; Stewart, Henderson, Hobbs, Ridout, & Knuiman, 2004) and is highest in the days and weeks

immediately following release (Binswanger et al., 2007; Kariminia, Law, Butler, Corben et al., 2007)

An estimated 449–472 deaths occurred in the first 12 months following release from prison in Australia in 2007–08, with a disproportionate number of these people dying in the first 4 weeks post-release (Kinner et al., 2011). Just over half of these deaths were drug related and the remainder were from natural deaths and all other causes including suicide. This is far higher than the deaths that occurred in custody in Australia, which was 45 deaths in 2007 (Kinner et al., 2011). The risk of post-release death begins at an early age with juvenile offenders and continues into the adult offender population (Coffey et al., 2003; Pratt, Piper, Appleby, Webb, & Shaw, 2006; Stewart et al., 2004). It has also been suggested that the risk of post-release death increases with the number of incarcerations, although this relationship does not appear to be well understood (Graham, 2003).

Apart from the deaths from drug overdose, little is known about the reasons for the high rates of suicide in the immediate post-release period, although the high prevalence of mental illness and substance use, combined with socioeconomic disadvantage in released prisoners, are considered to increase the risks (Fazel & Danesh, 2002). Other reasons may be community exclusion, stigma, homelessness, lack of paid employment and a lack of appropriate care and attention to suicidal ideation in released prisoners (Pratt et al., 2006). It is clear that this marginalised group of people, even in the absence of mental illness, has a very high risk of death on release. While there are no easy solutions, it would seem that many of these deaths are potentially preventable, and given that many of the deaths occur in the weeks and months following release, it is likely there is a key opportunity for intervention.

2.6 Criminal justice involvement of people with mental illness

A number of explanations have been posed as to why people with a mental illness are overrepresented in the criminal justice system and the debate continues about the contributing factors. While there appears to be no apparent link between mental illness and crime, there is a strong link between mental illness and incarceration. It is important to review this debate because it appears that prevailing beliefs and the interpretation of the research investigating these issues has had a profound impact on the way the prison-to-community transition experience for people with severe mental illness has been understood and responded to (Skeem et al., 2011; Wolff, Frueh et al., 2013).

Some observers suggest that prisons have become “de facto mental institutions” (Henderson, 2008) or “mental health institutions of the 21st century” (White & Whiteford, 2006). There has been debate for over 30 years or more as to whether the wide scale closure of psychiatric beds in western countries, referred to as “deinstitutionalisation”, has directly or indirectly caused the increase of people with a mental illness being incarcerated, or whether there are other explanations (Abramson, 1972; Lamb & Weinberger, 2005; Lamb, Weinberger, & Gross, 2002; Mullen, Briggs, Dalton, & Burt, 2000; White & Whiteford, 2006). It is a common view, according to Skeem (2011), that there has been a direct migration of the mentally ill from closed psychiatric beds to prison beds, mainly as a result of underfunded or inadequate community mental health services. However, this view is widely contested, and no study has been found that definitely confirms the hypothesis (Peterson et al., 2010; Skeem et al., 2011). The argument follows that if the overrepresentation of people with a severe mental illness in prison is as a result of not enough psychiatric beds or community mental health services, then the logical response is to focus primarily on providing more mental health services in prison and place stronger emphasis on referrals between prison and the community during the transition phase (Prins & Draper, 2009). However, it appears that there are a range of complex factors contributing to overrepresentation of this population in prison that are unlikely to be ameliorated by a primary focus on mental health services. There are three main explanations in the literature for this overrepresentation that are important in terms of understanding the population being studied, and their needs during prison-to-community transition.

First, there is research that both supports and disputes the deinstitutionalisation explanation. The support of this hypothesis began with the Penrose theory (Penrose, 1939), also known as the “hydraulic hypothesis” (Lurigio, 2011). The Penrose theory held that there was a stable population in industrialised countries who needed to be permanently confined because they lacked the capacity to survive in the community, and that there is an inverse relationship between prison inmates and patients of psychiatric hospitals. The reasoning is that following the wide scale closure of psychiatric hospitals, inadequate funding for the community mental health sector resulted in the criminalisation of people with a mental illness, who shifted en masse into prisons (Prins, 2011). Criminalisation has been described as when people with severe mental illness are arrested and detained in circumstances where there is no criminal intent, or for public order offences or survival crimes (Lurigio, 2011). For example, in an early study, Teplin (1983) found that after a street encounter, people with severe mental

illness were more likely to be arrested than non-mentally ill people for the same offence. This has been partially explained by the unnerving or frightening behaviour that people who are mentally unwell can display at times in public (Lurigio, 2011). Teplin (1984) also found that police were not necessarily biased or inhumane in their dealings with this population, but often made “mercy bookings” in order to obtain services for people in need of shelter and food. Other research has found that these situations could sometimes escalate to incidents, such as assaulting police, and thereby attracting a more serious charge and incarceration (Godfredson, Thomas, Ogloff, & Luebbers, 2011; Lamb & Weinberger, 2005). One study showed that people with a mental illness are more likely to have contact with the criminal justice system due to underfunded or ineffective social support services, particularly services to deal with crisis in the community other than police (Godfredson et al., 2011).

The picture is complicated by evidence that the criminal justice and the mentally ill populations share similar circumstances of social disadvantage (Draine, Salzer, Culhane, & Hadley, 2002a; Draine et al., 2002b). Social disadvantage — particularly poverty and homelessness — is strongly associated with offending in both the general custodial and mentally ill populations (Hartwell, 2003; Henderson, 2008). Some research indicates that a lack of affordable housing leads to homelessness and subsequent increased contact with police and more arrests (Allender, 2005; Osher & Han, 2002). The “institutional circuit” for this population, of homeless shelters, psychiatric institutions, drug rehabilitation centres and prison has long been observed (Hopper, Jost, Hay, Welber, & Haugland, 1997). While it is recognised that deinstitutionalisation and criminalisation of the mentally ill have contributed in some part towards the overrepresentation in prison, it is also clear that mental illness and the availability of mental health services is only one of a range of problems for this population. Prins (2011) comments:

The history of deinstitutionalisation provides an intuitive but reductionist narrative about the reasons why people with SMI are overrepresented in correctional settings. (p. 720)

There are many studies that dispute the deinstitutionalisation and criminalisation hypotheses. The Penrose theory (1939) was supported by some early researchers (Abramson, 1972; Lamb & Weinberger, 2005), but is increasingly disputed on the basis that data over three decades showed the rise in people with severe mental illness in prisons, that occurred around the same time as a decrease in hospital beds, were misinterpreted (Large & Nielssen, 2009; Prins, 2011). It is more likely, proposes Lurigio (2011), that the release of people from hospitals and

the increase in people with a mental illness in prison occurred for different reasons and involved different populations. This is based on arguments that the emptying of hospitals began a decade before the rise in prison numbers, most people who were released from long-term psychiatric care did not end up in prison, those people who were in psychiatric institutions have different characteristics from those of the mentally ill prison population, and evidence that the vast majority of people with severe mental illness, although they have multiple problems, survive in the community with community mental health support (Lurigio, 2011; Mullen, Burgess, Wallace, Palmer, & Ruschena, 2000; Prins, 2011).

Several studies have found that the mentally ill population being arrested were not homogenous. For example, Lurigio and Lewis (1987, as cited in Lurigio, 2011), found that there were three groups: those committing public order violations or “victimless” crimes such as public drunkenness; those committing “survival” crimes, such as begging on the streets or shoplifting; and those whose offences were indistinguishable from people without mental illness, such as robbery, burglary and assault. Peterson et al. (2010) found that the vast majority of offences committed by people with severe mental illness were as a result of anger and impulsiveness, often related to substance use, similar to the general custodial population, whereas only 7% were as a result of symptoms of mental illness or for survival offences. Lurigio (2011, p. 12) declared that the traditional notion of criminalisation is “antiquated” and that a more comprehensive view of the complexities of the overrepresentation of people in the criminal justice system should be considered.

A second and possibly the major factor considered to be contributing to overrepresentation of people with severe mental illness in the criminal justice system is related to the impact of substance use and the “war on drugs” in western jurisdictions (Lurigio, 2011; Prins, 2011). The prison population in the United States quadrupled between 1980 and 2000 with a 243% increase, and drug offences were among the largest category of arrest during that time (Lurigio, 2011). With the high proportion of people with severe mental illness using drugs, it has been noted that “like dolphins among tuna, many people with severe mental illness were caught in the net of rigorous drug enforcement policies” (Lurigio & Swartz, 2000, p. 70).

The prison population in Australia and Queensland has also increased markedly beyond the increase in population, and this has been attributed to sentencing practices and drug enforcement policies (Brown, 2013; Halsey, 2010; Henderson, 2008). Recent work in Australia is critical of the ‘penal culture’- in essence a punishment culture- in Australia that is

theorised as contributing to the overrepresentation of people with mental and cognitive disability in prison through a “complex of social cultural and decision making factors, in interaction with frameworks of legislation”. (Cunneen, Baldry, Brown, Brown, Schwartz & Steel, 2013, p. 3). This work uses the term ‘hyperincarceration’ to describe the targeting of particular racial groups such as Indigenous Australians and other marginalised groups such as people with mental and cognitive disability and drug and alcohol problems for ‘punishment’ that is less about criminal activity and more about legal, social and economic policy and political ideology (2013, p. 4-5).

Substance use has been widely recognised as a key factor in offending in the general custodial population. While people with a mental illness have no higher rates of offending than the general population, there appears to be a growing consensus that a combination of severe mental illness and substance use disorder is strongly related to offending and incarceration (Cloyes et al., 2010; Greenberg et al., 2011; Heinrichs & Sam, 2012). An Australian study found that only those people with a mental illness *and* a co-occurring substance use, and those people with substance use problems alone had significantly higher offending and incarceration rates compared to people with a mental health impairment who did not use substances (NSW Bureau of Crime Statistics and Research, 2010). The relationship between substance use, offending and schizophrenia has also been demonstrated in several studies, including studies where drug and/or alcohol use was identified as the most significant variable in relation to offending (Fazel & Yu, 2011; Greenberg et al., 2011; Mullen, Burgess et al., 2000). Recent work found there is a primary link between schizophrenia, substance use and offending, and also proposes some tentative suggestions about links between substance use, paranoid symptoms, command hallucinations and offending (Heinrichs & Sam, 2012).

The association between mental illness and substance misuse is widely recognised (Crawford, 1996; Lowe, 1999; Menezes et al., 1996; Siegfried, 1998). It is estimated that approximately one third of people with severe mental illness in the community have a co-occurring substance use disorder, and this has been found to rise to between 60% (Fowler, Carr, Carter, & Lewin, 1998) and 70% of offenders with severe mental illness (Hartwell, 2004a; Lurigio et al., 2003; Swartz & Lurigio, 2007). There is a particularly well-established link between illicit drug use and crime (Grann, Danesh, & Fazel, 2008; Johns, 1998; Sinha & Easton, 1999). It has been widely reported in the United States that that up to 75% of the general custodial population has been found to have a substance use history (Petersilia, 2003, 2005);

and it has also been found that alcohol abuse was linked to 80% of crimes committed by prisoners in the United States (Belenko, 1998). It is also well established that the presence of co-occurring mental illness and substance use disorders tends to result in greater impairment than occurs in a single condition. This group has been found to be additionally vulnerable to involvement in the criminal justice system because of a combination of decreased capacity to make “rational decisions and risk/ benefit calculations” (Hartwell, 2004a, p. 85), due to their illness and addiction and increased visibility to police related to non-normative behaviour (Heginbotham, 1998). Higher relapse rates of both mental illness and substance use, increased rates of hospitalisation for both physical and mental illness, increased episodes of violence and suicide, increased victimisation, higher drop-out rates from treatment, housing instability, poorer long-term recovery and increased rates of incarceration have all been found in international and Australian studies on co-occurring disorders (Butler, et al., 2011; Drake, Wallach, Alverson, & Mueser, 2002; Messina, Burdon, Hagopian, & Prendergast, 2004; Proctor & Hoffmann, 2012; Swartz & Lurigio, 2007).

A third contributing factor to the overrepresentation of people with severe mental illness in prison is related to entrenchment in the criminal justice system and the cycle of repeated short-term incarceration frequently experienced by people with co-occurring disorders (Prins, 2011). It has been found that people with a mental illness are less likely to be approved for community supervision, are up to twice as likely to have their community supervision revoked, and are more likely to be re-incarcerated for technical violations such as not presenting for appointments with their parole officer or minor drug use detected from urinalysis (Messina et al., 2004; Skeem et al., 2011; Travis & Petersilia, 2001). Some research has found that community corrections officers have a lower threshold for revoking community supervision for people with a mental illness compared with the non-mentally ill (Skeem, Encandela, & Eno Loudon, 2003). It has also been found that parole officers can use subjective criteria for making revocation decisions based on whether the parolee was likeable, responsible or pleasant (Steen, Opsal, Lovegrove, & McKinzey, 2013, p. 88).

Overall, the link between mental illness, offending and incarceration is complex, and new research is continuously emerging to assist in the understanding of the overrepresentation of people with a mental illness in prison, in order to inform an appropriate evidence-based response to prison-to-community transition support. The consensus in the contemporary literature is that while there is no inherent link between mental illness and offending, there is a link between mental illness and incarceration that is most likely mediated by co-occurring

substance use (Hartwell, 2010; Wolff, Frueh et al., 2013). Despite the criminalisation hypothesis being highly contested, the provision of services to people with a mental illness and criminal involvement has been largely driven by these ideas (Skeem et al., 2011; Wolff, Frueh et al., 2013). This has generated a response that focuses primarily on individual behaviour and treatment for mental illness in prison with post-release linkage to community mental health services. After reviewing the literature, however, Barrenger and Draine (2013) make the following statement:

Interventions to date, have not been successful in reducing criminal and psychiatric recidivism or improving mental health outcomes for persons with mental illness involved in the criminal justice system. (p. 158)

Hence, the understanding of prison-to-community transition for people with co-occurring disorders is at a crossroads. The historical approach to support during transition has been seriously challenged and a new approach is required.

2.7 Policy context of prison-to-community transition

The policy environment in terms of prisoners and ex-prisoners has been strongly influenced internationally by political ideology and more recently by economic forces. Brown (2013) suggests that historically expenditure on prisons has been “largely immune from cost-benefit analysis” and driven more by “law and order” crises, especially those generated by sensationalised individual cases (2013, p. 31). Since the global financial crisis, governments - particularly in the United States and the United Kingdom - have looked for ways of saving public expenditure (Green, 2013). Attention has increased on the expensive prison system, the rising prison populations and the high rates of recidivism, particularly for people with mental illness and co-occurring substance use disorder. This has resulted in intense focus on transition and reintegration along with other aspects of the criminal justice system (Brown, 2013). Green (2013) is optimistic that that a change of approach is pending and outlines a range of catalysts for “a turning point” in the “penal expansionism” of the last three decades, and the recent focus on “re-entry” in the United States NSW Law Reform Commission discussion papers features in that discussion. Brown’s (2013) analysis of the Australian context is less optimistic and suggests there is “no major push” politically for a similar focus on penal reform and that little attention has been paid to prison-to-community transition.

It appears from the literature that one of the difficulties with policy in terms of prison-to-community transition for people with severe mental illness is that at a system level, the

reasons for the overrepresentation of people with mental illness in the criminal justice system are multilayered and contested, and at an individual level the problems during transition are complex and multifaceted. As such, the policy solutions are far from straightforward.

System level contributors to overrepresentation of this population in prison and on release include lack of community mental health services post deinstitutionalisation, policing approaches to people with mental illness, judicial philosophies and sentencing practices (Mears & Cochran, 2012), all of which are resistant to change in environments of “popular punitiveness” (Pratt, Brown, Brown, Hallsworth, & Morrison, 2013). The complex needs of individuals during transition include mental health and substance use treatment, housing, employment, financial concerns and social support, all of which are traditionally managed by different government agencies that are seldom adept at working together to provide coordinated services (Mears & Cochran, 2012). Moreover, the different missions, philosophies and approaches between the mental health and criminal justice agencies involved with mentally ill prisoners during transition are frequently problematic and unresolved (Cleary, Horsfall, O’Hara-Aarons, & Hunt, 2013; Kavanagh et al., 2000; Lee & Stohr, 2012). There is also a body of literature that theorises that the criminal justice system can work against itself, in that its various parts are in conflict over punishment versus rehabilitation (Kurlychek, 2011; Petersilia, 2003; Travis, 2005). This can manifest particularly during transition, when there can be conflict between assistance to navigate into the community versus surveillance and supervision (Osher, 2012). Further complicating this picture, is that in the United States and in Australia there appears to be no one federal or state-wide approach, no uniform data collection, and no common classification systems or exchange of information processes across jurisdictions to facilitate continuity of care during transition (Fagan & Ax, 2010; Halsey, 2010). Both of these jurisdictions share a common problem of state-run correctional systems creating a major barrier for a national approach.

A significant advance in the policy arena was the World Health Organization (WHO) policy statements on prison health (WHO, 2009, 2013). These statements acknowledged for the first time at the international level that the overwhelming health and social needs of the prisoner population extend beyond any one government agency and require a whole of government response, a realisation that has been present in the academic literature for over a decade (Borzycki & Baldry, 2003). There was also a recognition by WHO (2013) of the special vulnerabilities of people with a mental illness and the need for a stronger focus on transition

and reintegration. This show of leadership at the international level may translate in the future to increased focus on prison-to-community transition.

In the United States, in response to their burgeoning prison population and concurrent growth in numbers of prisoners with a mental illness, there has been significant financial investment in re-entry programs and related research and evaluation, although this has been criticised as being somewhat fragmented and lacking an overall strategic plan (Fagan & Ax, 2011). First, more than \$100 million was invested in the *Serious Violent Offender Re-entry Initiative* (2002). Next the *Mentally Ill Offender Treatment and Crime Reduction Act* (2004) injected \$38.5 million between 2006 and 2010 into programs targeting people with a mental illness leaving prison (Skeem et al., 2011). Later, the *Second Chance Act* (2007) provided \$300 million to fund over 300 government and non-profit community agencies in 48 states to develop programs for all people leaving prison (Green, 2013). The focus was on collaboration, policy initiatives and research into prison-to-community transition, specifically emphasising employment, housing, mental illness and substance use, as well as supporting families and communities. It also encouraged state jurisdictions to collaborate across agencies and to review public policies impacting on people returning from prison (Prins, 2011). Green (2013) suggests that the Second Chance Act of 2007 “might signify that a more nuanced rethinking of simplistic tough on crime rhetoric and policy is underway at both state and federal government levels” (2013, p. 124). Prior to the adoption of any kind of program such as the Second Chance initiative there would be a need for comprehensive outcome and contextual evaluation in the Australian environment, given the differences in the prisoner populations, the differences in the health and criminal justice systems and the different economic and political environments.

The United Kingdom has taken an assertive national approach to improving mental health and criminal justice outcomes for offenders. In 2004, the UK National Health Service became responsible for healthcare, including mental health and substance use treatment, taking the responsibility from the Inspectorate of Prisons (Levy, 2007). A report titled *Too Little Too Late; an independent review of unmet mental health need in prison* (Prison Reform Trust, 2009) identified key areas in the United Kingdom that required attention, including recommendations about prison-to-community transition. Recommendations from this report included: the need for increased support for people with a mental illness on release, particularly to ensure that they are not returned to prison for breaching their conditions; assessment of the transition and resettlement needs of prisoners at an early stage well before

release; and that arrangements should be made prior to release for any prisoner requiring continuing mental health care, primary health care, support services and stable accommodation. There were no specific recommendations in this report about the provision of services to address co-occurring substance use disorder; however, the report did recognise that up to 50% of prisoners in the United Kingdom have a “serious drug problem” and urged integrated service provision between mental health and alcohol and drug services to prevent people “slipping through the net” (Prison Reform Trust, 2009, p. 3).

Following this, the influential *Bradley Report* (Bradley, 2009) specifically examined the policy mechanisms that were required to address the needs of prisoners with a mental illness, including transition support. The *Bradley Report* was critical of the lack of a coordinated response to the increasing crisis of the high rates of repeated return to prison of people with mental illness in the United Kingdom. It provided a detailed and comprehensive set of recommendations to improve prison-to-community transition, including the utilisation of a whole-of-government approach and the development of service level agreements between involved agencies. It also proposed major criminal justice reform, such as increased community sentences and diversion programs, increased mental health and substance use treatment during transition, an integrated case management approach, the use of peer mentoring to provide social support, and cross-training to increase awareness of issues in both health and criminal justice personnel (Bradley, 2009). With a change of government in the United Kingdom in 2010, a new report was released, *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* (Ministry of Justice, 2010). This report takes a hard line on punishment and attempts to balance “intelligent sentencing” with “effective rehabilitation”. The report states the intent of the UK government to break the cycle of crime and reincarceration through making prisons places of “hard work and industry”, with money generated going back to victims of crime. The policy describes promoting fundamental changes in the criminal justice system with “radical and realistic reform”, and there is a particular focus on prison-to-community transition. The policy has been widely criticised for putting a “progressive gloss” (Ryan, 2011, p. 519) on what is being viewed by some as a move to conservatism and essentially a cost-saving exercise (Collins, 2011; Fox & Albertson, 2011). For people with mental illness in prison-to-community transition, the policy (Ministry of Justice, 2010) commits to implementation of *The Bradley Report* recommendations, with the addition of a new approach, which is also being considered in the United States, of social impact bonds or “payment by results” (Fox &

Albertson, 2011). This approach is when the provider of prison-to-community transition support services is paid only if they deliver results according to agreed indicators (Fox & Albertson, 2011). The social impact bonds approach has not yet been evaluated; however, concerns have been raised as to how outcomes will be defined and measured, given the complexity of the prison-to-community transition process (Collins, 2011). Nevertheless, it is an interesting new development and may bring innovative ideas to the field.

There has been no national policy action in Australia in terms of attempting to address what appears to be a rising tide of repeated short-term incarceration of people with a mental illness and co-occurring substance disorder (Baldry, 2011; Baldry et al., 2008; Brown, 2013; Hanley & Ross 2013). While there is no comprehensive national data to confirm this trend, a review of state-based research taken as a whole would suggest that Australia is facing similar problems to the United States and the United Kingdom, albeit on a smaller scale (Hanley & Ross, 2013). For example, the high prevalence of mental illness and co-occurring substance use in New South Wales prisons has been established (Butler et al., 2011), and there are strong indications that the Queensland and South Australian populations reflect the same trend (Halsey, 2007, 2010; Kinner, 2006; Kinner, Lennox et al., 2013).

Nevertheless, there has been considerable advice to Australian governments on the need for the provision of adequate mental health services to prisoners and the need to pay attention to prison-to-community transition. *The Report of the National Inquiry into the Human Rights of People with Mental Illness* (Human Rights Equal Opportunity Commission, 1993) highlighted human rights concerns in relation to the care and treatment of mentally ill persons in custody. These included that people with a mental illness detained by the criminal justice system are frequently denied the health care and human rights protections to which they are entitled, and that denial of treatment to mentally ill prisoners and ex-prisoners often leads to further criminal offending, longer incarceration and aggravation of their mental illness. *The Australian National Statement of Principles for Forensic Mental Health* (AHMAC, 2006) was a starting point to guide individual states in the development of mental health service provision for prisoners. The principles were based on national and international policy frameworks.

In 2007–08, The Prison Mental Health Service in Queensland coordinated a national benchmarking exercise as part of a National Benchmarking Project on mental health services in correctional settings in four Australian states (Coombs, Walter, & Brann, 2011). The aim

of the project was to help better understand the mechanisms by which these services were delivered and add to the discussion about how to achieve “equivalence” of mental health care for people in custody. The major finding from the benchmarking project was that across Australia there was significant variation in prison mental health services, not only in the size, staffing profiles and types of services provided, but also in the links to other custodial and mental health services (Coombs, Taylor, & Pirkis, 2011; Hanley & Ross, 2013). This was identified previously by Mullen, Briggs et al. (2000) and Ogloff (2002, 2004), and while there has been some progress in the last few years, there is no evidence in any Australian state of equivalence to community mental health standards, and no active national agenda to improve this situation (Hanley & Ross, 2013).

There are fundamental data and policy instruments missing in Australia in terms of prison-to-community transition, in comparison to the United Kingdom. First, there is a startling lack of data on the number of prisoner separations in Australia, with scarce information on the prevalence of mental illness and substance use disorder in this population (Butler et al., 2011; Martire & Larney, 2010). Second, there is an absence of a national standard for the development and delivery of mental health services in correctional settings that are inclusive of the wide range of issues that are evident in the literature, including a focus on prison-to-community transition. There is also an absence of a national minimum data set to inform future development of services, plan goals and targets and monitor progress in this arena (Hanley & Ross, 2013).

Despite the lack of national policy direction in terms of prison mental health and transition services in Australia, the Queensland government initially provided funding in 1999 for one allied health worker and several sessions of a psychiatrist to service a prison population of over 5,000 inmates across the state. The program grew over 10 years to a state-wide service employing 40 staff. In early formative discussions after the implementation of these services, clinicians involved in the prison mental health service reported a high level of frustration that a significant proportion of the service users were people with multiple mental health, substance use and socio-economic needs, who had committed relatively minor offences and were repeatedly returning to custody. Clinicians also reported that they were neglecting, due to inadequate resources and overwhelming need, the appropriate discharge planning and transition support for this group leaving custody. In response to this feedback, funds were allocated to the establishment of a specifically targeted Transition Coordination Service alongside the broader in-reach mental health service for people being released from custody.

A case management style model of service delivery was developed and five allied health and nursing staff were employed as Transition Coordinators (later growing to eight staff). In the same funding round, a small allocation was made to a local community-based mental health support agency to provide longer-term support for this group (Evans & Stapleton, 2010). At that stage, Queensland was the only state in Australia that had significantly invested in transition support for people with a severe mental illness leaving custody, and these services still remain scarce and underfunded across Australia (Hanley & Ross, 2013).

Where the Australian government has taken a lead is in the development of strategic plans on mental health and drug use. There have been four national mental health plans developed, each spanning a 5-year period, and an equivalent number of alcohol and drug plans. Each of the mental health plans has mentioned the urgent need to address issues related to prisoners with mental illness; however, very little action on a national level has followed (Hanley & Ross, 2013). The *First National Mental Health Plan* (1992) acknowledged that immediate development and evaluation of new models of service for mentally ill offenders was needed. The *Second National Mental Health Plan* (1998) also supported this agenda. The “essential areas for reform” under the *Second National Mental Health Plan* included improved service access, better service responses, and further development and evaluation of appropriate service models for mentally ill offenders (Australian Health Ministers, 1998). The discussion paper preceding the *Fourth National Mental Health Plan* (2009) made several promising references to prison-to-community transition for people with a mental illness; however, the policy when released failed to deliver any relevant recommendations or associated funding that would impact on this population. The *Fourth National Mental Health Plan* (2009) has a strong emphasis on social inclusion, recovery, prevention, and early intervention for people with a mental illness living in Australia; however, it fails on the whole to make the link with these issues for people leaving prison with a mental illness (Hanley & Ross, 2013).

Aside from mental health, a relevant policy arena where the Australian government has been active and innovative has been in the development of a series of policies related to drug and alcohol use, most recently the *National Drug Strategy 2010–2015*. These policies have progressively moved towards a position of harm minimisation and harm reduction. The principle of harm minimisation is to reduce the health, social and economic consequences of drug use without necessarily requiring total abstinence (Hughes, 2004). Harm minimisation philosophy encourages a change in attitude towards drug users, from a stereotypical view of them being anti-social or criminal towards an understanding of the complex interaction of the

individual, the drug, the environment and the circumstances surrounding the drug use (Levy, 2007). The incongruence between a harm minimisation approach and criminal justice policy on mandatory drug testing and punishment for drug use, has been criticised by Halsey (2010), as follows:

The conflicting messages conveyed through drug and alcohol programs ... (based predominantly on harm minimisation philosophies) as against the administrative restrictions built into the conditions of parole (based on zero tolerance/abstinence models to alcohol and other drug use) only serve to add to the confusion and perceived punitiveness of the re-entry experience. (p. 550)

While there are some indications emerging from the international policy context to suggest a new direction towards more extensive post-release support for the target group, policy in this arena is fraught by political influences, contradictions, complexity and lack of coherent national leadership. In Australia particularly, there has been national policy rhetoric but little tangible evidence of action (Hanley & Ross, 2013).

2.8 Conclusion

This chapter outlined the health and social problems that are experienced by the general custodial population leaving prison and are exacerbated for people with more complex mental health and substance use disorders. Many of this population are young men serving relatively short amounts of time in prison. Along with the high levels of severe mental illness and drug and alcohol disorders, poverty, unemployment and unstable housing are frequently experienced problems. Some will have all of these problems in combination. Over half of the released prisoner population will have been in prison before and will return repeatedly. An alarmingly high number of these people will die an unnatural death in the weeks and months following their release. It is not fully understood why there is such an overrepresentation of people with severe mental illness in prison; however, deinstitutionalisation, co-occurring substance use, and sentencing and parole policy, particularly associated with the “war on drugs”, all play an important role. Moreover, there is growing evidence that once people with severe mental illness become involved in the criminal justice system they are more likely to become entrenched in repeated short-term incarceration. The policy context surrounding prison-to-community transition is complex. Nevertheless, it is clear that Australia is lagging behind North America and the United Kingdom in terms of adequately funding initiatives aimed at reducing the flow of people with a mental illness into and out of prison with appropriate support for their complex needs. It is also clear that Australia is lacking a

coherent national policy response to provide overarching leadership and direction in this important policy area, particularly in terms of national standards and a national minimum data set.

Chapter 3: A critical review of the prison-to-community transition literature

3.1 Introduction

This chapter examines how the transition from prison to community has been understood and theorised in the literature. In preparation for the development of a conceptual framework in which to situate the current study, a growing body of interdisciplinary work is explored that is gradually establishing an understanding of the complexity of the transition experience. First, what is understood about the transition experience of the general prisoner population is examined, followed by the specific literature exploring the transition experience for people with severe mental illness and those with co-occurring disorders. Much of the literature specifically discussing the mentally ill population has referred to and built on the generalist literature. Given that the majority of prisoners have at least some form of mental health problem and have been found to have high levels of substance misuse, most of the research on prison-to-community transition for the general custodial population includes some participants with these problems and therefore has relevance to understanding the target population.

The discussion is limited to literature from North America, the United Kingdom and Australia for three reasons. First, this study is set in Australia, and while research has been very limited in this jurisdiction, there is a small body of important literature that is relevant. Second, the emerging body of work from the United Kingdom is useful because of the similarity of the health, social and criminal justice systems to the Australian context. The third reason is that although the North American health, social and criminal justice systems are different in many ways from Australia, the US literature is the most comprehensive in this field and is growing rapidly. This is in part because of the crisis of “mass incarceration” (Travis & Visher, 2005) that the United States is experiencing as the country with the highest rate of incarceration per head of population in the world, and the subsequent resources that have been injected into understanding the re-entry process as a way of attempting to manage the situation. While the current estimate of 50,000 prison separations in Australia may appear to be insignificant in comparison to the estimated 735,000 North Americans leaving prison each year (Lattimore, Steffey, & Visher, 2010), the equivalent rate of growth in prisoner numbers over the past two decades in Australia is comparable, albeit on a smaller scale

(Martire & Larney, 2010). Hence, there is much to learn from the US research in terms of a response to the growing number of prison separations and the complex problems during prison-to-community transition that this raises for the individual, the community and the government.

3.2 Understanding the transition experience of the general prisoner population

The literature on transition and re-entry has expanded considerably in the last decade. At the beginning of the 21st century, Petersilia (2001), a leading scholar in the field, noted:

Virtually no systematic, comprehensive attention has been paid by policy makers to deal with people after they are released ... [and] we know little about the correlates of success and failure in the process of reintegration. (p. 360)

In a critical essay, Petersilia (2001) flagged many of the key issues that still remain current for people leaving prison, including the unmet needs of parolees, a tendency for parole supervision to replace support services, the high risk of homelessness post-release, the destabilising impact on communities and neighbourhoods from large numbers of returning prisoners, the important role of employment and difficulty in finding work due to stigma and economic changes, the impact of incarceration on families, and parole revocation practices that “almost guarantee parolees failure” (2001, p. 372). Travis and Petersilia (2001) built on this work by calling for a reform agenda to abolish parole and replace it with specifically targeted transition support. They proposed: the development of seamless systems between prison and the community, particularly in terms of health and employment; intensive preparation for release fostering independence; and the allocation of responsibility for reintegration from corrections agencies to community-based organisations to broker the relationship between prison and community. The combination of this work (Petersilia, 2001; Travis & Petersilia, 2001) and subsequent book (Petersilia, 2003) effectively laid out the research agenda for prison-to-community transition over the next decade; however, it would appear that most of the challenges remain unresolved and the same themes occur continuously throughout the literature.

There have been some advances over the last decade, however, in conceptualising the problem of transition more clearly, with both quantitative and qualitative research across criminology and health and social science disciplines contributing to this advancement of knowledge. An early attempt at understanding and theorising the transition experience was by O'Brien (2001), who conducted a qualitative study involving 18 formerly incarcerated

women, to understand “through their eyes” the strengths and resources they had used to manage their transition. The sample consisted of women who considered that they had negotiated a “successful” transition back into the community after imprisonment. O’Brien (2001) found that all of the women, to some extent, identified five “markers” that signified their success. These included: finding shelter, obtaining employment, reconnecting with others, developing community membership, and identifying consciousness and confidence in self. O’Brien’s work identified that both psychological and socio-economic factors were important in the transition experience. One participant in the study stated:

“It has to be a combination. It’s just like bakin’ a cake. You can’t leave out the flour. You need all the ingredients to make it come out right” (2001, p. 294).

O’Brien’s findings have been echoed in later studies and have potential relevance to people with a mental illness leaving prison (Davis et al., 2013; Graffam et al., 2005; McHugh, 2013; Shinkfield & Graffam, 2009; Trotter, McIvor, & Sheehan, 2012).

Subsequently, Visher and Travis (2003) developed a conceptual model to understand individual pathways in the transition from prison to community. The model included four dimensions affecting the re-entry process situated beside four stages of the re-entry pathway. The dimensions affecting the re-entry process included: individual characteristics; as well as situational characteristics of family relationships, community contexts, and state policy. The stages of the transition pathway included: the experiences of pre-prison; in prison; immediately after release; and longer-term post-release (Visher & Travis, 2003). This framework was important because it was one of the earliest attempts to draw the focus away from recidivism as the key outcome during transition, with recognition that avoiding crime was only one of many simultaneous challenges facing ex-prisoners during transition. Visher and Travis (2003) also introduced a longitudinal aspect to the framework to include experiences before and during incarceration as potentially impacting on the transition experience. While incorporating family, community and policy into the framework as situational characteristics, Visher and Travis (2003) essentially maintained a focus on recidivism and the individual during transition. They asserted that “securing employment, resolving conflict with family members, maintaining sobriety, joining a community organisation ... are all indicators of successful attachment to the institutions of civil society”, potentially leading to reduced offending (p. 107). Later work built on these ideas and the attention began to shift in prison-to-community transition research to social, economic and

support domains (Baldry et al., 2006; Graffam et al., 2005), to health as the central focus (Binswanger et al., 2011; Kinner, 2006; Kinner, Burford et al., 2013; Levy, 2005), to the relevance of social capital (Mills & Codd, 2008; Taylor, 2013; Wolff & Draine, 2004), and to the interaction between the individual and the environment (Farrall & Bowling, 1999; Farrall, Sharpe, Hunter, & Calverley, 2011).

The Urban Institute in Washington in the United States has contributed valuable and leading work on prison-to-community transition, with several of the largest studies of released prisoners to date (Baer et al., 2006; Lattimore et al., 2010). While remaining largely within a criminology paradigm with a focus on recidivism, the work has been increasingly influenced by broader perspectives over the decade. It includes an extensive portfolio of research (La Vigne, 2003a, 2003b, 2003c, 2004, 2006, 2007, 2008; La Vigne & Kachnowski, 2012; La Vigne, Naser, Brooks, & Castro, 2005; La Vigne et al., 2009; Visher, 2010; Visher, La Vigne, & Farrell, 2003; Visher, Naser, Baer, & Jannetta, 2005), evaluation of pilot re-entry programs, reports from roundtables involving multiple stakeholders, and scans of practice highlighting innovative programs to support transition (Baer 2006). The major contribution of the research conducted by this group was that it identified and quantified the enormous challenges that face people in prison-to-community transition in four states of the United States. The overall study involved a total of 2,391 adult and juvenile men and women leaving prison, who were followed up at 3, 9 and 15 months post-release (Baer, 2006). The framework guiding the study was to collect information on individuals' life circumstances prior to release, during release, and up to 1 year post-release in three dimensions: individual, family, and community (Visher, 2010).

Broadly, the Urban Institute research found that the cohort had multiple and complex problems, including extensive criminal and substance histories, and up to two thirds identified drug use as the primary cause of their past and current problems (La Vigne, 2004; Visher, Kachnowski, La Vigne, & Travis, 2004). Despite this, few participants received drug treatment while incarcerated, and those who did receive individualised in-prison treatment followed by coordinated community based aftercare reduced their substance use and dependency (Baer et al., 2006). Recidivism was strongly linked with substance use after release (Baer et al., 2006; Visher, 2010). Men with supportive families had better employment and substance use outcomes than those without family, and the study participants believed employment was protective in terms of staying out of prison (Visher et al., 2004). Housing was an issue post-release, with the majority of the cohort returning to live

with families or partners on release, often on a temporary basis and because they did not have the resources to secure housing of their own (Visher, 2005). There was a high prevalence of mental illness, chronic and infectious disease in the cohort. Less than half of those reporting conditions received treatment in prison and under 20% received referrals to community services (Visher et al., 2005). Less than 20% of the cohort had health insurance or a disability pension, significantly impacting on their access to health care, including mental health care post-release. There were three key implications drawn from the Urban Institute research, according to Lattimore et al. (2010). These were: the importance of comprehensive strategies to address housing, employment, health and other identified needs; programs and support that begin in prison and continue into the community were likely to be the most effective; and interventions directed at only a single problem were unlikely to have a substantial impact on the transition experience.

An important body of work began to emerge in Australia midway through the decade that contributed to the international literature by emphasising social, economic and support domains as potentially influential in the transition process (Graffam et al., 2005). These researchers developed a framework of six domains related to transition and community reintegration.

Table 1: Domains and variables affecting community reintegration (Graffam et al., 2005, p. 154)

Domains	Variables
Personal conditions	Motivation, physical and mental health, finances and education and training
Social networks and social environment	Family contact, social isolation and boredom, acquaintances, and community
Accommodation	Availability, crisis accommodation, transitional housing, public housing
Criminal justice system	Police, courts, correctional services, solicitors and barristers
Rehabilitation/ counselling support	Detoxification programs, outcomes, processes
Employment and training	Work experience, psychosocial aspects of work, employment support services

Graffam et al., used this framework to interview 12 released prisoners and 22 professionals in the field. Research participants were asked to identify variables related to each domain that

they perceived affected success or failure in prison-to-community reintegration (Graffam et al., 2005, p. 152). Table 1 outlines the domains and variables identified in the study.

The above framework has since been refined and developed to include three domains with corresponding variables (Graffam & Shinkfield, 2012; Shinkfield & Graffam, 2009):

- Intrapersonal conditions (physical and mental health, substance use, education levels and emotional state);
- Subsistence conditions (finance, employment, housing); and
- Support conditions (social support, formal support and criminal justice support).

This work built on Visher and Travis's (2003) framework beyond an individual, family and policy perspective. Graffam (2005) and Shinkfield (2009) broadened the focus to include social and economic domains, recognised the important role of emotional state during prison-to-community transition, and emphasised the importance of "support conditions", thereby adding a more detailed and nuanced understanding of the complexity of the transition process, while still focussed on recidivism as the key outcome.

Two other important scholars contributed to the Australian and international literature on prison-to-community transition during the middle of the decade. Borzycki & Baldry (2003) and Borzycki (2005) reported on a roundtable discussion on post-release issues organised by the Australian government, and advocated for a "throughcare" model of support for prisoners that commenced in prison and continued after release into the community. They suggested this approach would be facilitated through the development of "integrated, multi-agency partnerships" that required a whole-of-government response (Borzycki & Baldry 2003). Baldry (2010, p. 258) later questioned the notion of "throughcare" as good in principle but lacking relevance for women being released after short-term incarceration because it was designed more towards longer-term inmates and "falsely assumes" that women would be in prison long enough to develop a release plan. This point may also be relevant to the mentally ill incarcerated population. Borzycki and Baldry's (2003) work was followed by a government-sponsored report titled *Interventions for prisoners returning to the community* (Borzycki, 2005), which was a comprehensive analysis of the Australian context in relation to the needs of prisoners returning to the community. The report identified major gaps in data and services in relation to the released prisoner population and called for a shift in focus from an "offender-orientated" (individual) approach towards the recognition of the broader social

context in terms of prisoners leaving custody in Australia. Specific mention of these reports is important because this was innovative work in both the Australian and international contexts that was driven briefly by the Australian government, after which the momentum appeared to fade, with no further significant federal government reports or initiatives related to prison-to-community transition (Hanley & Ross, 2013).

Despite apparent lack of Australian government interest in the transition of prisoners following the critical report by Borzycki (2005), another body of significant Australian work on the transition process is continuing by Kinner et al. (Kinner, 2006; Kinner, 2008; Kinner, Burford et al., 2013; Kinner, Lennox et al., 2013). This work, which includes a large study in Queensland, has been attempting to shift the focus in prison-to-community transition research from understanding the correlates of recidivism to understanding and intervening in the “continuity of health impairment and substance misuse” experienced by prisoners in prison-to-community transition. Taking a joint health promotion and crime prevention approach to transition, Kinner’s (2006) hypothesis is that improving the health and wellbeing of prisoners and providing appropriate post-release health and support services, will address the individual and public health issues associated with ex-prisoners, as well as have an impact on re-offending.

In his initial study, Kinner (2006) interviewed 160 prisoners about to be released, who were then contacted by telephone on average 34 days and 120 days post-release. Kinner (2006) found that the majority of his sample reported a history of illicit drug use and two thirds a history of injecting drug use. Over half of the participants reported risky alcohol intake prior to incarceration. Kinner (2006) also found that almost half of his sample experienced moderate psychological distress pre-release. At 1 month post-release, over half of the sample reported using at least one illicit drug and one in three had injected a drug. At the first follow-up post-release telephone interview, over half experienced moderate distress, and one in five very high levels of distress indicative of a clinically significant mental disorder, according to Kinner (2006, p. 109). As a group, participants in that study had high levels of substance misuse and impaired mental health that continued from prior to incarceration through to post-release. Kinner (2013) followed with a large randomised controlled trial involving 1,325 released prisoners in Queensland, assessing the impact of a service brokerage intervention providing tailored health and referral information to prisoners during transition; however, while the method has been described in detail (Kinner, Burford et al., 2013), the results have not yet been published.

The above frameworks and research developed in Australia are important because they have shifted the focus to explore transition from different perspectives rather than the dominant criminal justice perspective in the international literature. Graffam et al. (2005) and Shinkfield & Graffam (2009), while remaining focussed on recidivism as an outcome, attempted to broaden the perspective from the individual to include “subsistence” and “support” domains, and recognise the importance of emotion state during transition. Kinner (2006) attempted to shift the focus to health outcomes and health care continuity. This is significant work; however, he does not fully include recognition of the social, political, economic and physical dimensions that may be impacting on the transition experience, or the potential impact on health outcomes. Kinner’s work (2013), for example, linking participants to community health services through a service brokerage model, may well prove to have limitations without attention to broader structural issues during transition.

A qualitative study by Binswanger et al. (2011) adds to the understanding of transition through a health-focussed lens, as well as incorporating an understanding of the social, emotional, economic and logistical challenges confronting prisoners on release. This was the only study located that specifically sought to understand, through qualitative enquiry, the high risk of death during transition from prison. Two researchers interviewed 29 participants within 2 months of being released from prison. They proposed a conceptual model for understanding prison-to-community transition that reflected an understanding of health-related behaviour in the context of complex life experience and high levels of emotional distress. The framework accounted for the logistical challenges of poverty, finding accommodation, accessing healthcare, maintaining continuity of medications, and dealing with criminal justice policies (Binswanger et al., 2011, p. 252). The study advocated for the need to pay attention to health and substance-related problems for released prisoners so that they can adhere to parole conditions and access employment. Importantly, Binswanger et al. (2011) also identified the emotional reactions to the challenge of transition, such as how stress, fear, anxiety and disappointment exacerbating logistical problems during transition put their research participants at risk of poor health outcomes, including suicidal thoughts and drug overdose. Some of the participants in their study made a clear link between negative emotions during transition and suicidal thoughts post-release. They also found ambivalence about leaving prison that was related to the difficulties of impending life in the community, and incongruence between expectations of life in the community and the reality of the experience (Binswanger et al., 2011, p. 253). Similarly, another qualitative study set in the

United Kingdom (Howerton et al., 2009; Howerton et al., 2007) found “prison tolerance” and ambivalence about leaving prison was related to the anxieties and fears associated with life in the community. Howerton et al. (2009) identified institutionalisation as contributing to ambivalence about leaving prison, but did not provide a detailed analysis of this dynamic.

Research has indicated that transition is more successful when practical need is met within 90 days after release (Wilson & Davis, 2006) and when plans are based on self-identified needs (Belenko, 2006; Mellow & Christian, 2008). A study involving 122 released prisoners, evaluated a program in the United States where the state allocated up to US\$3,000 each to released prisoners towards their self-identified needs as they transitioned from prison (Morani, Wikoff, Linhorst, & Bratton, 2011). The majority of participants allocated their funds from a predefined list to transportation, clothing, food, housing, and preparation for employment, in that order. Additionally, 17.2 % of participants allocated funds to psychiatric services and 10.7% allocated funds to other medical services. The study measured outcomes of the participants over 6 months and found that two thirds of the participants were employed for varying lengths of time during the program and earned a total of US\$225,132 between them, an average of US\$3,360 across the participants, an amount equivalent to the cost of the program for each person. Nineteen of the participants had entered into vocational or educational training and half of the cohort found employment during the 6 months. Of 113 participants where data were available, all but one had stable housing by the end of the program, although 31% were in transitional or temporary housing arrangements. The study also showed moderate success in terms of substance use. One quarter of the participants voluntarily attended substance use treatment during the program; however, this included 62% of the people who had continued to use substances after release. The results from this study are impressive compared with outcomes from comparable cohorts cited by Morani et al. (2011) and indicates that ex-prisoners may have the capacity to identify their own needs and self-direct their transition experience when given an opportunity and the resources to do so. Whether this approach is transferrable to other settings and other cohorts is yet to be investigated.

Social capital is an emerging concept in both criminology and mental health that has growing relevance to understanding the transition experience (Mills & Codd, 2008; Taylor, 2013; Wolff & Draine, 2004). Social capital refers to the resources or “assets” available to the individual as a result of their social networks (Wolff & Draine, 2004). Resources can include: emotional support; provision of care, particularly when the person has impaired functioning;

access to material support such as housing, food or money; and “gateway connections” to other family or community members who have access to resources (Draine & Wolff, 2009). It has been theorised that the social capital of prisoners can be affected by the instability of incarceration and that social assets can either be depleted or mobilised during transition, depending on individual characteristics and prison experiences (Draine & Wolff, 2009; Wolff & Draine, 2004). Accordingly, social capital can take the form of social networks in prison with other released prisoners that can potentially facilitate criminal activity. In contrast, positive relationships can increase the “stock” of social capital, thereby promoting a sense of belonging and usefulness and foster independence and enhance functioning in the community (Mills, 2008).

The support of families can be particularly important during transition when it comes to health outcomes, treatment compliance, quality of life and access to employment opportunities (Mills, 2008; Taylor, 2013; Wolff & Draine, 2004). Three key themes arise in the literature in relation to prisoners and family relationships during incarceration and transition. First, prison can strain family relationships through removal and distance as well as when contact occurs under surveillance in prison (Mowen & Visser, 2013; Spjeldnes, Jung, Maguire, & Yamatani, 2012). Second, it has been observed that prison can also at times improve the quality of relationships by providing respite to the family while the person is incarcerated (Visser, 2013; Visser, Bakken, & Gunter, 2013). Third, the experience of being in prison can negatively impact on the prisoner’s identity and they may identify more with the norms of prison culture than the norms of their family or other connections in the community, thereby weakening their social networks and hence their stock of social capital (Wolff & Draine, 2004). This may affect the resources available to them and their capacity to make a smooth transition back into the community, with decreased availability of informal supports (Mills, 2008; Taylor, 2013).

Family support was found to be crucial during transition in a major study of 413 released prisoners (Naser & La Vigne, 2006). Results from self-administered surveys with this cohort found that respondents relied heavily on family members for assistance with housing, finances and emotional support. The authors advocated for greater involvement of families in the pre-release phase of transition, given their important role. Family conferencing and family support groups have also been suggested (Bazemore & Stinchcomb, 2004, p. 41). It has been emphasised, however, that family involvement is not always positive, and that screening for domestic violence and other family-related conflict should be monitored on a case-by-case

basis (Naser & La Vigne, 2006). It was also suggested that there is a need to identify when those about to be released do not have a positive family support network, and to find some way to address that gap (Naser & La Vigne, 2006, p. 103).

Providing more formal support to people during transition, particularly those without family networks, appears to be important; however, the quality and nature of that support is crucial (Trotter et al., 2012). Much of the innovative work in understanding prison-to-community transition support has come from studies involving women offenders (Baldry, 2010; McHugh, 2013; O'Brien, 2001; O'Brien & Young, 2006; Reisig, Holtfreter, & Morash, 2002; Sheehan et al., 2010; Trotter et al., 2012). This research might also have relevance to men with a mental illness, or indeed to the broader male offender population. For example, the factor most strongly related to reduced offending for women leaving prison in an Australian study was if there was a positive client-worker relationship (Trotter et al., 2012). The worker needed to understand the women's perspectives, collaborate with them and have an optimistic view that the women could change. In addition, it was important to the women that the worker took a holistic view of all their concerns, was reliable and offered practical assistance. The authors argue that male-centric interventions tend to be more challenging of "pro-criminal comments and actions", whereas the women in their study responded more positively to explicitly strengths-based approaches that also recognised the structural context of offending and aimed "to promote self-efficacy and empowerment" (Trotter et al., 2012, p. 15). The concepts that emerge from the work about supporting women offenders in transition has strong resonance with the relational and strengths focus of the mental health recovery framework that is discussed later in this thesis.

Building on the concept of social capital and the importance of relationships, family support and employment in transition from prison, Maruna and Immarigeon (2004) theorised that the challenge in transition from prison was to mobilise the community both in terms of informal and formal supports. A key feature of these ideas was a shift in focus from the criminal justice system to a focus on the community, with a view to partnership between informal and formal community-based supports and services. A philosophical shift was proposed that cut across traditional organisational boundaries and away from allocating sole responsibility to justice agencies for providing transition services (Maruna & Immarigeon, 2004). The idea was to welcome released prisoners into a community-based service system, based on the needs of the client rather than the agency. A central theme in this work was that interventions should be organised around the concept of citizenship: "the productive citizen at work, the

responsible citizen at home and the active citizen in the community” (Uggen, Manza, & Behrens, 2004, p. 287). Two interrelated constructs of “belonging” and “usefulness” were emphasised as important in the prison-to-community transition in this work. This sends a message, suggests Maruna (2001), to the community that the person leaving prison is worthy of further support; and to the person leaving prison that he/she has something to offer and is a value to others. These ideas have many similarities to the mental health recovery framework explored further in Chapter 4, which also emphasises belonging and usefulness as key to development of an identity beyond mental illness. Social capital is also gaining increasing tenure as a way of understanding community inclusion for people with severe mental illness, whether or not they have been involved in the criminal justice system (De Silva, McKenzie, Harpham, & Huttly, 2005; McKenzie, Whitley, & Weich, 2002).

Complementing and extending the work on the role of social capital is a body of literature supporting the notion that both individual and social factors impact on the prison-to-community transition experience and that there is interaction between individual agency and the structural environment (Farrall, Bottoms, & Shapland, 2010; Farrall & Bowling, 1999; Farrall et al., 2011; O’Brien, 2001). Others debate the “chicken and egg” (LeBel, Burnett, Maruna, & Bushway, 2008) of the role of agency and structure, such as “which comes first” and which has the greatest impact on offending behaviour (Laub & Sampson, 1993). This literature is one of the few areas of criminology that theorises the interplay between individual agency and structural considerations in the context of offending, and as such provides a rich source of ideas in later chapters for understanding the prison-to-community transition experience for people with complex mental health and substance use issues.

3.3 Understanding the transition experience of people with severe mental illness and co-occurring substance use disorder

The research and conceptual frameworks developed to understand the transition experience for the general prisoner population have relevance to the population in the current research. People with severe mental illness also have to find a place to live, secure employment or an income, and access healthcare. These tasks are further complicated in the context of mental illness and co-occurring substance use disorder. Research aimed at understanding the specific problems confronting this population during prison-to-community transition has to some extent paralleled the work on the general prisoner population; however, many gaps still exist in understanding the special needs of the target group.

It has been suggested that people with a severe mental illness are “confronted with all their needs at one time” when leaving prison (Blank, 2006, p. 106), and it has been identified that this group might have fewer coping mechanisms than their non-mentally ill counterparts for dealing with the challenges of transition, along with limited resources and social networks (Hartwell, 2010). Very little is known about what contributes to the relatively poor outcomes for people with severe mental illness in prison-to-community transition (Barrenger & Draine, 2013) and there have been various attempts to understand and formulate responses to these problems (Angell et al., 2014; Barrenger & Draine, 2013; Draine et al., 2005; Epperson et al., 2011; Hartwell, 2004b; Osher, 2012; Wolff, Frueh et al., 2013). Nevertheless, there are still large gaps in knowledge and understanding, particularly in Australia, of the post-release mental health and social problems of this population and how the complex health and criminal justice dynamics interact at both the individual and systems levels (Baldry, 2011; Baldry et al., 2008; Kinner, 2006; Kinner, Lennox et al., 2013).

The literature addressing the prison transition experience of people with severe mental illness or co-occurring disorders has been through six main phases since the 1990s. These have overlapped and influenced each other and continue to develop. Figure 1 (p. 45) outlines an historical and thematic map of the literature and research specifically concerned with prison-to-community transition for people with a severe mental illness. The map also situates the conceptual framework (discussed in detail in Chapter 4) for the current research within the literature.

First, the focus in the literature was on trying to understand the overrepresentation of mental illness in the prisoner and released prisoner populations and on quantifying their outcomes as they returned to the community (Butler et al., 2011; Feder, 1991; Hartwell, 1999, 2003, 2004a; Petersilia, 2000; Steadman et al., 2009; Teplin, 1990, 1994). Poor outcomes post-release for people with a mental illness have been reported since the 1990s when Feder (1991) reported that half of his cohort were hospitalised and two thirds arrested within 18 months of release. Some of the earliest work specifically on people with a mental illness leaving custody with transition support was by Hartwell (1999), who studied 247 people in the first year of the Massachusetts Forensic Transition Program. In this quantitative study, Hartwell (1999, 2003) found that 67% of the cohort had a mental health service history before incarceration, 76% had substance abuse problems, and 30% needed housing post-release. When this group were followed up at 3 months, 63% had engaged in community services, 20% had been hospitalised, and 17% had been reincarcerated. Hartwell’s study

(1999) provided a useful demographic and diagnostic profile of the target group that was similarly reflected in an evaluation 10 years later (Denton, Hockey, & Heffernan, 2009) of the first 12 months of the Queensland Prison Mental Health Service Transition Program. These descriptive data do not, however, significantly increase our understanding of the multiple dynamics and complexities of the prison-to-community transition experience impacting on people with severe mental illness and co-occurring disorders.

The second phase of the literature focussed on the interaction of the service systems involved in prison-to-community transition services for the population being studied (Draine & Solomon, 2001; Hartwell, 1999; Lamberti et al., 2001; Morrissey, Fagan, & Cocozza, 2009; Roskes & Feldman, 1999; Wilson & Draine, 2006). Within the criminal justice system itself, the potential incompatibility of the dual goals of punishment and rehabilitation are frequently referred to in the literature (Jacob, 2014; Miller, Miller, Tillyer, & Lopez, 2010), and are often centred around the problem of whether people with a mental illness involved in the criminal justice system are “offenders, deviants or patients” (Davies, Heyman, Godin, Shaw, & Reynolds, 2006; Prins, 2005). Between service systems, there are three significant points of interface during prison-to-community transition where fragmentation of services has been observed: the criminal justice–mental health interface, the mental health–alcohol and drug service interface and the prison–community interface.

The interface between justice and mental health service systems has received attention because it has been observed that they have different approaches and philosophies that impact on the delivery of coordinated services. The criminal justice system has a mission for containment, correction and punishment, whereas the focus in mental health and substance treatment services tends to be on support, care and recovery (Draine & Solomon, 2001; Hartwell, 1999; Jacoby, 1997). Mullen (2001) was critical of the “spurious technology of risk management” in correctional rehabilitation practices that “privilege policies of control and containment as against support and management” (p. 23). There is further discussion of this interface below, focussing on the potentially conflicting paradigms of risk and recovery.

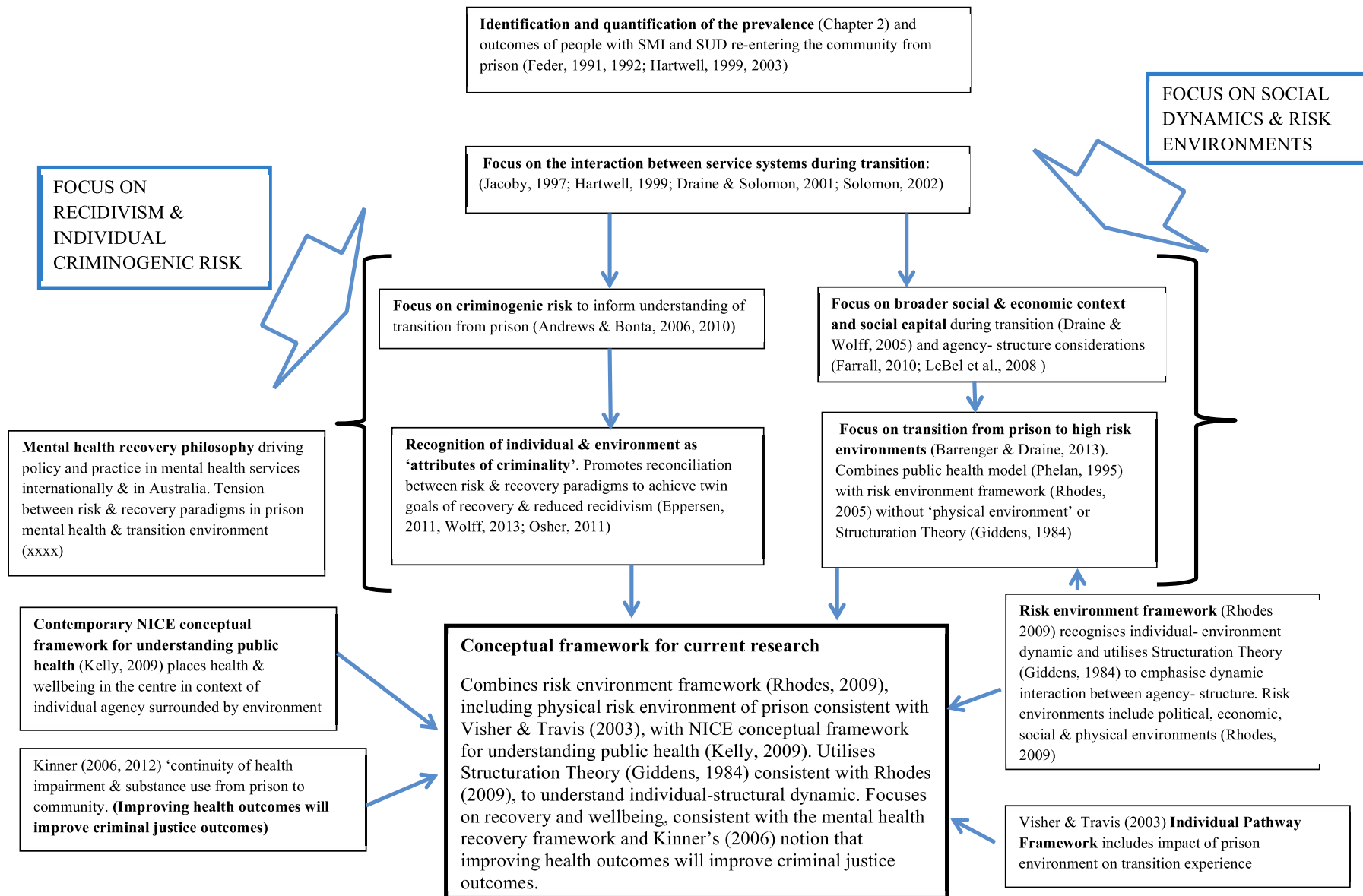


Figure 1: Historical and thematic diagram of literature and research exploring prison-to-community transition for people with severe mental illness.

The interface between mental health and substance use services has historically been problematic. Integrated mental health and substance use treatment programs have been considered best practice for several decades; however, working together has often been unsuccessful due to differing philosophies and approaches (Cleary, Hunt, Matheson, & Walter, 2009; Kavanagh et al., 2000). Mental health services have historically screened out drug users and drug treatment services have historically screened out people with severe mental illness (Danzer, 2012). Judgemental attitudes towards people with co-occurring disorders by mental health staff has been well documented, with a tendency for staff to differentiate between people with a mental illness who are “deserving” of care, and people who use substances who are perceived to have “brought it on themselves” (Adams & Ferrandino, 2008; Flanagan & Lo Bue-Estes, 2005). People with co-occurring disorders have been described as “a kind of mental health under-class” with many people experiencing multiple unmet needs (Hawkings & Gilbert, 2004, p. 57).

The interface between the services in prison and the services based in the community has generated a body of research on continuity of care across that divide. Research with this population has identified that mental health providers often have negative perceptions of people with a mental illness leaving custody and this can lead to access barriers (Lamb, Weinberger, & Gross, 1999; Visher et al., 2005). Other research has found that this group have low rates of community mental health treatment post-release, and for those people who do receive treatment it is often episodic with delays in assessment and is low in treatment intensity (Lovell et al., 2002; Visher et al., 2005). Moreover, individuals and the practitioners working alongside them often have to negotiate complex service systems to satisfy basic needs such as housing and income on release, before even contemplating the difficult task of accessing mental health services and substance use treatment (Blank, 2006; Davis et al., 2013).

At this point, the literature becomes conceptually divided, as shown in Figure 1, indicating a difference in emphasis related to interpretation of the underlying contributing factors to the ongoing overrepresentation of people with severe mental illness in prison. Both of the pathways start from the point of understanding that the provision of mental health services alone during incarceration and transition as has been implemented in the past, is unlikely to address the “revolving door” (Howerton et al., 2009) of short-term imprisonment for the population being studied. However, there appears to be a division in the next level of understanding of this problem. On the one hand, a body of work is primarily grounded in the

notion of individual criminogenic risk (Andrews, Bonta, & Wormith, 2006) and “attributes of criminality” (Epperson et al., 2011) contributing to offending, and reincarceration. It has also retained a focus on the interaction between the criminal justice and mental health systems and the tension between the risk and recovery paradigms (Epperson et al., 2011; Osher, 2012; Wolff, Frueh et al., 2013). On the other hand, a body of work built on an understanding of the role of social capital and the social processes underlying the prison-to-community transition experience (Draine et al., 2002a, 2002b; Draine et al., 2005; Maruna & Immarigeon, 2004) has begun to develop into an understanding of the impact of “risk environments” on the transition experience of people with severe mental illness (Barrenger & Draine, 2013). These trends in the literature are discussed below.

A large body of work has focussed on individual risk to inform the development of assessment and treatment interventions for prisoners and released prisoners, including those with mental illness during transition, and is widely accepted as the dominant influence in criminal justice agencies in the United States and Australia (Andrews et al., 2006). The Risk, Needs and Responsivity (R-N-R) model was first described by Andrews, Bonta, and Hoge (1990) and subsequently articulated in *The Psychology of Criminal Conduct*, now in its fifth edition (Andrews & Bonta, 2010). The focus in the R-N-R model is on actuarial risk assessment and management, and maintains that the most intensive rehabilitation should be directed to individuals with the highest risk of offending. Andrews and Bonta (2010) also maintain that there may be an adverse impact on lower-risk individuals from intensive interventions. The Risk Principle is premised on the assumption that it is possible to accurately predict at a population level which individuals are at higher risk of offending, and risk assessment is mainly concerned with the likelihood of an offence reoccurring.

The “needs” component in R-N-R refers to criminogenic needs (also referred to as dynamic risk factors or criminogenic risks). These are risk factors specifically associated with the offending behaviour, such as attitudes, associates, antisocial personality traits, anger and substance use. Within this paradigm, criminogenic needs are “targeted” in programs and during prison-to-community transition. Socioeconomic indicators are referred to as “more distal factors” (Andrews et al., 2006, p. 16) that may have some impact; however, the model essentially focusses on individual pathology and skill deficits, character flaws and problematic behaviour. The third principle of “responsivity” dictates that rehabilitation should be based on cognitive-behavioural and social learning theories and that programs

should take into consideration “special needs”, but these are not clearly defined in terms of people with a mental illness (Andrews & Bonta, 2010; Andrews et al., 2006).

While the risk approach is widely acknowledged to be empirically sound and evidence based (Fagan & Ax, 2011; Ward & Eccleston, 2004), it has strong critics. Criticisms of approaches that focus on individual criminogenic risk are that they focus on deficits and pathology (Blackburn, 2004) and the potential to create a culture of “otherness” for people with a mental illness as belonging to “risky” other populations rather than people with complex needs (Fenton, 2012b; Warner, 2004). Moreover it has been asserted that this approach can create a “surveillance framework on people and services” (Sheehan et al., 2010, p. 92) and is “a largely hidden method of controlling offenders” (Pollack, 2010, p. 217).

The emphasis in the R-N-R model is that the goal of rehabilitation and reintegration strategies is the reduction of risk to society through the prevention of recidivism. While the practitioner may work with the individual to increase their personal effectiveness by focussing mainly on their criminogenic needs so that the person can avoid further crime, it has been suggested that the goals of the intervention in this context are simply a “means to an end” of preventing reoffending (Blackburn, 2004, p. 310). Blackburn (2004) suggests that “here the goal is to *restrict* rather than *enable*” (2004, p. 310). Further, a narrative review of the re-entry research from 2000 to 2010 by Wright et al. (2013) raises questions about the focus on cognitive behavioural approaches, particularly cognitive behavioural therapy (CBT) in terms of transition outcomes. The review found that:

CBT, found in 42% of the 23 programs reporting positive treatment effects, was the least likely component to yield a statistically significant treatment effect, which was surprising given the widespread support for CBT-based interventions as the most effective treatment model in reducing recidivism. (Wright et al., 2013, p. 45)

Building on the work on risk and criminogenic needs is a body of literature that appears to frame the problem as related to individual risk in terms of the mentally ill, as well as retain a focus on fragmented service systems during transition (Epperson et al., 2011; Osher, 2012; Wolff, Frueh et al., 2013). This work advocates for reconciliation between the risk paradigm and the mental health recovery paradigm to achieve the twin goals of mental health recovery and reduced criminal justice involvement during transition and beyond. Two conceptual models dominate this approach. The first model, proposed by Epperson et al. (2011) and Wolff, Frueh et al. (2013), incorporates “attributes of criminality” as a central focus. This model was developed based on research with a sample of 86 practitioners involved in the

provision of prison-to-community transition services who participated in a web-based survey and a subsequent workshop with a subset of 19 staff representing 18 states in the United States. “Person-level” attributes of criminality, such as mental illness, addiction, poverty and antisocial thinking, were placed at the centre of the model. “Place-level” attributes of criminality represent the social, community and service system contexts. According to this model, these factors “work separately and interactively to affect the risk of criminal justice entanglement”. Trauma and stress are mediated between the person and place levels and act as catalysts to involvement in the justice system (Epperson et al. 2011, p. 10). A model developed by Osher (2012) is based on similar assumptions about the centrality of individual risk and is also intent on a “shared framework for reducing recidivism and promoting recovery”; however, it takes a slightly different approach. It proposes a matrix that weights the severity of criminogenic risk, substance use and mental illness and then creates groups of “high” and “low” combinations of these factors and applies the “risk principle” (Andrews & Dowden, 2006) to determine the nature of required interventions (Osher, 2012).

The models described above are based on evidence and incorporate many of the elements of contemporary theory about the complexity of prison-to-community transition. They acknowledge an interaction between the individual and the environment, and emphasise the impact of trauma and stress and the important role of substance use as an individual criminogenic risk factor. However, these models do privilege individual risk factors and pay less attention to the underlying social dynamics. Moreover, the focus is on recidivism rather than recovery as the desired outcome, and the language and philosophies of the individual risk paradigm are mixed with the mental health recovery paradigm, potentially impacting on the practical implementation of these models.

Wolff et al. (2013), Epperson et al. (2011), and Osher (2011), while acknowledging the tensions between the competing paradigms of risk and recovery, do not closely address these problems and seem to propose that there is potential for the risk paradigm to remain largely unchanged and be combined with a mental health recovery framework. They argue that the benefits of their integrated risk-recovery approach has the person as the focus of the intervention, allows the person to drive their own recovery, recognises that relapse is a reality and uses a process orientated “stages of change” model along with interventions to address risk factors (Wolff et al. 2013; Epperson et al., 2011). The main strategies proposed for resolving the paradigm clashes in their model is to advocate the avoidance of institutional methods of intervention, such as hospitalisation instead of prison wherever possible, and for

the recognition by criminal justice staff of the recovery framework (Epperson et al., 2011, p. 23). This approach of advocating the combination of the existing paradigms without any major alteration, while overlaying them with an aspiration of a “humanistic engagement philosophy”, is an interesting development and an important step forward in recognising and attempting to reconcile the tensions between the risk paradigm and the recovery paradigms that dominate the relevant service systems. Nevertheless, there remain major limitations that appear to have been brushed over by the researchers advocating this direction, which are discussed more fully in Chapter 4.

A parallel body of work has focussed on the broader social and economic context in attempting to understand the complexity of the transition experience for the mentally ill population. This work has strong links to the work on social capital previously discussed (Wolff & Draine, 2004) and also seems to have evolved in reaction to an individualised risk focussed approach in criminology and a biomedical model within psychiatry. According to Draine et al. (2005), both of these paradigms tend to ignore the social and political context in which offending, incarceration and transition for people with a mental illness is increasingly acknowledged as embedded. One early qualitative study explored the hypothesis that social support was associated with reduced recidivism for people with a mental illness in prison-to-community transition and found that social support was associated with higher quality of life after release, but was not associated with reduced recidivism or psychiatric hospitalisation, which remained unaffected (Jacoby & Kozie-Peak, 1997). This was an important study in that it signalled the complexity of the prison-to-community experience for people with a mental illness and raised questions about what other dynamics besides social support were at play. It appeared to pave the way for a body of research that began to explore the relationships between social and economic factors such as offending, poverty, unemployment, homelessness in the context of mental illness and substance use (Draine et al., 2002b) and the role of these factors in prison-to-community transition (Baillargeon et al., 2010; Barrenger & Draine, 2013; Draine & Wolff, 2009). The core of the hypothesis in this body of literature, that remains on the research agenda and is becoming progressively more nuanced, is that people with a mental illness leaving prison have many more problems than their individual risk behaviours and psychiatric symptoms, and that attempting to address complex social and economic problems may have an impact on offending and incarceration in this population.

In line with these ideas, a conceptual framework to understand prison-to-community transition for people with mental illness was developed by Draine et al. (2005). This was an attempt to shift some of the research attention away from service delivery and the interaction between service systems, or the focus on individual needs and risks. Rather, the emphasis was on incorporating a broader social context and the interaction between the individual and the community they were returning to (Draine et al., 2005, p. 690). Draine et al. (2005) summarise the rationale for this approach:

Community reintegration is more complicated than would be suggested by a list of psychiatric needs and criminogenic risk factors.... Re-entry planning is not just about treatment or rehabilitation or personal welfare; it is about placing a particular person with a particular medical and criminal history into a particular community.... Seen in this way, re-entry is a more complex social welfare issue that involves factors and resources for the family and the community as well as for the individual. (p. 691)

Prison-to-community transition for people with severe mental illness was therefore reconceptualised as an interdependent process that depended on both the individual's willingness and capacity to make changes as well as the community's willingness and capacity to support the individual (Draine et al., 2005). During transition, resources needed to flow to the individual to ameliorate the impact of poverty, and the individual needed support for the development of "mutual reciprocal" (p. 696) social relationships to foster the growth of social capital (Mills & Codd, 2008; Taylor, 2013). Successful transition occurs, according to the framework developed by Draine et al. (2005), when the resources and needs of the individual match the resources and needs of the community. Thus, the individual receives resources but also becomes involved in the community to reciprocate with a social contribution. The community provides resources but also has a need for safety and security. Problems occur during transition, according to this framework, when communities are unwilling or unable to provide the necessary resources to the individual, who is then likely to be economically and socially isolated and engage in criminal activity to meet their resource needs (Draine et al., 2005). Hence, the framework highlights the social processes underlying prison-to-community transition for people with a mental illness rather than just the service process.

A key, frequently cited model for transition support, Critical Time Intervention, was based on similar ideas (Draine & Herman, 2007). The model was adapted from prior work on homeless transition programs and for supporting people being released from psychiatric institutions. The program is a 9-month, three-stage model that aims to strategically develop individualised

links in the community in order to enhance engagement with treatment and community supports (Draine & Herman, 2007). The core elements of the model are small caseloads, active community outreach, individualised case management, psychosocial skill building, motivational coaching, integrated mental health and addiction services, and a focus on both mental health and criminal justice outcomes.

The most contemporary social perspective in terms of prison-to-community transition for people with severe mental illness (Barrenger & Draine, 2013) builds on the original framework developed by Draine et al. (2002b), Draine et al. (2005) and Draine and Wolff (2009), which focussed on the social and economic context and the role of social capital. The new framework, developed by Barrenger and Draine (2013), draws on insights from a public health model that explains social conditions as fundamental causes of public health outcomes (Link & Phelan, 1995; Phelan, Link, & Tehranifar, 2010). The authors combine the public health model (Link & Phelan, 1995) with an analysis of the interaction between the individual and the environment using the risk environment framework developed by Rhodes et al. (2005) from his work analysing drug-related harm and prevention of HIV transmission. This approach further shifts the main focus from individual traits and individual criminogenic risk to political, economic, and social physical components of the risk environment that operates at an individual and community level. While Barrenger and Draine (2013) do not openly reject or criticise a focus on individual criminogenic risk, the suggestion is that this approach may not be comprehensive enough because it assumes a limited view of the complex social phenomena operating during prison-to-community transition and has the potential to undermine and limit the effectiveness of evidence-based treatments and approaches. Further work in the socially focussed body of literature emphasises the importance of emotional support and of working side by side with clients in order to bolster engagement through “relational leverage”, to overcome distrust of service providers that is common in this population (Angell et al., 2014).

3.4 Conclusion

The review of the literature identified that the extreme morbidity and disadvantage of this target group is well established. Theoretical and conceptual work is progressing in the field; however, relatively few researchers are focussing on prison-to-community transition for people with severe mental illness, and the work is new and evolving. Overall, little is known or understood about the transition experience of the general offender population and less is

known about people with a serious mental illness and co-occurring substance use disorder. There is a particular gap in understanding the dominant paradigms and complex structural dynamics that may be impacting on the individual prison-to-community transition experience. This study is situated in the contemporary literature and builds on the current understanding of prison-to-community transition to develop a conceptual framework in the next chapter that shifts the focus closer towards health, recovery and wellbeing in the context of the structural influence of risk environments.

Chapter 4: Theoretical approach and conceptual framework

4.1 Introduction

In this chapter, key concepts and theories from the disciplines of criminology, psychology, mental health, public health, and sociology are combined to develop a conceptual framework to assist in understanding the prison-to-community transition experience of men with co-occurring mental health and substance use disorders. The conceptual framework recognises the lived experience of research participants as the subject of enquiry, acknowledges individual agency as a key element influencing the transition experience and focuses on recovery and wellbeing rather than recidivism as important for this population. Surrounding the individual dimension are four “risk environment” (Rhodes, 2009) elements in the structural dimension. The structural risk environment elements are divided into the political/economic risk environment, the social/cultural risk environment, the prison/post-prison risk environment, and the policy/organisational risk environment (see Figure 2). Hence, the framework situates recovery and wellbeing through a lens of individual action, but only in the context of the potential for the structural risk environment to impact on the ability of individuals to exercise agency.

The conceptual framework for this thesis has been influenced by the NICE conceptual framework for understanding public health (Kelly et al., 2009). This was combined with the “risk environment framework” developed by Rhodes et al. (2005) who utilised this framework to analyse risk behaviours related to drug use and HIV transmission. Both of these frameworks acknowledge two levels of influence — the “individual” and the “environment” — in order to shift the focus from individuals alone and to include social and structural influences on health outcomes and risk behaviour (Kelly et al., 2009; Rhodes, 2009; Rhodes et al., 2005). This is important, according to Rhodes (2009), in order to resist blaming individuals and communities and to shift responsibility to include the social and political-economic institutions that have a role in producing risk behaviours. Rhodes et al. (2005) define the risk environment as: “the space, whether social or physical, where a variety of factors exogenous to the individual interact to increase the chances of [individual risk behaviour]” (2005, p. 1025). The risk environment framework has been recently adapted for use by Barrenger & Draine (2013) in a conceptual framework for understanding the impact of evidence-based treatments during prison-to-community transition for people with severe

mental illness; however, there is no known published study that has used the work of Rhodes (2009) to build a conceptual framework to guide research of the transition experience of this population.

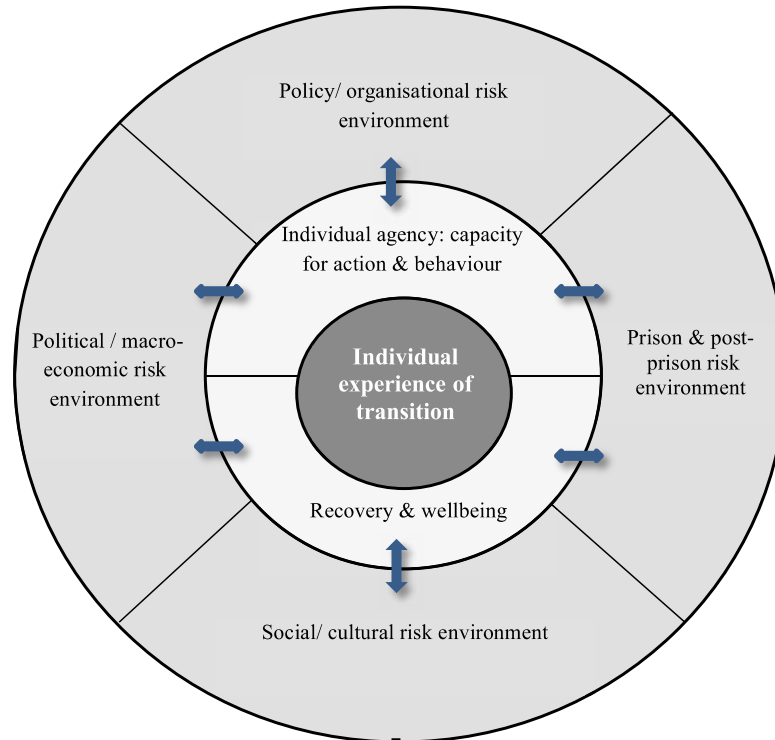


Figure 2: Conceptual framework to understand the prison-to-community transition experience for men with co-occurring disorders.

The NICE framework for understanding public health (Kelly et al., 2009) interprets the environment and the individual levels as distinct and analytically separate from each other, whereas Rhodes (2009) used Giddens’ (1984) structuration theory to understand the “reciprocal relationships” between individuals and environments as they interact (Rhodes, 2009, p. 194). Structuration theory (Giddens 1984) can be usefully employed in developing the current framework because it gives “proper weight to both structure and agency in continuous interaction” (Bottoms, Shapland, Costello, Holmes, & Muir, 2004). The core notion of the duality of structure in Giddens’ (1984) theory holds that structure is produced

and reproduced by social agents. Therefore, the implication in the current study is that the individual is an active participant in the process of transition and does have the potential for agency, albeit within the context of social and structural forces. The core tenet of the conceptual framework presented in this chapter is that the prison-to-community transition experience of men with co-occurring mental illness and substance use disorder, following short-term imprisonment, is situated in a complex and interacting dynamic between the individual and various elements of the structural risk environment.

The conceptual framework for this study is situated in the contemporary literature and provides a unique perspective that has not been previously used to frame research to understand the prison-to-community transition experience of men with complex mental health and substance use problems. Furthermore, as has been suggested by Rhodes (2009), qualitative accounts are useful because they can provide situated explanations of the relationship between structural determinants and individual behaviour.

4.2 Theoretical approach

The theoretical approach utilised in this thesis recognises the role of agency in the context of dynamic interaction with surrounding structural dimensions, and acknowledges recovery and wellbeing rather than recidivism as an important aspect of the transition experience for people with severe mental illness leaving prison. Awareness of the importance of individual and structural factors as largely separate but related analytical levels has been present in the literature on the transition experience of women offenders for over a decade (O'Brien, 2001; Sheehan et al., 2010; Zaplin, 2008) and more recently in the general offender literature (Davis et al., 2013; Graffam & Shinkfield, 2012; Graffam et al., 2005; Shinkfield & Graffam, 2009; Shinkfield & Graffam, 2010). It is clear, however, that while the transition experience has been largely neglected by theorists, what has been presented in the criminology literature to date has a tendency to focus either on aspects of individual human agency or on broad notions of structure.

Approaches giving weight to political, economic and social forces impacting on individual behaviour have been criticised, because as Rhodes (2009) has argued “they imply the need for large scale transformations”. Rhodes (2009) uses the example: “saying that poverty is a risk factor ... does not help much. What is the clinician to do, tell the person to stop being poor?” (p. 197). Broader structural determinism has also been criticised for underplaying

agency and positioning individuals as largely passive in the face of structural and social determinants (Fitzgerald, 2009; Giddens, 1984).

There is a small but growing body of literature that supports the notion that there is an interaction between individual agency and the structural environment and that both individual and social factors impact on the experience of prisoners and ex-prisoners, including during transition (Barrenger & Draine, 2013; Farrall et al., 2011; Farrall et al., 2010; O'Brien 2001; Farrall & Bowling 1999). Structuration theory proposes that structure is not entirely external to individuals and that structure and agency are not a dualism but rather a “duality” (1984, p. 374). The notion of the “duality of structure” is central to the theory of structuration, in that structure and agency have a reciprocal relationship: neither can exist independently and indeed they “represent two sides of a coin” (Farrall & Bowling, 1999, p. 261). The nature of the relationship between the two concepts is that human actors, or agents, are both enabled and constrained by structures and yet these structures are the result of previous actions by agents. That is, “action and structure are interwoven in the ongoing activity of social life” (Held & Thompson, 1989, p. 4).

Structuration theory (Giddens, 1984) has been used by researchers to argue the importance of structure in models that focus on individual factors, as well as to advance the importance of agency in perspectives that focus primarily on structure. Farrall and Bowling (1999), for example, commented on the relevance of structuration theory (Giddens, 1984) for understanding individual offending behaviour in the context of social structure and concluded that:

there is only limited theoretical development in this area ... and what is needed now is a programme of research ... which investigates offending from the perspective of the individual but which takes account of the social structure within which his or her actions unfold. (Farrall & Bowling, 1999, p. 265)

Conversely, more than a decade later, Tan (2011) used structuration theory (Giddens, 1984) to facilitate understanding of the post-release experience and argued that the dominant theoretical frameworks that placed crime within a broader context of social harm, were limited by a sole focus on structure. Tan (2011) asserted that this approach:

appears to be entirely devoid of the notion of human agency. More specifically, the concept is underpinned by an inherent objectivism which sees harm as a one-way manifestation, produced by “macro” structural conditions and impacted upon

“victims” who are constructed as completely passive “bearers” of the social conditions they have entirely no control over. (p. 183)

Tan (2011, p. 191) argued that structuration theory (Giddens 1984) was useful in understanding both the structural forces that shaped the experience of her study participants, as well as recognising the potential agency they possessed to devise and put into action what she termed “survivorship” after release from prison.

Giddens’ (1984) concept of agency has the potential to provide an alternative view to that presented in much of the literature of the prison-to-community transition experience for people with a mental illness. Rather than understanding this group as on the one hand, passive victims of the structural constraints of poverty, disadvantage and limited access to resources, or on the other hand as criminals with a personal responsibility to change their ways by addressing their “criminogenic” or dynamic risk factors, it is possible to expand and reframe the view of the cohort in this study. By utilising structuration theory (Giddens, 1984), the actors can be potentially viewed as active, knowledgeable participants in the process, as well as subjects of their position in the social structure (Ajzenstadt, 2009; Marino, Roscigno, & McCall, 1998). Structuration theory (Giddens, 1984) also assists in understanding that the capacity for knowledgeable, intentional action is not the same as unconstrained choice. This raises the question as to how the current population believe that they can be supported in light of the risk behaviours that resulted in their imprisonment. A further question about this group is whether they can reflexively monitor their behaviour, reflect on their situation with “active and dynamic sense-making” (Sarason, 1995), and attach meaning to the various alternatives for them that are shaped within a wider socio-political context. Giddens’ (1984) view is that human action and social structure influence one another in a reciprocal fashion and therefore the experience of subjects are crucial in making sense of social processes.

To adequately summarise the full extent of the discussion on structuration theory (Giddens, 1984) over several decades is beyond the scope of this thesis. Briefly, there are two streams of critique that are particularly relevant to this work: the use of structuration theory (Giddens, 1984) in criminology and the relevance of this theoretical approach for empirical study. First, Vaughan (2001, p. 185), is critical of the use of structuration theory in criminology for “binding structure and agency together so tightly”, particularly the “loss of each level possessing its own distinctive properties”. Vaughan (2001) is concerned that structure is not given a robust enough presence in the theory. Vaughan (2001) makes an important point

about structuration theory being unable to incorporate the concept of “systematic discrimination” (p. 194) because this concept implies “constancy over time”, which does not fit with Giddens’ (1984) notion of “instanciation” (structure exists only at the moment of interaction). Archer (1995) is also critical of this aspect of structuration theory and calls it “sociology of the present tense”. The cycle of chronic structural disadvantage described in the literature and the potential impact of stigma on the cohort being studied may be relevant to this criticism. Farrall and Bowling (1999, p. 261) deal with this by arguing that it is possible to “hold constant structural properties as chronically reproduced”, in line with Giddens’ (1984) approach. Second, there has been criticism of the usefulness of structuration theory to empirical research (Gregson, 1989; Stones, 2005). Gregson (1989), for example, calls structuration theory a “second order theory” (describing a more general conceptualisation of society), rather than a “first order theory” (which would analyse and explain specific events), and states that it is “too abstract and formal to be of much use” in empirical research.

Nevertheless, Giddens has established himself as a “figure of major significance” and a “theorist of global stature”, and he is considered among the top 10 sociologists in the world today (Bryant & Jary, 2003). Structuration theory has been lauded as a “distinct analytical and conceptual resource” (Stone 2005), and as an “original and influential theoretical framework” (Held & Thompson, 1989). In a review of disciplines where structuration theory has been successfully utilised in research, Held and Thompson (1989) identified work in psychology, geography, archaeology, management, accountancy, religion, education, technology, and criminology. Studies found from over two decades closest in topic to this thesis include: work on the housing position of ethnic minorities (Sarre, Phillips, & Skellington, 1989), the development of a theoretical model of Black on Black violence (Marino et al., 1998), an examination of decision making about criminal activity of women in Israel (Ajzenstadt, 2009), a study of the victims of wrongful imprisonment and their experience post-release (Tan, 2010), and studies to understand drug harms and HIV transmission (Rhodes, 2009). All of these studies have successfully used structuration theory (Giddens, 1984) to further understand and theorise about their cohort.

Giddens (1991, p. 213) commented that empirical researchers often imported his concepts *en bloc* in a way that cluttered their work with an excess of abstract concepts. Instead, he favoured researchers who used his concepts in a “sparse and critical fashion”. Following Giddens’ advice, only the key concepts relevant to this particular research will be utilised in the analysis of data in this study.

Despite the limitations as outlined, structuration theory is considered to be a useful and relevant resource in furthering the understanding of the cohort in this study because it provides a theoretical platform that transcends the subjective-objective, volunteerism-determinism dualisms that are encountered in the literature and facilitates the development of the conceptual framework that is presented and discussed in this chapter.

4.3 Recovery and wellbeing

Whether considering individual behaviour or the social and structural impact on the prison-to-community transition, the research to date involving the current population has tended to focus on recidivism as the key outcome (Kinner, 2006; Levy, 2005; van Dooren, Claudio, Kinner, & Williams, 2011). In contrast, the conceptual framework developed for this study acknowledges “recovery and wellbeing” as important in terms of the population being studied. There is a growing consensus, articulated by Kinner (2008), that “improving the health and wellbeing of prisoners and actively promoting integration post-release not only improves outcomes for prisoners, their families and communities, but also reduces recidivism” (2008, p. 587).

The WHO (2003) has recognised for over a decade that mental health is more than an absence of mental illness requiring treatment, and has described mental health and wellbeing as:

... subjective wellbeing, perceived self-efficacy, autonomy, competence, inter-generational dependence and recognition of the ability to realise one’s intellectual and emotional potential. (p. 7)

This broad definition of mental health is in line with the mental health recovery movement that has had an enormous influence on the understanding of mental health in the western world (Bland, Renouf, & Tullgren, 2009; Davidson, 2005; Slade, 2009). Having largely evolved from the consumer-led movement emerging from the disability, anti-discrimination and civil rights traditions of the 1960s and 1970s, the term “recovery” is somewhat contested in mental health discourse, being variously described as an idea, a process, a guiding principle, a paradigm, a philosophy, a set of values, a movement, a conceptual framework, a policy and a doctrine for change (Anthony, 1993; Bonney & Stickley, 2008; Davidson, O’Connell, Tondora, Lawless, & Evans, 2005; Deegan, 1998).

One of the areas of confusion is that the term “recovery” is used across health to mean different things: first, the notion of recovery from an acute illness when the person becomes

well again, such as cold or influenza, or in some cases complete recovery from a mental illness with no residual consequences; second, recovery from trauma or grief where there is an understanding that the person integrates the traumatic events, and the impact of the trauma/grief is minimised over time; and third, the term used in addiction recovery when the person is no longer using a substance but is “in recovery” from the effects and side-effects of the addiction. The notion of recovery in mental health, however, captures the ideas of empowerment and taking control of one’s own life, despite having a serious mental illness (Anthony, 1993; Davidson, 2005; Deegan, 1998). That is, recovery in mental health has come to mean that even if the person remains mentally ill, with symptoms and disabilities associated with the illness, recovery within the illness is still possible. Davidson et al. (2005, p. 483) point out that: “a person with paraplegia does not need to regain his or her mobility in order to pursue his or her aspirations and goals”.

Recovery in mental health has been defined as:

An ongoing dynamic interactional process between a person’s strengths, vulnerabilities, resources and the environment that involves a personal journey of actively self-managing psychiatric disorder while reclaiming, gaining and maintaining a positive sense of self, roles and life beyond the mental health system (in spite of the challenge of psychiatric disability). It involves learning to approach each day’s challenges, to overcome disabilities, to live independently and to contribute to society and is supported by a foundation based on hope, belief, personal power, respect, connections and self-determination. (Mulligan, 2003, p. 2)

While there is huge variation across the recovery literature in how these concepts are understood, an overarching theme is that recovery takes both the determination of the individual and the support of others (Deegan, 1998; Ralph, 2000). A useful framework capturing key elements of recovery comes from the Scottish Recovery Network (Bradstreet, 2004, p. 5), which identifies seven elements of the mental health recovery framework:

- **Recovery as a journey:** Recovery is not a linear process and people may move back and forth among the various stages.
- **Hope optimism and strength:** A belief that a better life is both possible and attainable.
- **More than recovery from illness:** Recovering a life and identity, as well as recovering from the consequences of mental illness, such as poverty, unemployment and stigma, is key and for some people.

- **Control, choice and inclusion:** Active participation in treatment and services is desirable, along with a belief that change and social inclusion are possible even in the presence of severe mental illness.
- **Self-management:** Having access to information about the illness and becoming “experts by experience”, in terms of involvement with service development and policy, facilitates recovery.
- **Finding meaning and purpose:** Meaning is found in different ways, such as spirituality, employment, meaningful activity, interpersonal or community links.
- **Relationships:** Trusting and supportive relationships with family, friends, community, professional and support staff are central in the recovery journey.

While recovery in the way it has been described above has been recognised largely as a personal journey, it is clear that many people with severe mental illness are interacting and involved with a range of environments and systems related to their mental illness. Hence, both the individual and their environment in recovery are relevant. Attitudes and expectations other people hold about people with a mental illness, the supports provided by services and the opportunities and obstacles people with a mental illness face in their journey, are all considered to be important factors (Bradstreet, 2004). Jacobson and Greenley (2001) identify key “internal conditions” as “hope, healing, empowerment and connection” and the “external conditions” that define recovery as “human rights, a positive culture of healing and recovery orientated services” (Jacobson & Greenley, 2001, p. 483). This conceptualisation is similar to Ward and Stewart (2003) in their Good Lives Model for prisoners and ex-prisoners, where they describe internal capabilities (knowledge and skill sets) and external conditions (opportunities, resources and supports). Nevertheless, there is much debate about what is meant by recovery-orientated services. Davidson, O’Connell, Tondora, Styron, and Kangas (2006) describe it elegantly as: “reframing the treatment enterprise from the professional’s perspective to the person’s perspective. In this regard, the issue is not what role recovery plays in treatment, but what role treatment plays in recovery” (p. 43).

There are many conceptual frameworks that place stronger emphasis on different aspects of recovery. Much of the literature on recovery promotes the idea that relationships underpin the task of recovery (Dorkins & Adshead, 2011; Slade, 2009; Turton et al., 2011). Relationships with peers, that is, people with their own experience of mental illness as well as professionals, family and community members, are identified as important in the recovery

process (Deegan, 1998; Slade, 2009). The efficacy of peer support networks is increasingly recognised. Services are encouraged to employ peer support specialists and to develop peer-run programs (Davidson et al., 1999; Moran, Russinova, Gidugu, Yim, & Sprague, 2012; Solomon, 2004). The concepts of partnership and mutuality in the relationships between service users and staff have also entered the discourse on recovery-orientated services. Within this construct, professionals work alongside the service user and provide choices rather than solutions. In addition, established relationships, based on partnership and mutuality, have been identified as very important in managing crisis situations (Slade, 2009). The importance of connections with family and friends and community members is frequently emphasised, particularly having someone who believes in the person with a mental illness and their capacity for recovery (Padgett, Henwood, Abrams, & Drake, 2008; Ralph, 2000).

Understanding the concepts of recovery in terms of the cohort in this study is challenging. Recovery is the driving force behind the contemporary development of mental health services, yet despite this, very little attention has been paid in the literature on recovery specifically discussing mentally ill prisoners or those with a co-occurring substance use leaving custody. However, the broader literature that explores the phenomena of recovery with people who have committed offences is slowly emerging (Doyle, Logan, Ludlow, & Holloway, 2012; Mezey & Eastman, 2009; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Pouncey, 2010; Turton et al., 2011). One of the core concepts in the recovery literature is “hope”. In a recent intersection between the criminology and mental health literature, hope studies in relation to the general offender population have begun to emerge (Bouch, 2011; Burnett, 2010; Martin & Stermac, 2010; Snyder, Feldman, Taylor, Schroeder, & Adams, 2000). Contained within this literature are attempts to measure hope and questions as to whether “hope” can predict risk (Martin & Stermac, 2010; Resnick, Fontana, Lehman, & Rosenheck, 2005). Nevertheless, “hope” is emerging on the edges of criminology as a factor that potentially has protective factors for negative behaviours and possibly offending. The suggestion is that focussing on hope can encourage inmates to “find a life worth living” and foster the motivation to make positive changes (Martin & Stermac, 2010). Whether the concepts of hope and recovery have relevance to understanding the prison-to-community transition experience for men with multiple and complex social, mental health and substance use problems and histories of repeated incarceration is of interest in this research.

4.4 Political/macroeconomic risk environment

The political/macroeconomic risk environment is increasingly recognised as impacting on health and wellbeing (Kelly et al., 2009; Rhodes, 2009), particularly for prisoners and ex-prisoners (Farrall et al., 2010; Farrall et al., 2011). This discussion has also recently commenced in terms of the Australian context (Cunneen, et al., 2013). Baldry, Dowse, and Clarence (2011) ask, in relation to the overrepresentation of people with mental disorders in prison: “How is it that such vulnerable persons are so concentrated in a system primarily for punishment when Australian society has such sophisticated health and support systems?” (p. 2). An important consideration in attempting to answer that question lies in a complex relationship between politics, economics, crime and incarceration, which has relevance to understanding the prison-to-community transition experience.

The “neo-liberal risk society” (Farrall et al., 2010; Farrall et al., 2011; Stanford, 2010) and “neo-liberal” economics and ideology (Kemshall, 2010) have been associated with a shift from social responsibility to individual responsibility, particularly in terms of social disadvantage. While “neo-liberalism” is a much used and contested term, it generally refers to political and legislative initiatives that push for fiscal austerity, lower taxes, privatisation, cuts in social spending, and overall reduction of government involvement in the economy (Boas & Gans-Morse, 2009). Fenton (2012, p. 2) argues that the consequence of neo-liberal policies is that “welfare is an expensive luxury”, and further that penal-welfare work with offenders is considered “absurdly indulgent”. She suggests that through the neo-liberal lens, offenders are viewed as “choosing to commit crime” and that any suggestion that welfare interventions may deserve attention and make a difference “is seen as indulgent and soft” (Fenton, 2012, p. 2). Both Farrall et al. (2010) and Brown (2013) suggest that the rise of “law and order” as a political platform has simultaneously occurred in this environment.

The connection between neo-liberalism and a “law and order” agenda is complex but essentially the argument advanced by several authors is that there tends to be a rise in particular types of “petty” crime related to poverty and social disadvantage in response to cuts in social and welfare supports, followed by punitive responses to individuals being held entirely responsible for their criminal activity without paying attention to structural influences (Farrall et al., 2010; Farrall & Hay, 2010; Gilmore, 2006). Indeed, Wacquant (2010, p. 214) comments that “the invasive and expensive penal state is not a deviation from neo-liberalism but one of its constituent ingredients”. The net effect, according to Farrall et al. (2010):

Has been subtly to redefine the relationship between the offender and the state ... by an ideology in which the individual being punished becomes a sort of “non-citizen” or “other” who is permitted to return to civil society either grudgingly or not at all. (p. 558)

Hence, the neo-liberal political environment, in combination with a “law and order” agenda, may impact on the transition experience of the population being studied in terms of a system that holds them fully responsible for their social disadvantage and does not acknowledge the links between their incarceration and how they are situated in their environment. For example, Farrall et al. (2010) notes that there is firm empirical evidence that economic changes in the past 30 years has impacted on employment and housing. Moreover, the economies of western countries have undergone significant structural changes, with an increase in the knowledge economy and a decrease in the availability of manufacturing and other manual labour (Farrall et al., 2010). Alongside the shrinking of the manual workforce has been an increased tendency for criminal record checking. Hence, people leaving prison with few skills and low levels of education and a criminal history have even less chance of finding employment than they did in the past (Farrall et al., 2010). Similarly, reduced housing stock, rising costs of living, and the reduced tendency for governments intent on fiscal restraint to invest in socially supported housing is making it more difficult for all people living on the margins to find affordable housing (Farrall et al., 2010).

In summary, the political and economic risk environment is included in the conceptual framework because of the potential importance of this element in understanding the transition experience. The political and economic environment is likely to directly and indirectly shape human services and criminal justice policy in relation to the study participants, as well as have an impact on the availability of services, housing and employment as they transition from prison to the community.

4.5 Social/cultural risk environment

It has been well established in the literature that the social/cultural risk environment impacts on the transition from prison to community (Barrenger & Draine, 2013; Farrall et al., 2010). For example, the impact of stigma has been recognised as important in the transition experience. According to Brinkley-Rubinstein (2013), stigma refers to “unfavourable approaches, views, and at the macro level policies that are directed towards people who belong to a shunned or socially marginalised group” (p. 9). People who have been in prison can be stigmatised, marginalised and excluded (Hartwell, 2004a, 2004b), particularly from

housing and employment. Stigma can also weaken social ties and social support, according to Petersilia (2008). It has also been found that stigma can cause significant stress that can impact on psychological state, help-seeking and access to health and social services (Brinkley-Rubinstein, 2013; Hartwell 2004). Stigma towards people involved in the criminal justice system can extend deeply into the realm of moral judgement. For example, Ward and Birgden (2007) observed that:

[there are] two fundamental attitudes towards crime and individuals who commit crime:

Offenders are [either] dismissed as *alien* others ... *as moral strangers* who do not merit consideration and therefore whose interests are of peripheral concern.... Or [prisoners] are accepted as valued *fellow* human beings ... and, as such, deserve the chance to redeem themselves and to live worthwhile and better lives. While they may ... deserve punishment for their actions, they do not forfeit their basic dignity as persons. (p. 269)

The term “triple stigma” has been used for people with a mental illness and substance use disorder who are involved with the criminal justice system (Hartwell, 2004). Moreover, according to Wolff (2002, p. 803), the concept of mentally ill offenders tends to incite “moral panic”, leading to stigmatisation and marginalisation on release. Braithwaite (1989) found that people with a mental illness who have a history of offending experienced a great deal of stigma, and that stigma may in fact contribute to ongoing offending and continue the cycle of involvement in the criminal justice system due to marginalisation into subcultures.

In addition to stigma, it is well documented that there is a strong link between the risk factors for repeated involvement in the criminal justice system and the risk factors for poor social integration, such as mental illness, substance use, unemployment and poverty (Hartwell, 2003; Seymour, 2010). A qualitative study conducted by Richards and Jones (1997), for example, where they interviewed 30 men just released from prison, found that economic and legal barriers were the main structural impediments to successful community reintegration after prison. They conclude that “the prison system is a perpetual incarceration machine growing on failure” and that “structural impediments contribute to parole failure and recidivism” (Richard & Jones, 1997, p. 4). Further, Hillyard, Pantazis, Tombs, and Gordon (2004) describe the “narrow focus” of criminology, particularly in relation to petty crime, as a deflection from broader social harms resulting from government failure to address structural issues such as poverty, unemployment and homelessness. Other authors (Reiman, 2007;

Thompson, 2008) discuss the role of race, gender and class in crime and promote the idea that maintaining a visible criminal population serves the interests of the rich and powerful.

Rhodes (2005, 2009) draws on the concept of “structural violence” to illustrate “how the social–political economy of risk is a product of multiple forms of structural subordination” (2005, p. 1033). Other authors have described structural violence in terms of a form of systemic marginalisation that extends beyond the individual to social structures that perpetuate a cluster of circumstances such as poverty, unstable housing, unemployment, social isolation and stigma (Gilligan, 2000; Kelly, 2005; Rose & Hatzenbuehler, 2009). Structural violence is different from personal violence in that it is often invisibly embedded in social structures. The “institutionalisation and everyday internalisation of structural violence” (Rhodes, 2009, p. 196) can render structural violence unnoticeable. Gilligan (2000) explains:

Where violence is defined as criminal, many people see it and care about it. When it is simply a by-product of our social and economic structure, many do not see it; and it is hard to care about something one cannot see. (p. 386)

In risk environments, unequal power relations result in unequal opportunities, thereby constraining agency, according to Rhodes (2009). Risk environments may constrain agency; however, they are also a “product and adaptation” (Rhodes, 2009, p. 197) of agency. Rhodes (2005, 2009) suggests that structural violence can be “embodied” by individuals and result in “oppression illness” (Rhodes, 2005, p. 1033). Oppression illness can be understood as a type of “stress disorder”, as a result of social discrimination. One of the ways that oppression illness manifests in drug users, suggests Rhodes (2009), is through “self-medicating” for “oppression illness”, which results in “a cycle of risk production in which those marginalised can become complicit, including unconsciously, in their ongoing structural subordination” (p. 196). This is an example of what Giddens (1984) understood as “structuration”, where individuals and social structures are not separate independent phenomena, a dualism; rather, they have a reciprocal relationship and “represent a duality” (Giddens 1984, p. 25). Structural violence and oppression illness is one way of explaining how individual risk behaviours such as drug use and crime can be produced and reproduced in an interplay with the social/cultural risk environment.

4.6 Prison and post-prison risk environment

The physical and psychological risk environment of prison and the immediate post-prison period are important to consider in the conceptual framework because there is a well-

established link between incarceration and health and wellbeing outcomes in the literature that has implications for understanding the prison-to-community transition experience in the current research. Rhodes suggests that “prisons are built expressions of the risk environment ... and like most other forms of criminal justice intervention, disproportionately affect minority populations” (2009, p. 196). Prisons are, in the main, not conducive to recovery and wellbeing, and prisoners transition back into the community with complex physical, mental and emotional problems (Binswanger, Krueger, & Steiner, 2009; Binswanger et al., 2011). As most prisoners will return to the community after short periods of time (Petersilia, 2005), it has been frequently argued that prisoner health is public health (Fazel & Yu, 2011; Levy, 2005; van Dooren et al., 2011). Indeed, prisoner health appears to be influenced as much by the impact of prison itself in combination with individual health problems, exacerbated by structural factors (de Viggiani, 2007).

Prisoners with severe mental illness appear to be especially vulnerable to the impact of the prison environment. It has been found that overcrowding, noise, strict rules and lack of privacy in the prison environment can both exacerbate existing symptoms of mental illness, as well as cause new symptoms, such as anxiety and depression (Gelman, 2007). There is also some evidence that prisoners with severe mental illness have increased risk of self-harm and suicide that can be related to the prison environment (Adams & Ferrandino, 2008; Soderstrom, 2008). Much is still not known about the access and quality of healthcare in prison, which varies between jurisdictions. Petersilia (2008), for example, found that only one quarter of people with mental health and/or substance use issues received treatment for these conditions while in prison. De Viggiani (2007) argues that prison physical and mental health services have long been entrenched in a biomedical paradigm that leads to a focus on short-term acute healthcare rather than more long-term public health priorities, particularly in terms of drug use and suicide, where the approach has been “containment and treatment rather than prevention” (2007, p. 116).

The physical and mental health and wellbeing of prisoners as they enter the community has been theorised as directly and indirectly impacting on individuals, families and communities during transition (Brinkley-Rubinstein, 2013). Patterson (2013) found that each year in prison translated to a 2-year decline in life expectancy for parolees from a range of physical-health and mental-health related deaths. Other researchers have found that the post-release period is associated with anxiety and depression (Schnittker, Massoglia, & Uggen, 2012; Shinkfield & Graffam, 2010) and symptoms suggestive of post-traumatic stress disorder post-release (Liem

& Kunst, 2013). There is some initial evidence that multiple incarcerations have a greater impact on these effects (Schnittker et al., 2012).

The post-prison environment has also been found to have a specific impact on health and social wellbeing in international studies. One of the important effects of incarceration on the post-release experience has been found to be weakened ties or total breakdown of family support (Wildeman & Western, 2010). Khan et al. (2011) found, for example, that 55% of primary partnerships ended during incarceration in a sample of 64 participants. Links between social isolation and return to drug use have been made by Binswanger et al. (2012), with important implications for post-release deaths related to drug overdoses.

Institutionalisation has been theorised as being important in terms of the impact of the prison environment on the transition experience (Howerton et al., 2009). Johnson and Rhodes (2008) cite some very early theory about institutionalisation (Bettelheim & Sylvester, 1948), where it was considered to be a “deficiency disease in an emotional sense” caused by the “absence of meaningful, continuous interpersonal relationships”. Goffman (1961) developed a theory about the “total institution”, where inmates were cut off from society to lead “an enclosed formally administered round of life” (1961, p. xii). Goffman (1961) identified the four central features of total institutions as: first, that work, recreation and sleep are conducted in the same place; second, daily activity is conducted in a large group, where everyone is treated alike; third, activities are organised with a tight schedule imposed from above; and finally, the activities are designed to fulfil the aims of the institution rather than the inmates (p. 6). In these environments, staff tend to “feel superior and righteous”, whereas inmates tend to “feel inferior, weak, blameworthy and guilty” (Goffman, 1961, p.7). The impact of these environments, according to Goffman (1961), is a process of “the mortification of the self”, where inmates are stripped of their social roles and identities (p. 14). Individuals adapt to these environments in different ways, either through withdrawal, rebellion, or adaption to the environment. However, the net effect of institutionalisation, according to Goffman (1961), is to disrupt “self-determination, autonomy and freedom of action” (p. 43) and the subsequent dependence on the institution, leading to difficulty in coping outside of it. This is consistent with Rhodes’ (2009) notion that risk environments constrain agency.

The notion of institutionalisation remains current in the literature on prison-to-community transition. For example, Howerton et al. (2009, p. 457) used the term “readjustment anxiety”

to explain leaving prison, and Baldry (2010, p. 256) coined the term “serial institutionalisation” to refer to the impact of repeated short-term imprisonment. However, no in-depth analysis was found of institutionalisation in relation to the transition experience of this population. Institutional theory, such as Goffman’s “total institutions” (1961) and Giddens’ structuration theory (1984) share complementary insights, in that action is organised by institutions and institutions are created and maintained through action (Barley & Tolbert, 1997). These theories are therefore compatible and have relevance to understanding the interrelated relationship between the individual and the environment in terms of the prison-to-community transition experience.

4.7 Policy/organisation risk environment

The policy and organisational risk environment is important in this research in terms of understanding the systems and structures that impact on the individual transition experience. The transition experience for the population being studied occurs at the nexus of the criminal justice and mental health systems. The tension between “care and control” (Telfer, 2000) and “care and custody” (Jacob, 2014) has long been acknowledged in the forensic mental health and critical criminology literature. Further, the goals of punishment and rehabilitation are not necessarily compatible (Miller et al., 2010) when seeking to understand the relationship between these systems and policy environments. It has also been suggested by Roberts and Bell (2013) in relation to drug policy that:

... there may be a tendency to fall back on appeals to the crime reduction and community safety benefits of drug treatment. While these are genuine and substantial, there is a risk that an appeal to public fears will squeeze out a developing discourse framed in terms of hope and recovery. (p. 82)

One of the ways of thinking about the tension at the nexus between mental health and criminal justice is to focus on the dominant paradigms of risk and recovery that are driving contemporary policy and practice at this interface (Epperson et al., 2011; Wolff, Frueh et al., 2013). The recovery paradigm as described above is reflected in international mental health policy, as well as both Australian and Queensland mental health policy. *The Queensland Plan for Mental Health 2007–2017* (Queensland Government, 2008, p. 2) for example, states the aim: “to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders”. Recovery is described in the Queensland plan as the capacity to lead a fulfilling life not dominated by illness and treatment and the possibility of experiencing improved quality of life and higher levels of functioning despite mental

illness. To this end, the Queensland government proposes coordinated and integrated approaches that enable people who live with mental illness to participate meaningfully in society (Queensland Government, 2008). People with severe mental illness making the transition from prison to community, however, are not specifically mentioned in the Queensland policy, despite the evidence that they are highly at risk of multiple disadvantage and post-release death in comparison to their non-mentally ill counterparts (Kariminia, Law, Butler, Corben et al., 2007; Kinner et al., 2011; Stewart et al., 2004).

In contrast, the criminal justice system both internationally and in Australia, is driven by a focus on individual risk factors (Ward, Yates, & Willis, 2012). Following the international trend, correctional services in Queensland have embraced and adapted an individual risk-focussed approach as the foundation for how they categorise prisoners and allocate resources to support rehabilitation and transition support services (Queensland Corrective Services, 2010). There has been a rich discourse over the past decade discussing the use of risk assessment, risk prediction, risk classification and risk management in both criminal justice and mental health arenas, as well as in child protection, disability and aged care, with many theorists and researchers supporting and defending the approach as scientifically rigorous and evidence based (Andrews & Bonta, 2010; Ward & Eccleston, 2004; Wolff, 2002; Wormith et al., 2007). No system, however, has incorporated risk principles as decisively as the criminal justice system, where it has been observed as “close to becoming a law in the study of criminology and criminal justice” (Gaes & Bales, 2011, p. 984). Within the criminal justice context, the focus is on individual risk and community safety and hence resources are primarily directed towards the prevention of recidivism (Andrews & Bonta, 2010; Ward et al., 2012).

While the individual risk-focused approach appears to have merit in terms of impacting on recidivism in the general offender population, the preoccupation with risk assessment “technology” has been widely criticised (Coffey, 2012; Fenton, 2013; Hannah-Moffat, 2005; Hudson, 2001; Ward et al., 2012) particularly in relation to women (Sheehan et al., 2010; Trotter et al., 2012) and in relation to people with a mental illness (Blackburn, 2004; Farrow et al., 2007). Some of the concepts underpinning the criticism arise from the work of Beck (1992) and his theory of “the risk society”. Beck (1992) argues that the more we look for risk, the more risk we find, thereby generating a sense of insecurity that “dims the horizon”. Beck proposes that a focus on risk paralyses action and that “risks only suggest what should not be done, not what should be done” (Beck, 1992, p. 9).

In contrast to the focus on recovery articulated in mental health policy, the individual risk paradigm tends to portray prisoners and ex-prisoners primarily in terms of their criminal activity and criminal thinking. Ward, Melser, and Yates (2007) argue that through this lens, the “criminal” is viewed as fundamentally different from the “non-criminal”, and problems are attributed to deviance and individual pathology (Ward & Birgden, 2007). Maruna (2001) also comments:

On average we social scientists tend not to hold out much hope for offenders, at least those who by virtue of characterological defects or warped personalities are presumed different from the rest of us. Emphasising the difference is a time honoured psychometric task and a frequent concern of forensic psychologists. (p. xv)

The risk principle maintains that the most intensive rehabilitation should be directed to individuals with the highest risk of offending. Andrews and Bonta (2010) also maintain that there may be an adverse impact on lower risk individuals from intensive interventions. The assumption in this approach is that it is possible to predict which individuals are at higher risk of offending, and individual risk assessment is mainly concerned with the likelihood of an offence reoccurring. There is also a focus on criminogenic needs (also referred to as dynamic risk factors), which are those risk factors specifically associated with the offending behaviour, such as attitudes, associates, antisocial personality traits, anger and substance use. Within this paradigm, it is criminogenic needs that should be targeted in programs. Socioeconomic indicators are referred to as “more distal factors” (Andrews et al., 2006, p. 16) that may have some impact; however, the model essentially focusses on individual pathology and skill deficits, character flaws and problematic behaviour. Within the individual risk paradigm, mentally ill prisoners tend to be viewed as dangerous and “a risk” (Stanford, 2010, 2011) to community safety, irrespective of the nature and severity of their offending (Skeem et al., 2011; Wolff, 2002; Wolff, Plemmons, Veysey, & Brandli, 2002).

A summary of the criticisms of the risk paradigm include that this approach:

- portrays the problems of individuals as a result of deficient thinking and behavioural problems and draws attention away from structural inequalities such as social and economic constraints (Hannah-Moffat, 2005; Kemshall, 2002, 2010; Trotter et al., 2012);

- can promote a culture of “otherness” in relation to people with a mental illness and offending behaviour by viewing them as belonging to risky “other” populations rather than people with complex needs (Blackburn, 2004; Fenton, 2013; Warner, 2004);
- redefines risk factors as criminogenic needs that are related to recidivism and limits interventions to those risks that have a direct link to offending (Mullen, 2001; Trotter et al., 2012; Ward et al., 2007; Ward et al., 2012);
- undermines rehabilitation by creating a surveillance framework and a policing role for practitioners and services (Hudson, 2001; Sheehan et al., 2010);
- promotes control and containment rather than support and management and that the goal is “to *restrict* rather than *enable*” (Blackburn, 2004; Mullen, 2001);
- diverts resources towards those who are considered to be of high or future risk rather than providing resources to the majority or those considered to have high needs (Mullen, 2001; Sheehan et al., 2010);
- claims to be morally neutral but is viewed as generating stigmatising, defensive and blaming cultures across human service agencies (Coffey, 2012; Fenton, 2013; Kemshall, 2002; Sawyer, 2009; Stanford, 2010, 2011).

Overall, the individual risk approach tends to promote acceptance of a punitive and punishment model (Travis, 2005): the “correction” of pathology through rehabilitation strategies and an assumption that the criminal justice system has no responsibility for transition support beyond supervision (Austin, 2001). Within this paradigm the cohort being studied would be understood as rational actors, lacking in motivation, making poor choices and failing in their attempts to live a normal life. This view leaves very little room for an understanding of the potential impact of the structural risk environment in constraining or enabling agency during transition from prison to community.

Stanford (2010) identified a construct where practitioners differentiated “client identities” between those who were considered to be “at risk” and those considered “a risk”. There is potential relevance to the current study with a cohort who are clearly “at risk” of multiple disadvantage and also “a risk” in terms of their criminal histories and potential risk of re-offending. One of the potential pitfalls, however, of the constructs of “a risk” and “at risk” is that it may not be helpful at a theoretical level to polarise this cohort into either victims (“at risk”) or perpetrators (“a risk”), both terms which evoke a sense of risky “other” populations

(Fenton, 2012), rather than recognising the individual with complex needs with the potential for wellbeing and recovery. Baldry and Mapleton (2013) have recently utilised the concepts of “at risk” and “a risk” in an interesting way in terms of the target population. They conceptualise that people with mental or cognitive disabilities and criminal justice involvement have often moved from being “at risk” as a child to being “a risk” as an adult. As a result, it is argued that needs and risks become inflated (p. 231). At the core of the criticism of an overly risk-focussed approach is that without acknowledging the social and political context in which crime occurs, the responsibility for rehabilitation and reintegration largely rests with the individual. A broader sociological perspective, with a more strength-based, humanistic approach, may be more appropriate when considering the prison-to-community transition for men with a mental illness and co-occurring substance use.

A unique aspect of the conceptual framework in this thesis is to situate the tension between the risk and recovery paradigms within a broader framework than has previously been considered in the literature. This is important because the mental health recovery philosophy underpins mental health service delivery and policy internationally and in Australia. It is the approach that is now “central to hopes for progress” in mental health policy, according to Pilgrim (2008, p. 285). The role of recovery in terms of the population being studied, however, remains unclear and unresolved in the literature. First, recovery is essentially an individualistic model focusing on the “individual journey” (Anthony, 1993; Deegan, 1988), and this refers to people setting their own goals for recovery. This is an important concept in the recovery literature, to differentiate from medical and clinical approaches that have been identified as “paternalistic” (Oades & Anderson, 2012) by recovery advocates, where the expert is the clinician who knows what is best to treat the “deficits” in the patient (Pilgrim, 2008). Braslow (2013) argues, however, that there is a concerning tendency for recovery approaches to coalesce with the neo-liberal push to “shift care from collective social responsibility to private individual responsibility” (p. 799) in mental health policy by sharing the same vision of independence and empowerment. Braslow (2013) refers to the neo-liberal push towards individual independence and the aspiration in this philosophy to divest responsibility for supporting the disadvantaged, stemming from the belief that the root cause of poverty is the welfare system. At the same time, Braslow (2013) is critical of the recovery literature for failing to articulate a system of care:

Though brimming with well-meaning platitudes about hope and the urgent need for “system transformation,” the recovery literature tells us much less about how to practically construct a recovery-based system of care. (p. 801)

There have been some recent attempts in the literature to discuss the tension between the risk and recovery paradigms in relation to prisoners and ex-prisoners with mental illness (Wolff, Frueh et al., 2013; Epperson et al. 2011; Osher 2011). While this is an important step forward, there remain important questions in this literature. First, the history of the development of the risk and recovery paradigms is very different and there is a likelihood that the risk paradigm will dominate and the recovery paradigm will be lost. The risk assessment and management tools used in contemporary western correctional systems were developed over many years using randomised controlled trials, are considered to be evidence-based and “what works” in correctional rehabilitation, and are used extensively, including in Queensland prisons. In contrast, the recovery framework has developed organically through the consumer-led movement emerging from the disability and civil rights traditions (Pilgrim, 2009). It is based on the assumption that mental illness is primarily a subjective experience and that the consumer generally understands their own needs and what is in their best interests (Slade, 2009). While recovery is becoming the dominant philosophical platform driving mental health service provision, it is still contested as a theory, and according to Mancini (2008, p. 358) has no “overarching theoretical or empirical framework”. Clearly, the risk paradigm is stronger theoretically and empirically and is likely to dominate in any combined framework if applied in transition programs without careful consideration.

Second, risk and recovery are located within very different philosophies (Wolff, Frueh et al., 2013; Epperson et al. 2011) that have long been encapsulated by the phrase “care or control” (Hylton, 1995). This is reflected, for example, in that the language used in each paradigm is conflicting and potentially incompatible. Terms such as “anti-social” and “criminal thinking” convey very different meanings from the recovery language of “hope”, “equality”, “respect” and “empowerment”. The former can be viewed as negative labelling that fails to capture the complexity of the problems of the population being studied and fails to take a holistic, humanistic view of the person that encourages hope, as the recovery language attempts to do.

4.8 Conclusion

The theoretical approach and conceptual framework presented in this chapter incorporates and builds on the existing literature discussing prison-to-community transition for the population being studied. Giddens’ (1984) structuration theory and Rhodes’ (2009) “risk

environment framework” were employed to explore the notion of the interaction of individual agency with four components of the structural risk environment. Goffman’s (1961) theory on the “total institution” was also introduced to understand the risk environment of prison. Unlike much of the literature discussing prison-to-community transition for this population, the framework for this thesis shifts the emphasis away from recidivism towards recovery and wellbeing. Together, this literature provides a unique framework to facilitate both breadth and depth of understanding of the prison-to-community transition experience for a cohort of men with severe mental illness and co-occurring substance use disorder. The analysis chapters that follow the outline of the methodology in the next chapter, explore the lived experience of research participants during prison-to-community transition, through the lens of the theoretical ideas and conceptual framework presented in this chapter.

Chapter 5: Methodology

5.1 Introduction

This chapter presents the methodology used to explore the prison-to-community transition experience of adult males with severe mental illness and co-occurring substance use disorder after short-term incarceration. The overall aim of the study was to understand the experiences, needs and challenges of this population, and the impact of systems and structures on the individual during transition.

Research questions:

1. How did men with a co-occurring severe mental illness and substance use disorder experience prison-to-community transition after short-term incarceration?
2. How did the participants perceive their needs and challenges during their prison-to-community transition?
3. How did the systems and structures surrounding participants during transition impact on their individual experience?

A qualitative research design utilising repeat semi-structured interviews provided three data points: prior to release, immediately post-release, and 3 months post-release. The qualitative research design addressed the importance of hearing the voices of the research participants in order to facilitate an in-depth analysis of the transition experience.

5.2 Epistemological approach

The focus in the study was on the subjective experience of the participants. This research sits broadly within the interpretative tradition and seeks to learn “what is meaningful or relevant to the people being studied” (Neuman, 2006, p. 88). Repper and Perkins (2003) have argued that research within an interpretive paradigm must involve the “voice of first-hand experience”. In this tradition, the assumption is that meaning is described, interpreted and constructed in a partnership between the researcher and the participant during the process of undertaking the research (Crotty, 1998; Seale, Gobo, Gubrium, & Silverman, 2007). The view in this thesis is that the individual experience is strongly influenced by social, political and cultural processes. That is, meaning arises in different traditions, cultures, communities and institutions, and the setting affects how people make sense of their world (Gergen, 1985).

Maxwell (2009) challenges the idea that there is a “correct” philosophical stance for qualitative research and encourages a more careful toolkit approach to meet the needs and accomplish the goals of the research. In this thesis, both the ontological reality of mental illness, substance use disorder and criminal activity are acknowledged alongside an acceptance that meaning about these conditions and activities is constructed by both the researcher and the research participants. Much of the research in the fields of mental health and criminology attempts to objectively measure factors related to mental illness, drug use and offending behaviour without necessarily acknowledging the construction of meaning that is influencing the conception of these phenomena. For example, how people *think* about mental illness, or the *social construction* of mental illness, often includes perceptions that mental illness is associated with deviance, unpredictability and chronic dysfunction (Wolff, 2007). Similarly, there are many negative constructs and beliefs about alcohol and drug use, and addiction and dependence; and people who have spent time in prison are frequently constructed as morally reprehensible individuals who are essentially “bad” (Stanford, 2011; Ward & Birgden, 2007). These socially constructed beliefs and attitudes are not usually explored in quantitative research; however, they are important because they can restrict the view of this population.

In this research, the lived experience of prison-to-community transition for people with mental illness and substance use disorder is explored in order to learn more about the complexity of this phenomenon. This is not to deny the usefulness of quantitative research in the field, but rather to add to existing knowledge and understanding by an in-depth and contextualised exploration of the transition experience. The common approaches in biomedical and criminology research are frequently typified by premises such as “scientific rationality” and “objective numerical measurement” (Miller & Crabtree 2005, p. 610). Policy makers frequently call for evidence-based research, and randomised designs are frequently prioritised over qualitative approaches (Denzin & Giardina, 2009). In contrast, Miller and Crabtree (2005) call for discovery of the “missing evidence” that can be provided by qualitative approaches. It is proposed that through exploring the experience of participants, “the clinical research space is expanded, dominant paradigms are challenged and hope is reimaged” (Miller & Crabtree 2005, p. 610).

5.3 Research design

The research was designed to explore the prison-to-community transition experience for men with severe mental illness and co-occurring substance use disorder leaving prison in Queensland. The qualitative research design utilised repeat in-depth interviews with three data points: (1) within 1 month pre-release from prison, (2) 1 to 2 weeks post-release, and (3) 2 to 4 months post-release. This approach provided a view of the transition experience spanning the time of preparation and planning for leaving prison; the immediate post-release period; followed by the process of settling into the community. Baldry (2010) in her article on women in transition described 'transition' as follows: "The post-release period may extend for some months to over a year depending on the range of material, psychological, legal and social adjustments and needs that a person has. It includes 'transition', a shorter period of time just before, and for a month or two after, release" (p.254). The assumption in the current study was that this would be a time of change and upheaval, and that the plans and expectations that the participants had pre-release may or may not reflect their eventual experience in the community. It was therefore important to attempt to capture the entire transition phase in order to facilitate a fuller understanding than would have been possible with a cross-sectional view. The interviews were conducted in four prisons in South East Queensland and in a variety of community settings.

5.4 Sample

The study used "typical case" sampling (Patton, 2002, p. 236) and focussed on a typical group of people with a serious mental illness leaving prison in Queensland, as evidenced by the literature and demographic profiling of the client group from an internal Queensland Health evaluation (Denton et al., 2009). Prior to the commencement of the current project, an evaluation study was conducted to describe the demographic characteristics and preliminary continuity of care outcomes of 100 people with a mental illness receiving transition support on release from prison in Queensland. One of the findings of the study was that the demographic and clinical data of approximately 60% of the cohort was consistent with the profile of what was to become the inclusion criteria in this current study (Denton et al., 2009). This finding was also largely consistent with several studies examining the population of people with a mental illness leaving prison in the United States (Hartwell, 1999, 2003, 2004a, 2004b, 2010; Hartwell, Fisher, & Davis, 2009).

Men experiencing a psychotic illness, co-occurring substance use disorder and low level offending indicated by a history of multiple short-term incarcerations are of interest because while they form the dominant group of people with a mental illness leaving prison in several studies (Hartwell, 1999; 2003; Denton et al., 2009), they are arguably the least known about. There has been a tendency for researchers in the field to focus on groups of high interest related to their extremely poor outcomes, such as women and Indigenous prisoners. These groups, while sharing many of the challenges of the current population, have specific complex problems that have been documented in various studies. Multiple studies have focussed on the special needs of women prisoners, including in transition. (For example see Baldry, 2010; Richie, 2001; Sheehan et al., 2010; Trotter et al., 2012). The research on Indigenous prisoners is still in its infancy however some important work has recently been undertaken in Queensland (Heffernan et al., 2012; Morseu-Diop, 2010). It is clear from the literature that a widely diverse sample for the current study would most likely have resulted in a broad spread of multiple and complex findings. Containment of the sample to a typical group as outlined, allowed an in-depth focus on the population of interest, that was less distracted from multiple outlying threads of data. Nevertheless, while this thesis is intent on developing insights rather than generalisations, some of the findings and recommendations will have relevance to a broader group of people with a mental illness, substance use disorder and low level offending leaving custody.

The six inclusion criteria were:

1. young men aged 18–40 years;
2. clinical diagnosis of a psychotic illness made or confirmed by a psychiatrist while in custody;
3. diagnosis of a substance use disorder made or confirmed by a psychiatrist while in custody;
4. current incarceration is expected to be less than 2 years' duration;
5. assessed by their psychiatrist as suitable for the study, have the capacity and are well enough to participate; and
6. currently incarcerated in South East Queensland.

Men aged between 18 and 40 were included in the typical group sampling for three main reasons. First, men outnumber women by 12:1 in the Queensland prisoner population, which

is similar to other jurisdictions (Butler et al., 2005; Butler et al., 2006; Fazel & Danesh, 2002; Steadman et al., 2009). Second, women prisoners have been widely described in the literature as having a range of specific needs during their incarceration and transition and therefore need to be studied separately (Baldry, 2010; Mc Hugh, 2013; Sheehan et al., 2010; Trotter et al., 2012). Third, younger men are overrepresented in the Australian prisoner population with 70% less than 40 years old (ABS, 2013). Older men are reported as having significantly different outcomes than younger men, such as less chance of recidivism on release and high prevalence of chronic physical illness leading to a range of support needs that are not the focus of this study (Fazel, Hope, O'Donnell, & Jacoby, 2004; Rikard & Rosenberg, 2007).

Clinical diagnosis of a psychotic illness while in custody was included in the typical group. This is a debilitating range of illnesses with unique characteristics likely to impact on the transition experience, such as the need for medication and follow-up, as well as the occurrence of perceptual changes, impairment of judgement, and possible difficulties in communicating (Warner, 2004; White et al., 2006).

Clinical diagnosis of a co-occurring substance use disorder was an inclusion criteria in the typical group sample because it has been widely reported that approximately 70% of prisoners with a serious mental illness have a co-occurring diagnosis of substance use disorder (Butler et al., 2011; Lurigio et al., 2003), and this was also the finding in a study in Queensland (Denton et al., 2009). Additionally, evidence links substance use with increased offending and recidivism and a typical cyclical pattern of offending, incarceration, release, relapse, and reincarceration (Cloyes et al., 2010) that is of interest in this study.

Less than 2 years incarcerated is included in the typical group because the literature describes a population which is repeatedly incarcerated for relatively minor offences that are related to mental illness or substance use disorder (Baillargeon et al., 2009; Cloyes et al., 2010; Howerton et al., 2009). This group is of interest because less than 2 years incarcerated would suggest a relatively minor offence, and the combination of mental illness, substance use disorder and short-term incarceration is known to be a strong indicator of repeated cycling in and out of prison (Borzycki, 2005; Howerton et al., 2009).

Assessment by a psychiatrist as being well enough or have the capacity to participate in the research was included in order to protect the safety of participants who were considered by their psychiatrist as particularly vulnerable due to their mental or physical health. Incarcerated in the South East Queensland area was included for practical reasons related to

the large geographical spread of the eight prisons in Queensland housing male prisoners, four of which were in close proximity to Brisbane and therefore accessible for the research.

Given the anticipated multiple challenges of interviewing men with a mental illness and other complex problems in prison, the exclusion criteria were designed to contain the sample to a group that was more likely to be able to engage in a series of interviews and also to maintain the focus of the study as outlined. The decision to exclude Indigenous prisoners from this study is potentially controversial, given their extreme overrepresentation in prison combined with their poor mental health and criminal justice outcomes (Heffernan et al., 2012). The decision to exclude this group was made after careful consideration for the following reasons: First, research involving a psychiatric diagnosis of Indigenous people and particularly Indigenous prisoners has been clearly documented as complex and potentially problematic due to the frequent lack of clarity between psychiatric phenomena and cultural phenomena . For example, Heffernan et al., 2012 in their large study of Indigenous prisoners in Queensland used a complex, culturally appropriate methodology to determine the presence of a psychotic illness, involving an expert panel of Indigenous advisors to plan the study and interpret the results, the use of trained Indigenous interviewers and multiple stages of diagnosis including two psychiatrists and the employment of an expert Indigenous cultural advisor. They advocate strongly that this approach is very important in any research involving Indigenous people due to the potential for a mis-diagnosis from the presence of cultural phenomena. Clearly this ‘best practice’ methodology was beyond the scope of the current research. Second, it is well documented that Indigenous prisoners experience a range of complex problems beyond those of the broader prisoner population related to discrimination, trauma, grief and loss (Heffernan, Andersen & Kinner, 2009; Heffernan et al., 2012) linked to historical events such as colonisation and the stolen generation (Morseu-Diop, 2010). Review of this material would have been important to do justice to the complex problems potentially experienced by Indigenous prisoners in prison-to-community transition and this was unrealistic given the nature of this small qualitative study.

The exclusion criteria included:

1. assessed by their psychiatrist as lacking the capacity to give informed consent or were too unwell to participate;
2. identified by their psychiatrist as having intellectual or cognitive impairment;
3. did not speak English;

4. identified as an Indigenous Australian

5.5 Recruitment

Participants were recruited through the Queensland Prison Mental Health Service. There was a four-stage approach to the recruitment process. At stage 1, participants were identified and approached 1–2 months prior to expected release by the clinician who was allocated to their mental health care, including discharge planning. The study was explained to the client by the clinician and written information given before they were invited to participate. The information included assurances that confidentiality would be strictly maintained and that there would be no adverse impact on the provision of services or treatment resulting from refusal to participate in the study. This “gatekeeper” approach was designed to allow potential participants to discuss their involvement in the study prior to any contact with the researcher, and the researcher only approached the participant when they fully agreed to the next discussion. It was particularly important in this study to separate the roles of clinician and researcher, given the potential conflict of roles of the researcher, who was also the senior manager of the Queensland Forensic Mental Health Service, which had oversight of the service from where the recruitment was occurring. This issue is discussed in more detail below. Given that it has been estimated that up to 40% of prisoners may be functionally illiterate (Henry, 2005), consideration was given to this possibility at all stages of recruitment, and steps were taken to help the participant understand the material when this was required.

At stage 2, the researcher and participant met prior to release. The researcher more fully explained the study, ascertained that the participant fully understood what was being asked of him and obtained signed consent. Informed consent is discussed more fully in the section on ethical considerations. The third stage was to meet with the participant in the community within 2 weeks post-release and confirm that the consent was still present at this stage. It was important to re-establish consent outside of the prison setting to confirm that there was no sense of coercion related to the agreement to participate inside prison, and that there would be no consequences in terms of impact on the provision of community services if the participant wished to withdraw from the research. At the fourth stage, consent was re-confirmed prior to the third interview, which was conducted at 2–4 months post-release.

5.6 Participant characteristics

Eighteen participants were recruited with a mean age of 31. Seventeen of the participants had a diagnosis of schizophrenia and of these, 10 participants reported that their diagnosis had been confirmed as paranoid schizophrenia. This information was provided by the psychiatrist on referral, in order to ascertain conformity to the inclusion criteria; however, the self-report by the participants of the diagnosis was largely consistent with the psychiatrist. The youngest participant (age 21) was given a diagnosis of “psychotic illness, yet to be defined”.

All of the participants had a secondary diagnosis of substance use disorder that conformed to the inclusion criteria. While all participants reported use of more than one drug, all participants identified a primary drug of dependence during interview. Eight of the participants identified the use of intravenous amphetamines as their primary drug, four participants identified heroin, four identified alcohol dependence as their primary problem, and two identified marijuana consisting of heavy or daily use.

Three participants were returning to live with one or both parents. Two were returning to live with their partner, and of the remaining participants, five had regular contact with immediate family and eight participants were estranged from immediate family. ‘Estranged’ was defined as not having had contact for 12 months or more. While two of the participants had completed some tertiary studies while in prison, none of the participants had completed more than Year 10 at school, including the two participants who went on to study in prison.

The mean number of incarcerations this cohort had experienced in an adult prison (from age 17 in Queensland) was seven times, ranging from one to eighteen incarcerations. The most recent period of incarceration was on average 6.7 months, in keeping with the inclusion criteria of less than 2 years. Data on juvenile detention were not collected. Twelve participants reported that the longest period of time they had spent in prison at any one time was less than 2 years. While one participant had spent up to 7 years serving a previous sentence, this was the exception, and the self-report data largely describe a cohort that can be broadly defined for the purposes of this study as low-level offenders, based on an assumption about the relatively short sentences and periods on remand.

Collection of self-report data on criminal histories was very time consuming in the interviews, because there were many variables and technical complexities to these data and the participants required significant prompting and clarification in giving their accounts. Given the challenges of the interview environment and maintaining participant engagement,

the demographic data collection was kept to the minimum information directly relevant to the study.

Six of the participants reported that they were subject to an Involuntary Treatment Order (Community) under the *Queensland Mental Health Act, 2000* prior to entering prison for the most recent incarceration. While the involuntary treatment order is temporarily suspended during incarceration due to regulations in the *Queensland Mental Health Act, 2000*, which does not allow involuntary treatment in prison, the order is immediately re-established on release. Table 2 provides an overview of participant characteristics.

Table 2: Participant characteristics (n = 18)

Age	Range: 21–40 years Mean: 31 years
Diagnosis	Paranoid schizophrenia: 10 (18) Schizophrenia: 7 (18) Psychotic illness: 1 (18)
Primary drug of dependence	IV Amphetamines: 8 (18) Heroin: 4 (18) Alcohol: 4 (18) Marijuana: 2 (18)
Family contact	Living with parent/s: 3(18) Living with spouse: 2 (18) Regular contact with immediate family: 5 (18) Estranged from immediate family: 8 (18)
Education completed	Year 7: 1 (18) Year 8: 2 (18) Year 9: 6 (18) Year 10: 9 (18) Commenced tertiary studies in prison: 2 (18)
Length of this incarceration	Range: 2 weeks–2 years Mean: 6.7 months
Number of incarcerations as an adult (17 years +)	Range: 1–18 times Mean: 7 times
Longest period of time spent in prison	Range: 2 weeks–7 years Mean: 2.2 years
Involuntary Treatment Order (<i>Queensland Mental Health Act, 2000</i>)	Forensic Order: 2/18 ITO (Community) 4/18 Total Involuntary Treatment Order: 6/18

5.7 Data collection

Semi-structured, repeat in-depth interviews were conducted at three time points with 18 participants between July 2011 and March 2012. Eighteen men were interviewed in prison prior to release in one of four prisons located across South East Queensland. Thirteen of these participants were interviewed at the second data point and seven at the third data point. This

yielded a total of 38 interviews. The interviews lasted between 20 minutes through to 2 hours, with the majority approximately 40 minutes in duration. The interviews were digitally recorded with the consent of the participants. Questions were designed using pre-prepared interview guides. Specific domains explored at each of the data points are detailed below. Due to the fact that all participants had a serious mental illness and the sensitive nature of the research topic, a responsive style of interviewing was utilised. For example, some participants needed extensive support and encouragement during the interview process. The researcher has had experience in working with people who have a mental illness and recognised that considerable flexibility in interviewing style was needed to build rapport and trust with the participants. Participants were advised they could cease the interview at any time or have a break at any point.

The first interviews were conducted 1 month prior to expected release. These interviews explored demographic detail, the experience of being in prison, the experience of receiving mental health and drug and alcohol services in prison, family and other supports, plans and expectations of the post-release period, including perceived expectations of service providers, and the participant's hopes and fears for the future. Previous experiences of leaving prison were also explored, including perceived supportive factors and barriers for prison-to-community transition.

The second interviews were conducted in the community, at 1–2 weeks post-release. These interviews explored the experience of leaving custody and what had occurred in the time since being released. This included discussion about physical and mental health and substance use; family relationships, social networks; accommodation; the impact of criminal justice system; support received or perceived as necessary; and employment conditions. Of the 13 participants who were interviewed at this point, four participants were interviewed while living in temporary accommodation, three participants were interviewed in a residential drug rehabilitation centre, three participants were interviewed while living at home with one or both parents, one participant was interviewed while living with his partner and children, one participant was interviewed while living in a rented group house with friends, and one participant was interviewed while an inpatient in a local mental health unit. Of the remaining five participants who were not interviewed at this second data point, two were not released from prison as expected, which is detailed below; two participants were lost to follow-up by all involved agencies; and one participant informed the researcher when contacted by

telephone that he was “on the run from police” and was therefore not interviewed at that time. This incident is discussed below.

The third interviews, conducted 2–4 months post-release, explored similar themes to the second interviews, with the additional factor of more time having elapsed since release. Current living and employment situation, relationships and support networks, contact with services and agencies, and reflections on looking forward, maintaining progress and perceived supports and barriers of transition were discussed. Of the seven participants who were interviewed at this point, the three participants who were living with one or both parents were able to be located and interviewed at home. Three of the other participants had been rearrested and were interviewed back in prison, and one participant had remained in the residential drug rehabilitation centre and was interviewed there. Of the remaining 11 participants who were not interviewed at this point, 5 participants were unable to be contacted (see Table 3). Three participants refused a further interview when contacted. One participant was visited by the researcher twice; however, he was intoxicated on both occasions and was unable to be interviewed. One participant was due to be interviewed, but unfortunately had a serious accident in another state and was unavailable for the interview during the time period allocated. Two of the participants who were expecting to be released within a month of being interviewed were subsequently retained in custody, in one case because the participant was unexpectedly refused bail, and the second participant because he was re-sentenced to further charges that at the time of interview he was not expecting would lead to a further sentence. While retaining these two participants in the study further reduced the percentage of potential follow-up interviews, the decision was to retain them because they provide another example of potential outcome for this group who were preparing to leave prison. The intention was to undertake the follow-up interviews in prison for these participants; however, the participant who was re-sentenced was subsequently moved to an out-of-scope facility and the other participant refused a further interview.

The data presented in Table 3 illustrate the transient lifestyle that the majority of the research participants were experiencing over the time of the project. The seven participants who were able to be located and interviewed at all three data collection points were living either at home with one or both parents, in a residential drug rehabilitation centre, or had returned to prison.

Table 3: Description of data collection at three data points

RP	1st interview (n = 18)	2nd interview (n = 13)	3rd interview (n = 7)
01	Prison A	<u>Interview</u> : Home with parents	<u>Interview</u> : Home with parents
02	Prison B	<u>Interview</u> : Boarding house	Refused 3rd interview
03	Prison C	<u>Interview</u> : Mental health inpatient ward	Left Queensland. Lost to follow-up by all agencies
04	Prison A	<u>Interview</u> : Rented group house	Intoxicated on two visits: Unable to interview
05	Prison B	<u>Interview</u> : Residential drug rehabilitation centre	Phone number: Left messages. Lost to follow-up by all agencies
06	Prison B	Re-sentenced. Not released	No further contact: Transferred to out-of-scope prison
07	Prison A	<u>Interview</u> : Residential drug rehabilitation centre	Rearrested: <u>Interview</u> in prison
08	Prison D	<u>Interview</u> : Home with parent	<u>Interview</u> : Home with parent
09	Prison D	<u>Interview</u> : Residential drug rehabilitation centre	<u>Interview</u> : Residential drug rehabilitation centre
10	Prison D	Refused parole: Remained in custody	Remained in custody: Refused further interview
11	Prison C	<u>Interview</u> : Temporary accommodation with ex-wife	Rearrested: <u>Interview</u> in prison
12	Prison A	<u>Interview</u> : Boarding house	Lost to follow-up by all agencies
13	Prison C	Lost to follow-up by all agencies	Lost to follow-up by all agencies
14	Prison A	<u>Interview</u> : homeless men's hostel	Refused 3rd interview
15	Prison C	Brief phone contact: "On the run from police"	Rearrested: <u>Interview</u> in prison
16	Prison D	<u>Interview</u> : Home with partner and children	Brief phone contact: Involved in accident.
17	Prison A	Lost to follow-up by all agencies	Lost to follow-up by all agencies
18	Prison A	<u>Interview</u> : Home with parent	<u>Interview</u> : Home with parent

The attrition rate from the interviews and the reasons for the attrition, typically reported in this type of study indicate the extent to which this group is impacted on by numerous social

exclusion factors such as mental illness, substance use, criminal history and economic deprivation. It can be argued that the extent of their social exclusion also excluded them from being able to fully participate in and contribute to the research. The study sought to give voice to participants, however it is possible that the participants who were lost to follow-up, may have had the most to contribute to the research, about the impact of social exclusion on the post-release component of their prison-to community transition experience

5.8 Data analysis

The purpose of the analysis was to draw out themes in the interview transcripts through an inductive process guided by the conceptual and theoretical ideas framing the thesis. The aim was not to find a truth but rather to understand and interpret the empirical material in order to assist in the development of an in-depth knowledge of the complexities of the transition experience for each individual and develop an analysis of the transition experience as a whole. While the literature on qualitative data analysis was consulted extensively (Bazeley, 2009; Miles & Huberman, 1994; Seale et al., 2007; Silverman, 2005; Yin, 2010), analytical methods were specifically drawn from Attride-Stirling (2001), Ritchie and Lewis (2003), and Yin (2009), to complete the analysis. These approaches were chosen because much of the literature on data analysis is based on similar guiding principles, yet few provide specific detail as to how to conduct the analysis. The methods used were complementary as a whole, and best suited to the analysis of the complex set of data. The Framework approach, described by Ritchie and Lewis (2003), guided the first stage of sorting and managing the data; Lin (2009) provided guidance on managing the “set” of interviews for each participant in order to conduct a cross case analysis; and Attride-Sterling (2001) provided a method to move to a more abstract level of analysis, using a thematic network approach.

The interviews were transcribed verbatim as soon as possible after the interview, usually within 1 week. Completed transcripts were checked by replaying the recordings to ensure accuracy and as a means of enhancing familiarity of the content. While the initial analysis was completed over 6 months of intense engagement with the data, the analytical process continued through to the final draft of the thesis as an understanding of the material was extended and deepened through writing and reflection (Ziebland & McPherson, 2006). Throughout the data analysis, the process was documented and an audit trail maintained. It was important for trustworthiness and rigour of the research that each of the concepts related

to participants raised in this thesis could be traced back to their original source (Miles & Huberman, 1994).

The first stage in the data analysis was to group the interviews for each individual as a “set” of interviews for analysis of the individual’s experience of transition (Yin, 2009). Drawing on the interview data, a brief case summary was written for each of the participants. Participants had on average left prison seven times previously and were highly familiar with the transition process. At the pre-release interviews, all participants discussed their expectations of their impending release, their past experience of transition, and their previous experience of life in the community. At the second ($n = 13$) and third ($n = 7$) data points, participants talked about their experiences of leaving prison and their life in the community, in some instances referring back to previous experiences of leaving prison. These data were combined to build a sense of the transition experience as a whole for each individual, drawn from both past and present reflections. To some extent, this approach compensated for the missing data, as a result of losing participants at follow-up.

The Framework approach, developed by the National Centre for Social Research in the United Kingdom and described by Ritchie and Lewis (2003) was utilised to manage and sort the data in preparation for the analysis. Drawing on the theoretical and conceptual ideas guiding the thesis and emerging issues in the individual case summaries, a “framework” or index was developed consisting of six broad topics, each with six subtopics. The material was then labelled or “coded” using NVivo software according to this framework. The framework was modified and adjusted as the text was explored.

Following this step, the data were transferred to six charts developed as a spreadsheet: Chart 1 contained self-reported demographic data for each of the participants; Chart 2 contained data about personal history; Chart 3 contained data related to being in prison; Chart 4 contained data about leaving prison and experiences immediately post-release; Chart 5 contained data about experiences with services, systems and structures; and Chart 6 contained data about community reintegration and relapse. This meant that without including the demographic data, there were 30 subtopics of data, each numbered accordingly.

The data were used to produce one large matrix where the relevant extracts from each participant were visually represented across the chart in rows organised into subtopics that were represented in columns. Using this technique it was possible to locate the experiences of individual participants in the context of the entire data set. The large paper chart printed from

the combined spreadsheets could be rolled out across a surface. The text on the chart was circled, colour coded and linked across participants and columns with notes and comments to capture thoughts and insights as the analysis progressed. The analysis involved comparing and contrasting the transition experience for each individual and interpreting the meaning of the data in the context of individual participants, the entire data set, the literature and the conceptual and theoretical ideas framing the research (Ritchie & Lewis, 2003; Yin, 2009).

The next step in the analysis was to engage in a process of developing thematic networks, as outlined by Attride-Sterling (2001). These are “web-like” illustrations used to capture and summarise the structures and underlying patterns in the data (Attride-Sterling 2001, p. 386). The Framework approach (Ritchie & Lewis, 2003) and the thematic network approach were complementary in this analysis because the initial framework index had identified 30 subtopics that formed the “basic themes” in the thematic network approach. These were then grouped together to form “organising themes” (Attride-Sterling, 2001). Organising themes are “middle order” themes that are more abstract, thereby beginning the process that was identified by Miles and Huberman (1994) as moving step by step up the ladder of abstraction. The organising themes were then grouped into “global themes” that summarised and made sense of lower order themes that had been extracted from and supported by the data. These global themes became the “principal metaphors” representing the text as a whole (Attride-Sterling, 2001). The thematic network that was produced using this method is presented as Figure 3 (p. 105). The thematic network was revised and refined on numerous occasions throughout the final drafting of the thesis; however, the main ideas in the network remained intact. It represents the extensive analysis and interpretation of the data and illustrates a model of the experience of prison-to-community transition from the perspective of the participants in this research (Bazeley, 2009).

5.9 Ethical considerations

Ethical approval was received from Queensland Corrective Services, Queensland Health and The University of Queensland prior to conducting this research (Approval no. 2010001288). While all three institutions were supportive of the study, the ethical approval process took more than 6 months to complete. The difficulty of gaining access to interview and tape record participants while incarcerated in Queensland has been documented elsewhere (Ellem, Wilson, Chui, & Knox, 2008). This study required significant negotiation and use of professional networks to achieve approval.

The ethical principles of social research were rigorously followed throughout this study (Crotty, 1998; Denzin & Giardina, 2009; Seale, 1999). It is well documented that some researchers have exploited prisoners in the past. This resulted in some extreme human rights abuse such as introducing diseases to otherwise healthy individuals, for example, for the purposes of experimentation by the pharmaceutical industry (Hornblum, 1997). In addition, researchers in the past have been guilty of failing to ensure the participation by prisoners in research was truly voluntary and that confidentiality was maintained (Appelbaum, 2008; Hornblum, 1997; Kalmbach & Lyons, 2003). The responsibility of the researcher is to protect subjects from any harm that may result from participation in the research (Loxley, Hawks, & Bevan, 1992). Three of the specific issues that emerge in the literature on research with prisoners and ex-prisoners that relate to this study include the relative vulnerability of prisoners and ex-prisoners, the informed consent process, and confidentiality.

In terms of vulnerability, some authors speculate that while there have been previous abuses of prisoners in research, perhaps the pendulum has swung too far, and there is a debate as to whether prisoner subjects are now overprotected and ethical guidelines too restrictive (Wakai et al., 2009). The use of a risk-benefit framework for conducting research with prisoners, which suggests that it is ethically permissible to conduct research when the benefits to prisoners outweigh the risks, has been proposed (Mobley, Henry, & Plemmons, 2008; Roberts & Roberts, 1999). This project was relatively low risk to participants and it was “intent on achieving some good” and to be “valuable, significant, timely and justified” (Roberts 1999, p. 1107).

A number of authors discuss the environment of prison where every aspect of the prisoner’s life is controlled and regulated, with little or no opportunity to act with independence or autonomy (Mobley et al., 2008; Wakai et al., 2009). This may result in a marked vulnerability to be exploited by researchers and others as prisoners strive to have their needs met (Mobley et al., 2008). Further vulnerability can stem from educational and economic disadvantage, including an estimation of up to 40% of prisoners with literacy problems (Mobley et al., 2008, p. 37). The research was conducted rigorously and carefully with the use of mentors and advisors to assist in avoiding exploitative use of participants (Mobley et al., 2008, p. 1108). The use of the “gatekeeper” approach, described earlier in the recruitment process, was strictly adhered to in an attempt to mitigate the risk of participants feeling coerced into the research. Consent was revisited prior to each interview to clarify that the participant understood their rights in relation to the research, particularly to withdraw without

consequence at any time. The issue of literacy was approached sensitively in order to avoid embarrassing the participant if he could not read, while at the same time offering to read the material if it was easier for them to do it that way.

According to (Roberts, 2002), informed consent consists of the elements of information, decisional capacity and volunteerism. There are a number of suggestions in the literature to address these concerns that were utilised in this study (Roberts & Roberts, 1999). The participants were provided with an invitation to participate in the study. The information provided was comprehensive but easily understood and included:

- an explanation of the protocol;
- potential discomforts and risks;
- a plan in case of unexpected consequences;
- the potential benefits to the participant;
- assurances of confidentiality and explanation of the circumstances that would warrant breach of confidentiality.

Further strategies included (Roberts & Indermaur, 2003):

- repeating the consent process at each interview point;
- reading the information to the participants with reading difficulties;
- clearly informing participants that they did not have to do the interview if they did not want to;
- pointing out that the person did not have to answer any questions they did not want to;
- pointing out that the person could stop the interview and leave at any time.

Appelbaum (2008, p. 274), in a discussion on the opportunities and barriers in correctional mental health research, points out that confidentiality is very difficult to maintain in correctional environments where it may become common knowledge as to who is being interviewed by the researcher. Extra vigilance was required to ensure that participant information and their involvement in the study was protected as much as possible by avoiding open discussion in front of other prisoners and staff. Security of documents in all phases of the research was important and was maintained throughout this study.

Clearly, when interviewing prisoners and ex-prisoners, there is potential for the person to disclose criminal activity that is not known about by the authorities. Ellem et al. (2008, p. 504) discuss the pressure the researcher may experience to disclose this information, the damage this may do to the trust between researcher and participant, and strategies to avoid this material wherever possible. The researcher drew on the experience, support and advice of the mental health clinicians who were working with these individuals on a daily basis and used the departmental protocols to guide practice.

In this study, there were two instances of disclosed information from a participant that required further discussion with mental health workers; however, in both cases consent was obtained to resolve the situation to the satisfaction of the participant and the clinicians. In the first example, one participant (RP06) disclosed in the pre-release interview that he had stopped taking his large dose of anti-psychotic medication several days prior to the interview and that he had not informed medical or nursing staff of this fact. This information placed the researcher in a difficult position, because of an awareness of the potential consequences for the participant and staff of the possible physical or psychiatric side effects from this action. After some discussion with the participant about the potential implications of his decision to stop taking his medication, the researcher was able to negotiate an agreement to visit the nurse after the interview so that the participant could disclose the information, which subsequently occurred.

A second instance occurred in a post-release interview with a participant (RP07) conducted in a community-based residential drug rehabilitation centre in Brisbane. The participant disclosed that he had been experiencing suicidal thoughts in the previous few days and had not disclosed this to anyone other than the researcher. This again placed the researcher in a difficult position and lengthy negotiations were required in the interview to gain agreement from the participant that he would disclose this information to his counsellor after the interview.

Another disclosure was more complex and the pathway less clear. Participant RP15 had provided his mobile phone number while in prison to contact him for the post-release interview. When he was contacted 1 week after his release, the participant said he was happy to meet for the interview but that he was “on the run from the police”. This immediately placed the researcher in an ethically untenable position, and the only clear alternative was to terminate the conversation before any information was disclosed as to the participant’s

location. This participant was subsequently interviewed on his return to prison approximately 6 weeks later. The above examples illustrate some of the difficulties inherent in undertaking research with this population. On several occasions, rapid decisions were needed in order to avoid psychological or physical harm to the participant or researcher and/or negative impact on the research process.

5.10 The role of the researcher

There is recognition that within the qualitative tradition the subjectivity of the researcher will have an influence on the outcomes of the study and that the goal of this type of research is not about establishing “truth” as such. Therefore, it was important in this study that there was strength in the design and analysis to maximise the potential for the study to be “useful and believable” (Maxwell, 2005, p. 106) and that it showed “balance, fairness and completeness” (Patton, 2002, p. 51). Researcher bias refers to understanding “how a particular researcher’s values and expectations” influence the findings of the study (Maxwell, 2005, p. 108) and it was an important concept that was addressed in this study. A process of critical reflection through the use of field notes immediately following each interview, and frequent discussions with advisors throughout the process, helped mitigate the risk of researcher bias. The aim was to capture as honestly as possible the range of perspectives in the data (Silverman, 2005).

Reactivity has also been identified as a threat to the research quality. This refers to the effect of the researcher on participants during the interviews (Maxwell, 2005, p. 108). As the manager overseeing the program from where the participants were recruited, it was important to remain aware of power issues that may have influenced the participant responses. Strategies to minimise this impact included ensuring that there was no contact with the individuals prior to the research and clarifying that the research role was unrelated to the service manager role. It was carefully emphasised that participation or non-participation in the study or the nature of the information participants provided would have no impact on access to ongoing services.

In order to separate the roles of service manager from researcher, a part-time policy role in a separate area of the health department was negotiated for 9 months while conducting the interviews. These dealt to some extent with the potential conflict of interest inherent in this situation, as well as allow more time for the fieldwork. However, it was important to remain mindful of the inherent authority of the previous manager role, and it was reiterated at every contact with each participant that the project was being conducted as a research student from

the university. The staged approach to recruitment described above was rigorously adhered to in order to avoid any sense of pressure on the clinicians or participants to take part in the research.

A systematic approach to the collection and analysis of the data included clear and consistent records of all steps in the process in order to enhance dependability. An audit trail was maintained in order to ensure transparency of the research. This involved keeping all raw data, documenting all methodological decisions, and keeping a record of coding and data analysis procedures (Lincoln & Guba, 1985).

5.11 Methodological challenges

Conducting this study presented many challenges for the researcher, some of which have been documented in the literature when discussing research in criminal justice facilities and with people who have committed offences (Carter, 1996; Lane, Goldstein, Heilbrun, Cruise, & Pennacchia, 2012). The main challenges in this study were access to prisons, delays waiting to see participants, interviewing in the prison environment, following up participants in unpredictable community environments, the capacity for participants to respond and communicate, and the emotional challenges for the research student conducting this type of research.

Interviewing in a prison environment was often very difficult during this study. Accessing the prisoner was the first barrier. Once initial contact by the clinicians had been made and the potential participant had agreed to further discussion about the project, initial interviews were pre-arranged by email with a nominated contact person who had been identified by the corrective services department at the commencement of the project. However, with approximately 50% of the interviews that were conducted in prison, this information failed to be communicated to the front gate of the prison, or the officer on the gate was reluctant to allow access, resulting in extensive and unpredictable waiting periods to enter the prison environment. This meant large amounts of time needed to be allocated to each interview session to allow for delays. For example, despite having an identification badge and the appropriate paperwork and having arranged the interview by email, one particular officer on three occasions said, "I don't know anything about this, you will have to wait". On one of these occasions it took over 2 hours to gain entry into the prison.

Once inside the prison, other difficulties occurred. On two occasions, the unit where the prisoner was residing had been locked down because of staff training events, which resulted in the prisoner being inaccessible and the interview had to be rearranged to another day. Finding an interview room was also a challenge. The majority of the interviews were conducted in the health centre of the prison. In all four of the prisons these centres were small, cramped, noisy and frequently overcrowded spaces with doctors, nurses, dentists, radiologists and other health practitioners sharing the rooms. It was not possible to book a room in advance, and on most occasions the researcher and the participant needed to wait until an interview room was available after arrival. The participant had to wait in the secure waiting area of the health centre and the researcher waited inside the health centre. On several occasions, the participants were required to wait for up to an hour in the waiting room of the health centre after leaving their unit, and the majority of times the wait was 20 to 30 minutes before the interview commenced.

While no data were collected on the prevalence of nicotine dependence in this cohort, daily cigarette smoking has been reported as 83% in the Australian prisoner population, in comparison to the general community of 15% (Australian Institute of Health and Welfare, 2013). The researcher was frequently aware of growing agitation during the interviews when there had been a prolonged waiting period in areas where smoking was not allowed. On three occasions the participants had cigarettes tucked behind their ears during the interview, and this correlated with marked agitation after about 20 minutes into the interview. While comparatively a relatively minor issue, it appeared that nicotine withdrawal was one of the barriers of interviewing in the prison environment related to extensive delays. Another cause for agitation occurred when a participant was at risk of missing a meal because they stayed too long at the interview. On one occasion when there had been a considerable delay in waiting for a suitable room to commence the interview with Participant 10, the correctional officer was approached to ask if lunch could be put aside for the participant until the interview was finished. The correctional officer replied briefly, "If he is not there, he misses out".

When rooms did become available, they were frequently very noisy, exacerbated by clinicians coming in and out of the room to collect equipment and files, which made it difficult for both the participant and the researcher to focus on the interview. Following is an extract from field notes illustrating some of the above points. This interview was conducted in January, 2012 with RP17.

The interview was conducted in a seclusion room in the medical centre of the remand prison, due to a shortage of interview rooms. The only furniture in the room was a plastic mattress on the floor where the participant sat and I took a plastic chair to sit on next to him. There was a young Indigenous man in the next seclusion room who was clearly angry about something and continually banging on his door and yelling out. Occasionally the correctional officer yelled back with comments, for example, “jerks don’t get nothing here”. There were phones ringing and doctors, nurses and a dentist seeing patients. The correctional officer was coordinating patients by yelling into the prisoners waiting room from his desk to call up the next patient for example, “SMITH, NEXT!!”. It was an extremely noisy environment. The participant I was interviewing had a long-standing diagnosis of paranoid schizophrenia and several times during the interview began to look quite agitated (i.e., eyes darting, sweating, fidgeting). I checked in with him several times and he said he was hearing voices and they were bothering him a bit. I reassured him that we could stop the interview at any time; however, he said he was OK to continue and I spoke with him for over 30 minutes. I didn’t want to push him beyond his tolerance, however, so I cut the interview short once I had covered the basic questions.

A further issue faced by the research has been labelled “Baron’s paradox: that those who most need to have their stories heard may be least able to tell them” (Booth & Booth, 1996, p. 59). While a few of the research participants in this study were relatively articulate, the majority struggled to find words to tell their story, and required significant amounts of prompting and probing and a direct and flexible style of interviewing. For example, open questions were not always a successful way of eliciting a response in this study and many additional questions were often required. It has been suggested that inarticulateness is not just about restricted language skills, but is impacted on by other factors such as “lack of self-esteem, learned habits of compliance, social isolation or loneliness and the experience of oppression” (Booth & Booth, 1996, p. 56). Some of these factors may have impacted on the capacity of the participants in this research to tell their stories.

There is a large body of literature on conducting qualitative research in risky, hostile or unpredictable environments (Fielding, 2007; Pitts & Smith, 2007). The consensus in these commentaries is that fieldwork in these environments can be emotionally challenging and have an impact on the investigator. Interviewing in prison was far more challenging than expected at the commencement of the research. Previous visits to prisons had been over a period of 10 years to negotiate contracts or to attend meetings to discuss aspects of mental health service provision as the Manager of the Queensland Forensic Mental Health Service. In retrospect, it was clear that these visits were accorded VIP status, where access was rapid and uncomplicated and involved only contact with senior management.

By the fieldwork stage of this project however, the researcher had moved to a part-time policy position in another area of the health department, and while not denying or hiding her previous status or connections, was careful to present herself in this context as a research student. As can be expected, this experience was quite different from that as a senior health service manager with privileged access. As Dammer (1994) commented, quoted by Carter (1996, p. 23): “Prison is not a comfortable place to live, to work or to carry out criminological research”, and this proved to be the case in this project. In the first few interviews, the distractions of the access barriers, the noise, the scrutiny of the inmates and officers eyes (one feels constantly and carefully watched throughout the prison visit), the uncertainty of meeting men with a known severe mental illness in prison, combined with the anxieties of a relatively novice researcher embarking on a new project, were overwhelming and the researcher found herself exhausted after each interview visit, at times wondering whether she had the fortitude to return. Nevertheless, the experience became easier over time and towards the end of the project, the levels of comfort and familiarity with the environment improved considerably.

When it came to interviewing participants in the community, the challenges were different. While the researcher had met each of the participants at the initial interview conducted in prison, the environment in the community settings were varied and at times quite unpredictable. For example, when visiting Participant RP04 in his shared house for the second post-release interview, he was markedly intoxicated and this also occurred on a subsequent visit. There were several other people at the house and on both occasions it was deemed inappropriate for the interviews to proceed. On another occasion, while interviewing Participant RP08 at his home, he began talking about some stabbings he had threatened and committed in the past when mentally unwell. As this participant had also just disclosed that he had been only taking his medication intermittently, the researcher began to feel quite unsafe, terminated the interview, and left the house.

While a quiet interview room was always the preference in terms of privacy, this was seldom achieved for the community interviews. For safety and for opportunistic reasons related to finally locating the participant, interviews were conducted in various settings. For example, one interview was conducted sitting on the front steps of a house and another while sitting on a low-set brick fence on a busy main road. Other locations included a garden table in front of a homeless men’s hostel, and on another occasion the interview was conducted on a park bench.

There is no clear answer as to how this situation could have been improved. The environments where the majority of participants were living in the community, apart from the residential drug rehabilitation centres where an interview room was sometimes available, were temporary, overcrowded, poorly resourced and unpredictable in various ways. Frequently, participants' post-release experience involved trying to organise their lives through appointments with agencies, catching up with family or friends, or trying to secure employment and so there were many competing priorities that came before participation in a research interview. On a number of occasions, participants were difficult to locate, as not all of them had a mobile phone, requiring several return visits in attempts to secure the interview. All of the participants interviewed post-release were unemployed and struggling with insufficient income, and therefore they were reluctant or unable to travel for the interview. In addition, many of them lived a considerable distance away from the city in outlying suburbs where accommodation is cheaper and easier to obtain. Opportunistic interviewing may be a reality of doing research with this cohort in their environment where transience, poverty and some level of chaos is evident. Nevertheless, this research required a level of assertion, persistence and flexibility in order to attain a maximum rate of response, particularly in the post-release phase.

5.12 Strengths and limitations of the study

The major strength of this research is that it begins to address a knowledge gap in the understanding of the prison-to-community transition experience from the perspective of men with severe mental health and social problems after short-term incarceration. Much of the literature over the last decade has used quantitative methods to focus on recidivism outcomes, which has provided valuable data as to the extent of the problems in community transition; however, many gaps in understanding the complexity of the problems remain (Wright et al., 2014).

Being able to utilise professional networks built up over a decade of working in the field to gain access to potential participants through the Queensland Prison Mental Health Service was a strength of the project. Professional networks facilitated and supported the process of obtaining identification and paperwork to be able to enter prisons, interview prisoners and tape the interviews. Other researchers have been refused this permission in Queensland (Ellem et al., 2008), and there is little doubt that personal and professional contacts assisted in this process.

This study is limited to a small sample of men with a diagnosis of a psychotic illness and co-occurring substance use disorder who were about to be released from less than 2 years in custody. The small sample size of 18 participants and the high dropout rate in the post-release interviews are clearly limitations of the study; however, it compares favourably with other studies that employed a similar design, including attempts to track prisoners after release. For example, in a qualitative study undertaken by a team of four researchers at the Sainsbury Centre for Mental Health (2008) to examine continuity of health care outcomes for released prisoners, the retention rates were extremely low, especially for the male participants who were all lost to follow-up after release. The Sainsbury Centre study design, similar to the current study of interviews pre-release, 2 weeks post-release and 3 months follow-up, was revised on encountering such difficulties, and attempts at the 3-month interview were abandoned. The Sainsbury study highlighted the difficulty of undertaking research in this area, even in a funded project team.

Another limitation of the current study was relying on self-reported demographic data from participants. Other than the diagnostic data provided by the psychiatrists at the recruitment stage in order to clarify conformity to the inclusion criteria, obtaining demographic data from participants in the interview required considerable time, with significant amounts of prompting and clarification. Given the environmental and engagement difficulties encountered in this project, in retrospect it may have been more efficient and effective to collect this data from the clinical files with consent from participants, and to have used the valuable and often limited interview time to focus on the issues being discussed.

The correctional service is a very large and diverse institution and it was largely possible to maintain identification as a researcher rather than a manager when conducting interviews. This had the dual outcome of reducing the chances of conflict of interest and bias in dealing with participants and correctional staff, as well as facilitating the development of insight by the researcher of the realities of being a non-privileged “outsider” inside the prison.

It is not intended that the findings of this study will be able to be generalised beyond the group who were interviewed. However, given the absence of information about this group in the Queensland and Australian context, this study will be of interest and have relevance and usefulness for policy makers, program managers and workers in this field as a first exploratory study of this cohort.

5.13 Conclusion

This chapter has described a qualitative exploratory study utilising a repeat interview design to investigate the prison-to-community transition experience following short-term incarceration of 18 men with co-occurring severe mental illness and substance use disorder. The approach taken to the data analysis was described. A range of ethical dilemmas and challenges that confronted the researcher during this project were discussed. The participant characteristics demonstrate a high level of clinical morbidity and psychosocial disadvantage in this group. The high dropout rate for post-release follow-up and the difficulty of locating participants and conducting the interviews in a variety of unpredictable settings highlighted the itinerant and chaotic lifestyle that many of the participants experienced post-release, other than those who were returning to a family or a drug rehabilitation setting. In the following chapters, the findings of the study are presented and discussed in light of the conceptual framework discussed in the previous chapter.

The prison-to-community transition experience: Introduction to study findings

Overall, the participants in this study were characterised by multiple, complex and enduring social and psychological unmet needs during transition, leaving them vulnerable to loss of hope, relapse to drug use, and return to prison. The post-release experience for the majority of participants was that they re-entered the community into unstable accommodation and unemployment and that they lost contact with mental health services soon after leaving prison. Participants had little access or engagement with alcohol and drug services either in prison or post-release, and the majority remained disconnected from their families and children. Suicidal thoughts or serious suicide attempts immediately prior to release or post-release were reported by one third of the participants. Three of the 18 participants returned to prison within 3 months of release. Three themes were developed from the analysis of interviews with the participants: “hoping against hope”, “adrift in freedom” and “the slippery slope” (Figure 3). The three themes represent the transition experience across pre-release, immediate post-release and 2–3 months post-release. Participants were very familiar with the transition process, having left prison on average seven times. At the pre-release interviews, they discussed their expectations of their impending release, their past experiences of prison-to-community transition, and their previous experience of life in the community. At the second and third data points, participants talked about their experiences of leaving prison and their life in the community, in some instances referring back to previous experiences of release. Extracts are labelled according to whether the data was extracted from the interview at pre-release, immediately post-release (post-release 1) or the 2–3 months post-release data point (post-release 2). Post-release 2 also included the three participants who had returned to prison at this point and were interviewed there. Participants were assigned a number from RP01 to RP18 to maintain their confidentiality. The next three chapters (Chapters 6, 7 and 8) report the findings from this research. In each chapter the analysis is reported by the major theme and subthemes, followed by preliminary reflection and discussion in terms of the conceptual ideas and the literature related to that theme. Chapter 9 presents a comprehensive discussion of the overall findings of the research as they relate to the three themes, the conceptual framework and the literature.

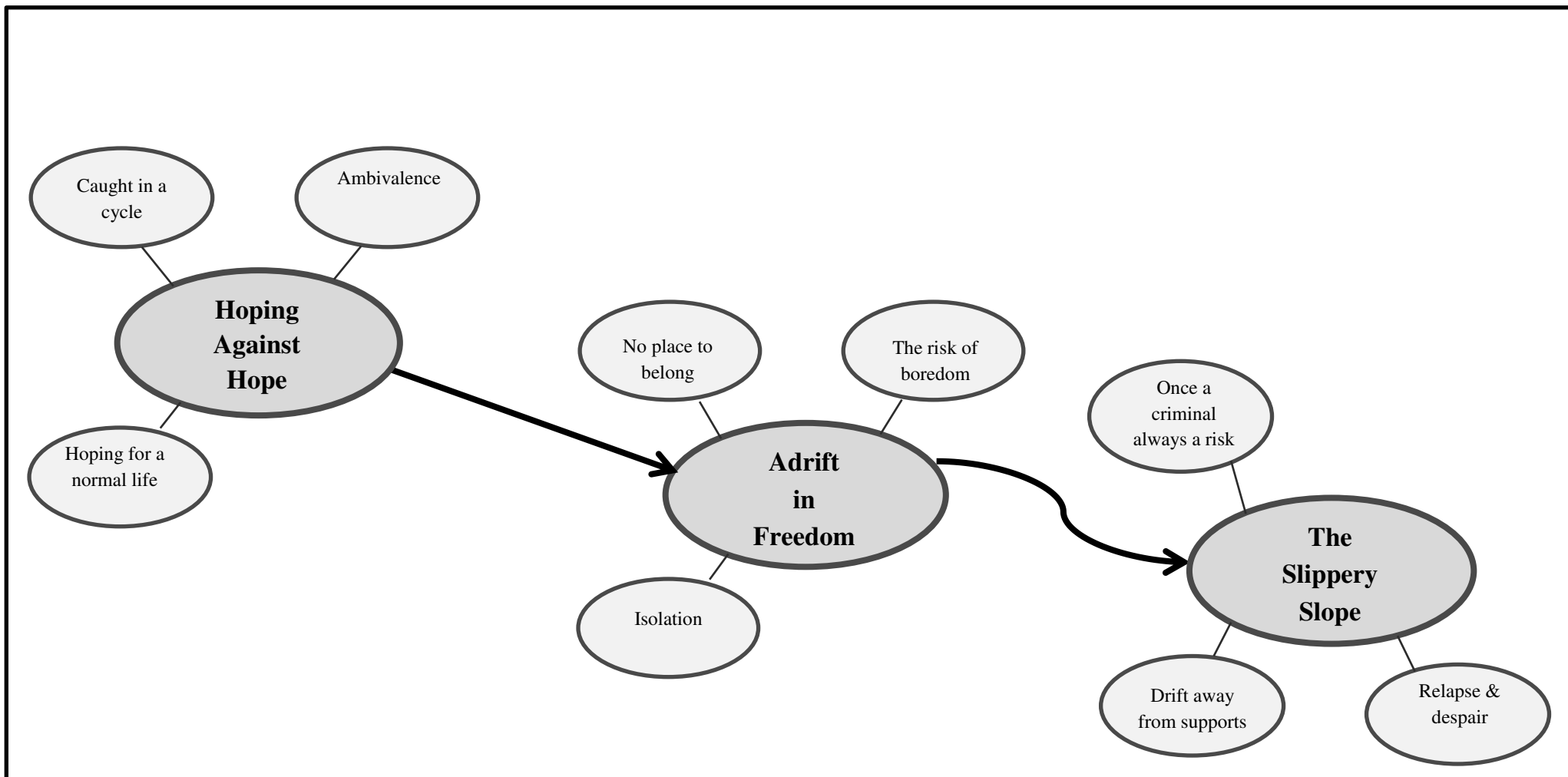


Figure 3: The experience of prison-to-community transition.

Chapter 6: Hoping against hope

6.1 Introduction

In the weeks prior to leaving prison, participants had strong hopes for the future, which they consistently described as a “normal” life. This was despite an awareness of their severe and complex psychosocial problems, histories of multiple incarcerations and little realistic expectation of breaking out of the cycle of involvement of the criminal justice system. The theme, ‘Hoping against hope’ captures the tension that was evident for participants between hope for the future and ambivalence about leaving prison in the context of their recognition that a different life was likely to be out of reach (Figure 4).

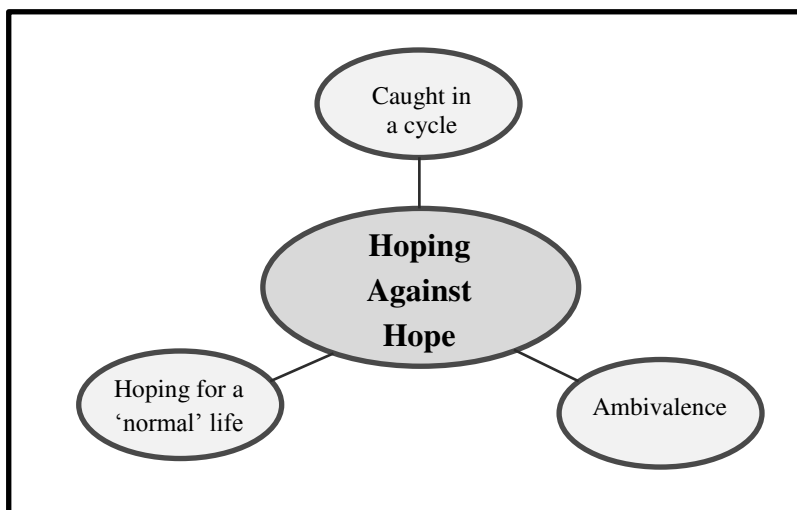


Figure 4: Hoping against hope.

The first subtheme of “hoping for a normal life” captures participants’ hope for a different future, despite insight into how difficult this would be given their history of mental illness and substance use, and their lack of skills for community living. The second subtheme, “caught in a cycle”, reflects their perception of a “merry-go-round” of involvement with the criminal justice system. Participants perceived that the foundations of the cycle had commenced in their childhood or teenage years and they had become so entrenched that it was difficult to find a way out, undermining their hope for a normal life. The third subtheme of “ambivalence” about leaving prison identifies that the majority of participants experienced ambivalence associated with the relative material and social benefits of prison life compared to the anticipated struggle, based on previous experience of life in the community. The coexistence of hope and ambivalence, mediated by the

realisation of being caught in a cycle of involvement in the criminal justice system, along with a sense of impending, inevitable failure associated with a lack of confidence in their skills necessary for living in the community, builds the theme of hoping against hope.

6.2 Hoping for a “normal” life

The majority of participants in this study were hoping for what many of them referred to as a “normal” life. Consistently for these participants, “normal” had four components: secure accommodation, stable employment, a partner, and some level of recovery from their mental illness and substance use disorder. It was striking that the hopes expressed by participants aside from a job, a house and a partner, were for equally ordinary achievements, such as buying a car, finishing school, gaining an apprenticeship, attaining a university degree, or finding a job other than labouring. Most participants wanted some basic possessions and also wanted to do “normal” activities such as playing sport, as the following extract from a 27-year-old man with a diagnosis of paranoid schizophrenia and a history of intravenous (IV) amphetamine use illustrates:

... like a car, a house and getting all the house stuff, TV, bed, fridges that type of stuff. I want to play sport. I played squash when I was young so I want to get back into playing squash and going down the park and kicking the soccer ball around. (RP12, pre-release)

Only one participant (RP14) hoped for lots of money and “*living the high life*”. This 38-year-old man, who was planning to return to the homeless men’s hostel on release, was nostalgic about the lifestyle that he had experienced in the past when he was involved in criminal activity, making large amounts of money “... *and going to restaurants and night clubs and hotels and the rest of it and travelling ... first class.... Now I am on the streets*’ (RP14, pre-release).

The majority of participants had hopes for how they wanted their “normal” lives to be, though they did not have a clear plan or pathway to achieve their goals. They did, however, express an awareness of the complexity of the journey required, an underlying fear of failure, and insight that it probably would not be possible for them to achieve their dreams. The following extract is from a 34-year-old man with co-occurring disorders who had been in prison nine times, each for less than 12 months. It illustrates the tendency that participants had to hope for an ordinary normal life, along with an awareness of the barriers to achieve this. In this case, the limitations of his own experience and the isolation awaiting him in the community:

Well, I don’t really want to do any more time. I’m 34 years of age, I’m getting older, I’m getting slow, life is flying by me, and I really haven’t done nothing other than spend a lot of time in jail since I was a teenager, you know, there’s so much more out there ... you know, I just want to go back to work, maintain a stable job, maintain a stable life, save a little bit of money and end up with my white little picket fence, you know what I mean, so I can die in

my own bed, in my own house, in my own yard, you know, or in a car (laughs) either way, you know, but that would be nice, you know. That's it, you know, like I've got no responsibilities, I don't have a missus, I don't have no kids, none whatsoever, right, I've only been in a couple of relationships throughout my life, cause of me criminal aspects and life, so relationships haven't really worked out very well ... it's a lonely old life out there when you're a criminal, you know. (RP02, pre-release)

The tendency was for participants to want their lives to be different, without necessarily having the support, skills, strategies or confidence to make the changes. This was likely a result of spending so many of their adult years in prison and having limited time and experience of living in the community. Participants expressed a range of barriers to achieving their goals. Difficulties with household skills such as cooking and shopping, inability in the past to maintain housing tenancy, overwhelming debt, limited experience with intimate relationships, loss of contact with family, loss of access by welfare services to see children, long criminal histories affecting employment prospects, and not having been free from drugs and or alcohol outside of prison for many years, were some of the problems participants disclosed.

The older participants were thoroughly tired of prison and were aware that time was running out to create the life they envisaged. The following 39-year-old participant, with 15 previous incarcerations, had spent most of his adult life in prison. He had experienced brief glimpses of how he wanted his life to be outside prison; however, like many of the others, he recognised that it was unlikely that he had the skills or experience to be able to live the life he wanted in the community:

I've lived short periods of straight life where I've had people backing me, you know what I mean, and I was incredibly successful. Mum always sort of said to me if you put 10% into your efforts into doing the straight life as you do when doing things wrong you will be outstandingly successful. And now I sort of see what she means.... Like I've said, I've got to the point now where I'm 40 ... the rest of my life is the next half of my life sort of thing. I'm too old to do this stuff anymore. The things I want in my life ... this is the only way I can do it. Fully stop everything and go back to work, get a job, get my own place. I know in theory how it's all supposed to work, I just never done it, that's all. It's a little daunting but if other people can do so can I. (RP03, pre-release)

In many ways, the above participant was typical of the majority of the cohort. While he lived with severe paranoid schizophrenia characterised by acute and disabling episodes of psychosis and a history of heavy use of intravenous amphetamines and marijuana, he was also quite insightful and articulate in his presentation when interviewed in prison. He was full of hope for a job and somewhere to live, but it was clear that he was hoping against hope; that he was somewhat naively hoping for his life to change, even when his situation appeared to be relatively hopeless.

The younger participants also expressed a keen regret at having missed out on years of their life as a consequence of the time that they had spent in and out of prison, and they wanted something more in their life:

I'm 26. I've done nearly 8 years jail. I've spent pretty much my entire adult life in jail where I could have been out here. My mates that didn't go to jail, I can see they've got the house, they've got the car, the wife, kids, all that. It's realising what I missed out on by doing all that stuff. (RP08, post-release 1)

Several of the participants had clearer ideas than the others about how they wanted their life to proceed. For example, a 26-year-old with seven periods of incarceration, who was returning from prison to live with his father and had a supportive extended family, presented detailed plans for his future and displayed considerable determination when speaking about them:

My plan is I want to finish my Cert III in Hospitality. I'm about halfway through that at the moment ... I've got to try and organise external studies ... then I want to get away [and] start afresh [by] getting a job in the kitchen out in the mines because I've been working in jail kitchens now for probably four and a half years ... and the plan is to work there for a couple of years to put a deposit down on a house. (RP08, pre-release)

Another related aspect of normality that participants spoke about was their desire to be able to maintain some level of recovery from mental illness and problematic substance use that had been achieved in prison with the assistance of regular psychiatric medication and abstinence from substances. All of the participants said they were receiving psychotropic medication in prison and described themselves as being relatively mentally and physically well in comparison to when they had previously lived in the community. Participants expressed a strong desire to maintain this state of relative wellbeing as they transitioned into the community. For example, the following participant was trying hard to maintain and improve his health:

Yeah like, to stay well, to keep on my medication, keep taking it every day and stuff like that, and yeah, just to be focussed, on taking it.... Just to get better and better and get healthier. I'd like to quit smoking but it's hard. (RP01, post-release 1)

The following two participants had been recently identified and offered treatment in prison and were in the early stages of coming to terms with having a mental illness:

I saw the psych there and told the psych there that I was having real bad, bad paranoid thoughts and he said that I was paranoid schizophrenia and he started putting me on medication just to stop the voices or whatever going through my head. I was thinking

everyone wanted to bash me. I was scared and they put me on medication. (RP15, pre-release)

... in the past I never approached anybody for help ... I just started to do really bizarre things, running from things, I would think I was being followed, but now I'm starting to come good — it wasn't really happening but at the time I felt it was happening. I find it hard to see what's fact and fiction. I was driving myself mad. I was staring at the wall ... (RP09, pre-release)

Other participants who had been in treatment for longer were at a different stage of feeling more settled and were engaging with mental health support beyond medication, such as the 27-year-old man who had been diagnosed with paranoid schizophrenia in prison several years previously:

This time I think it's going to be even easier for me because I've got a good support network from the mental health side of things. (RP12, pre-release)

A few of the participants could see that they had made small gains; for example, the 39-year-old participant who was feeling pleased with his progress just prior to leaving prison:

I was really ill. That's how bad things were ... but now I've been stable and I've been medication compliant for quite a while now. This is the longest I've been clear for as long as I can remember. (RP03, pre-release)

Some of the participants accepted a high level of responsibility for their recovery, as the following extract demonstrates:

I just wanna be normal, normal ... but I've got to put in the work. I'd love to be able to [have] ten years of sobriety, no jail and a new life. (RP07, pre-release)

The majority of participants in this study perceived drug dependence as the root of their problems and the main barrier from achieving their goals for a normal life. Many of them expressed a strong desire to refrain from using drugs or drinking as they transitioned into the community this time. However, while they acknowledged that it was drug use causing many of their problems, the desire to use drugs and the desire to stop was often in constant conflict. Participants tended to associate their relapse to substance use with a lack of belief in their capacity to sustain the changes and the emotional highs and lows of cycling in and out of prison. In the following extract, for example, the participant was trying to come to terms with this dynamic a week before he was leaving prison:

To be very honest, I don't know whether I will stop using drugs totally even on my release ... I don't know why I use drugs but I feel like they are nearly the most important thing in my life. Drugs have a very strong hold on me and I don't really want to use them but I don't really not want to use them either. (RP12, pre-release)

For many of the participants, while they demonstrated insight into their previous patterns of behaviour and strongly expressed a desire to change, they perceived that they had often been the agents of their own undoing. This is illustrated in the following extract by a participant who earlier in the same interview outlined his strong desire to achieve some level of recovery and change in his life, particularly so that he could reconnect with his teenage daughter:

... when you get out all you want to do is go and have fun, go and enjoy yourself, go and do this, go and do that. You experience everything because you know you're coming back.
(RP03, pre-release)

Overall, the analysis indicated that normal life was something that participants imagined rather than remembered. While prior to release they were hoping for a normal life, they appeared to lack confidence in their capacity to achieve their goals due to the impact of their mental illness and substance use disorder, their awareness of their lack of experience of living in the community and the emotional turmoil of repeatedly leaving and returning to prison. They had few concrete plans to achieve their goals and they readily acknowledged that they often did not have the skills that they needed. It was evident that without significant levels of support, both short- and long-term, that they were “hoping against hope” that they would be able to achieve the level of normality and recovery that they so strongly expressed a desire for.

6.3 Caught in a cycle

Another dimension of the theme of hoping against hope was that participants perceived that they were caught in a cycle of involvement with the criminal justice system, which some also referred to as “the revolving door” or “the merry go round” (Figure 5).

Participants indicated that the cycle had become entrenched over time, commencing and exacerbated by events in their childhood, to the point where they now found the mechanisms of the criminal justice system surrounding them to be all powerful, with no sense of seeing a way out, further undermining their hope for a normal life:

There are worse people than me, you know, but it's just that revolving door. It's like the government just shoving me in here and wasting taxpayers' money. I should be getting help. You don't get help in here. I didn't really have much of a chance from the very beginning, the way I was brought up. Because my father was an alcoholic and my mum was a schizophrenic. (RP07, pre-release)

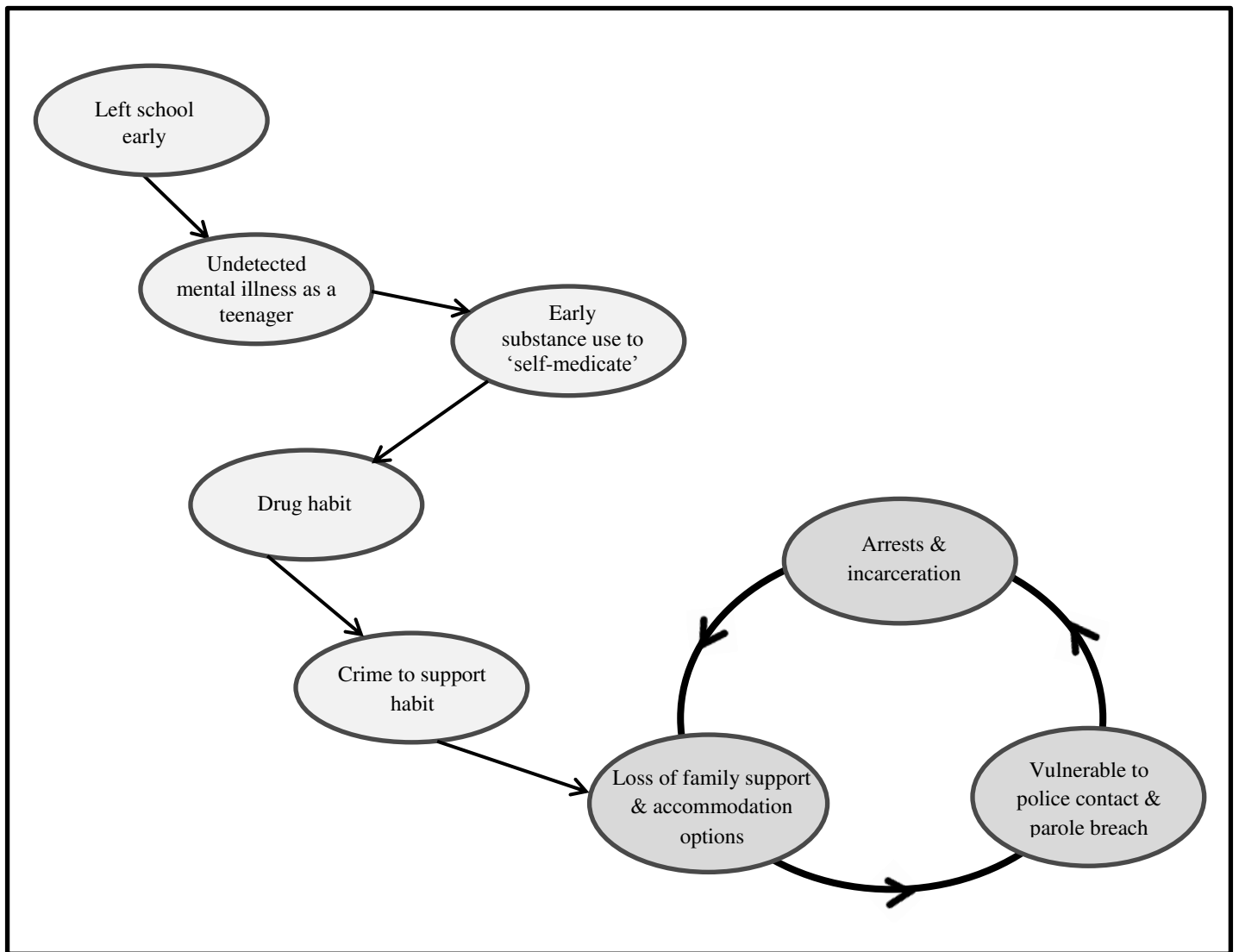


Figure 5: Caught in a cycle.

One of the striking aspects of the data was the similarities in each of the men’s stories in terms of their circumstances and experiences in the lead-up to criminal involvement as a young adult. When discussing the transition experience at all three data points, participants built a picture about the trajectory of their lives prior to becoming involved in the criminal justice system (Figure 5). These data were important in that participants perceived that their experiences prior to and leading up to imprisonment impacted on their hope for a “normal” life in two key ways: the development of drug dependence as a result of using drugs to cope with the symptoms of mental illness and their involvement in crime to fund their drug dependence.

How participants spoke about their experiences beginning in childhood and leading up to their current circumstances indicated that they had rarely experienced a “normal” life prior to being caught in a cycle of involvement in the criminal justice system. The men began with stories of chaotic family life and disrupted childhood and teenage years. Participants tended to have

experienced a poor ability to integrate into the school system, and none of the participants completed high school as teenagers. Many of them indicated that leaving school early was partially related to the experience of their first symptoms of mental illness, linking behavioural problems or lack of concentration with psychotic symptoms developing in their late teenage years and early twenties. The majority of participants also linked their early substance use to symptoms of mental illness, and described the development of a drug and/or alcohol dependence by their late teens. For example, the participant in the following extract described his experience with alcohol in terms of his undetected mental illness:

I was 19 when I first come to jail and that's why I'm always in trouble, cause I'm medicated by drinking. I didn't want to go to a psych cause I thought it was all in my head. Then I come to jail and I hear them [the voices] so I went and talked to the psych and they put me on medication. (RP10, pre-release)

All of the participants described early substance use in their teenage years, and over half of the participants referred to their initial drug use in terms of “self-medication” to dull symptoms such as hearing voices. Some explanations were also suggestive of medicating distress associated with not understanding what was happening to them in terms of their mental illness, as well as other reasons for using drugs, such as to mitigate boredom and to enhance social connectedness. The following participants began using drugs in their teenage years to dull symptoms:

I have been hearing voices since I was probably 12 or 13 ... I just self-medicated myself with drugs ... I got picked up in jail [by mental health] ... every other time I've gone off my medication I've ended up using drugs again to self-medicate. (RP08, pre-release)

I just used to take drugs to calm down the voices and stop seeing things.... It worked momentarily but not full time, not like the pills have done now, and injection. (RP01, post-release 1)

The above extracts suggest that the men were attempting to exert some control over their early symptoms of mental illness. In the absence of recognition of their illness and access to treatment and support, they found that drug use fulfilled that role to some extent.

Participants tended to link their development of drug or alcohol dependence to becoming involved in crime. For those who were using drugs such as amphetamines ($n = 8$), they described needing money to support their habit. The following participant described this process succinctly:

The next minute you are doing crime to support your drug habit and then you are just back on the merry-go-round and the cycle starts all over again. (RP09, pre-release)

While all participants described poly drug use, the primary drug of choice for half of the participants was IV amphetamines. The use of these drugs is expensive, as described by a participant who had been struggling with a large amphetamine habit over several years:

I was always breaking the law to support my habit. Like robbing people or robbing factories and selling stuff to get money for drugs. It's just landed me in a whole heap of shit.... I just couldn't afford to buy it anymore, so I just had to go out and break the law and get money and buy it that way. (RP16, pre-release)

Participants described their deteriorating circumstances, with arrests leading eventually to incarceration. One participant perceived this sequence of events as an inevitable consequence of drug use:

I eventually made my way back to jail. Which happens if you get involved with drugs sooner or later... (RP05, pre-release)

The ensuing downward spiral of involvement in the criminal justice system was described by participants as being accompanied by a gradual loss of accommodation options and family support. Participants perceived these losses to be as a result of spending time in prison, which was then linked by them to becoming more vulnerable to police contact as they became known to police, the courts and the parole system. They described the social and economic consequences of spending time in prison, such as losing possessions and housing tenure, and gradually moving closer to homelessness with each incarceration. For example, one participant lost his room in a group house while he was in prison:

I need help getting somewhere to live and that.... Usually I have a place to go to but this time I haven't. The people I was paying rent to they weren't paying rent and we got kicked out. (RP11, pre-release)

Indeed, several of the participants experienced the loss of accommodation options to the point of homelessness; for example:

... the worst time was not last time but the time before, I come out [of prison] on a Friday and I didn't get out to 7 o'clock at night and I had no money so I had to sleep on the streets for the weekend. Yeah, that was pretty bad. (RP04, pre-release)

For several participants, this decline in circumstances was further complicated by the cycle of prison and hospital stays prolonging the time away from the community and exacerbating the associated losses:

I was diagnosed and spent four months in hospital then I went back to jail then I came in and out of jail. It started with the first time I was just released to nothing ... basically. (RP03, pre-release)

While there was awareness expressed by most participants that they were caught in a cycle, there were minimal signs of personal capacity to change this situation related to the many complex barriers in the way. The following participant described his feeling of being trapped:

There's always something — bail, parole, suspended sentence, notices to appear, notice to give particulars, searches of my street, someone's picking me up — I'm just sick of it. I feel like I'm trapped in the criminal way of life. (RP07, pre-release)

Despite these descriptions of being caught in a cycle of involvement with the criminal justice system, prior to release, participants held on to their hopes of a normal life, wanting to believe that changes in their life might occur at the next release. This discussion provides both a background and context to the analysis, as well as illustrating how the experiences of participants prior to imprisonment impacted on their transition experience by undermining their hope for a normal life after prison. The reality for the majority of participants was that they had experienced a downward spiral of cumulative problems prior to coming to prison, and the idea of a normal life was largely based on what they imagined a normal life might be. It was understandable in light of this that participants had difficulty planning their way out of their current circumstances because they didn't have a clear idea about the life that they thought they were aiming for.

6.4 Ambivalence

The third subtheme describes the tension evident in participants, between wanting to leave prison for a better life and the ambivalence related to a sense of social belonging and material ease in prison compared to the impoverished life and social isolation that they anticipated was facing them in the community. While several participants loathed every aspect of being in prison, and almost all participants expressed eager anticipation for their pending release, participants' stories indicated that they experienced prison to be in many ways a kind of sanctuary from the harsh world "outside" in the community.

Only three of the participants said they liked being in prison, because it kept them away from substances and because prison was much easier to navigate than life in the community. The other participants experienced ambivalence about leaving prison, despite the anticipation of leaving. Almost all participants expressed the excitement to the point of euphoria associated with leaving prison on the day of release:

To leave jail? It's overwhelming, it's exciting. It's the best feeling, it really is. For instance, you can look at the sky without looking through a cage or a window with bars. It's different. You can walk on grass. The simple things — to be able to wake up in your own time with a coffee out on your own veranda and a smoke. You feel part of the whole thing. (RP07, pre-release)

This euphoria, however, had previously been experienced as temporary and short lived before the realities of survival in the community emerged:

But then that feeling goes away and you get used to it again ... and there's no excitement. (RP07, pre-release)

Participants were looking forward to the excitement of release, and at the same time they reflected on the comforts of prison:

Yeah your friends are here. You got three meals a day, a roof over your head... And you don't have to worry about, I don't know, you don't have to worry about trying to get your next feed. (RP01, pre-release)

The structure and routine of prison appeared to suit many of the participants, as one participant described:

Getting out of jail is just like finishing school, you just go home, do what you want to do, but it's really hard because when you are in jail for so long, you've got a routine that you follow every day and when you get out of jail you've just gotta start another routine, but it's more bigger. (RP15, pre-release)

Going into prison was seen by some of the participants as an opportunity to get off drugs and become fit and well. One participant had some ideas about why he and some of his cohort had chosen the path of using prison for detoxification when life as a drug user in the community became too difficult:

Some people like to go in there, like to get off the drugs and take some time out from society ... on the outside they're not really doing too well. A lot of people find it's a better life inside than they [have] on the outside. (RP04, pre-release)

The above extract suggests that some participants had few reasons to keep them in the community and that prison provided structure and comfort that was more difficult to attain “outside”.

The strongest expressions of ambivalence related to participants' discussion of their friendships with other prisoners and a sense of social belonging in prison. Many of the participants said they had more friends inside than outside of prison. For some participants, this was related to the social isolation and lack of connectedness with other people facing them in the community, and the reality

that they either did not have any friendship networks or family supports other than their friends in prison.

I know a lot of people in here. I've been coming in here and out for so many years ... I've got more friends in jail than out. (RP06, pre-release)

One participant expressed how he was sad to be leaving his friends in prison, and organised his last morning to say goodbye:

I've got a lot of friends in jail ... I had the Tuesday off so I could see all my mates who worked in the morning when I was working in the afternoon. So I could say goodbye to all my mates, sit around and have a coffee and all that. (RP08, post-release 1)

For those participants who had been in and out of prison many times, knowing that return to prison would mean reuniting with old friends appeared to soften the prospect of re-incarceration, along with knowing what to expect from the routine and the relative physical comforts of prison life compared to the community. There was a sense from participants that many of them were hoping against hope of finding a better life beyond prison, but if this did not work, the idea of coming back to prison was not too bad in that they were familiar with the environment and at least they would meet up with their old friends. A participant who had returned to prison by the third interview commented on his welcome:

most of the fellas out in the unit [were]so happy to see me yesterday. They were like, "you're back, so good that you are back. It's good to see you" ... They [were] happy to see me. (RP15, post-release 2)

Not all of the participants experienced prison as a sanctuary. A small number of participants intensely disliked being there, found it extremely stressful, counted the days to release, and never wanted to return. For example, a 36-year-old participant with six incarcerations described his experience of prison:

Is stressful, terrible. It's hell. It's hell on earth ... I don't fit in much in jail ... I get around always nervous, always stressed. After a few months you can feel it in your face, the eyes are heavy and black and your hair starts to go grey. You feel like it's killing you. Just the stress. There's nothing like it. (RP07, post-release 2)

For this participant, there was nothing comforting about prison. Interestingly, this man (RP07) had just spent several months in a drug rehabilitation centre where he described feeling comfortable and supported. In comparison, prison was almost unbearable.

Overall, there was a strong tendency for the majority of participants to feel excited and anxious about their pending release, combined with an ambivalence about leaving prison connected to the uncertainty and unpredictability of life in the community compared to the social bonds and relative material comfort of life in prison. Participants were hoping for a normal life in the community, but this hope was undermined by their ambivalence about leaving prison and their experience of being caught in the criminal justice system.

6.5 Discussion

Prior to leaving prison, participants were hoping for what they perceived as a normal life after release, which consisted of a job, a house and a partner. While they were able to articulate what they hoped for, they often lacked the capacity and means to generate successful pathways to achieve their goals, hence they were “hoping against hope”. The role of hope has been under-explored in the literature on prison-to-community transition from for men with co-occurring disorders (Wolff, Morgan, & Shi, 2013). Hope has been associated with longer periods of abstinence and higher quality of life for people attempting to manage their substance use disorder, and there has been research suggesting that working with hope can help to manage relapse to drug use and criminal activity (Resnick et al., 2005, Roberts & Bell, 2013). It has been theorised, however, that “genuine” hope requires motivation, goals and pathways, without which there tends to be an illusion, or at best optimism (Snyder et al., 2000). Hence, the research on the role of hope within the general offender population is based on the assumption that it takes individual determination and capacity to plan the development of pathways to attain goals (Snyder et al., 2000).

In the current study, hope was strongly expressed by participants, albeit mediated by ambivalence and lack of confidence in managing in the community. In contrast, Wolff, Morgan et al. (2013) found elevated levels of hopelessness in prisoners with severe mental illness compared to their non-disordered peers. Using the Beck Hopelessness Scale in their large quantitative study involving inmates about to be released, Wolff, Morgan et al. commented on their findings as follows:

Inmates with mental illnesses may feel hopeless because “normal” goals appear unachievable.... Being hopeless disables the motivation critical for achieving goals, such as successful re-entry, finding a job, healthy parenting, and so forth ... (2013, p. 1104)

Wolff, Morgan et al. (2013), rather than finding hope, found hopelessness in their study, that they theorised disabled motivation for achieving goals when returning to the community. These authors acknowledged, however, that the role of hope in terms of people with a severe mental illness leaving prison is important, complex, under-conceptualised, and that there are major gaps in understanding (Wolff, Morgan et al., 2013).

Participants in the current study were ambivalent about leaving the relative structure, routine, predictability and social connections in prison, which they linked to a lack of confidence in their own capacity to achieve their goals for a normal life. This insight by participants was based on previous experiences of failure to maintain their tenure in the community. Ambivalence about leaving prison has been previously understood in terms of institutionalisation, as has been observed in long-term prisoners who become so used to the routine and their role and function in that environment that they fail to adapt to new situations (Goffman, 1961). Baldry et al. (2008) observed that short-term prisoners can also experience “serial institutionalisation” from repeated incarceration. Institutionalisation means that prisoners can become very dependent as “self-determination, autonomy and freedom of action” (Goffman 1961, p. 43) are stripped away in rigid environments where choice or decisions are neither available nor allowed. It is therefore likely that the institutional effect of prison life directly impacted on the capacity for participants in this study to realistically plan life in the community.

There has been a small amount of research during the transition phase that extends understanding about ambivalence beyond institutionalisation as an explanation. Participants in this study reported feeling a range of extreme emotions related to cycling in and out of prison. Shinkfield and Graffam (2010) found in their quantitative study investigating the role of emotional state during transition in the general offender population, that measures of depression and anxiety fluctuated between the pre-release and post-release points. Scores initially dropped immediately on release, showing relatively lower levels of anxiety and depression, and rose again at the 3 to 4 months post-release data point. These data suggest that there may be other factors contributing to ambivalence other than can be explained by institutionalisation. Shinkfield and Graffam (2010) comment:

... an initial optimism and enthusiasm of ex-prisoners immediately following release may have contributed to reduced depression, being tempered in the longer term by the frustration and realisation of the difficulties associated with the process of reintegration. (p. 356)

Along with hoping for a normal life, participants in the current study were struggling to come to terms with their mental illness, and particularly their substance use disorder, to which most of the participants attributed their involvement in the criminal justice system and repeated return to prison. Participants perceived that the circumstances and events in their life before prison had significantly impacted on their current circumstances, leading to a “revolving door” (Padfield & Maruna, 2006) of repeated short-term incarceration. This supports the conceptual framework developed by Visser and Travis (2003) with the notion that the individual transition pathway needs to be understood in a longitudinal framework, including the experiences prior to incarceration. These researchers suggested that underlying social processes, particularly related to family relationships, prior

employment status and job skills, and the nature and extent of previous involvement with offending need to be understood in all their complexity in order to be able to understand the transition experience (Visher & Travis, 2003). They argue that the data about frequency of return to prison and the associated variables are useful but limited in understanding the transition experience and how to improve it, and further exploration is needed to understand the dynamics associated with the process (Visher & Travis, 2003).

Participants in the current study reported early substance use as a form of “self-medication” to deal with their psychiatric symptoms prior to incarceration, developing into frequent and heavy use that they consistently linked to their entrenchment in the criminal justice system. The finding related to substance use prior to prison is similar to Kinner (2006), who also found a “continuity” of substance misuse prior to prison that was rapidly reinstated in the transition phase for the majority of his cohort. Substance use in this population is a long-term, complex problem that requires close attention.

Self-medication to ameliorate symptoms of mental illness is likely to only partially explain the entrenchment in drug use of this population. Binswanger et al. (2012) found relapse to drug use after release from prison related to depression, anxiety and frustration. Rhodes (2009), drawing on the work of Farmer, Connors, and Simmons (1996), linked drug use with socio-economic stress and stressful life events, conceptualising it as a form of self-medication for “oppression illness” (Rhodes 2009, p. 196). “Oppression illness” has been described as the “process by which an oppressive social environment is incorporated into the everyday practices of those subjected to multiple subordinations” (Rhodes, 2009, p. 196). Hence, it can be theorised that the men in the current study embodied their social disadvantage through drug use and thereby reproduced the circumstances that oppressed them. This notion is in line with Giddens’ (1984) structuration theory, which holds that the actions of social actors simultaneously reproduce the social conditions, systems and practices in which they are situated.

The participants in this study were struggling with mental illness and substance use disorders, and were ambivalent about leaving the social bonds they had created in prison. This was compounded by the anticipation of sudden disruption to routine and structure to face the unpredictability and isolation that they had previously experienced as life in the community. Intense emotions during prison-to-community transition may be an important factor in understanding the experience. Giddens (1984, p. 61) observed that “critical situations” can lead to a focus on “immediate events” and loss of “long term perspectives”. It is possible that when participants in the current study felt anxious about the uncertainty awaiting them in the community, they had additional difficulty

beyond the usual limitations of their capacity in planning pathways to achieve their goals, resulting from the anxiety generated by the upheaval of leaving prison. While preparing to leave prison, participants experienced a complex mix of anxiety, lack of confidence, anticipation and above all, hope that life outside prison would be better than it had been previously.

Chapter 7: Adrift in freedom

7.1 Introduction

Although participants experienced their freedom post-release with initial feelings of excitement, the reality of being adrift in the community, without the anchors of family and social ties, stable housing, employment or meaningful activity, was soon realised. Leaving prison with hopes for a different future clashed with the harsh realities and struggle of surviving in the community. The theme of “adrift in freedom” (Figure 6) was most prominent for participants at the second data point, soon after leaving prison, as well as from discussions in prison of experiences following previous releases.

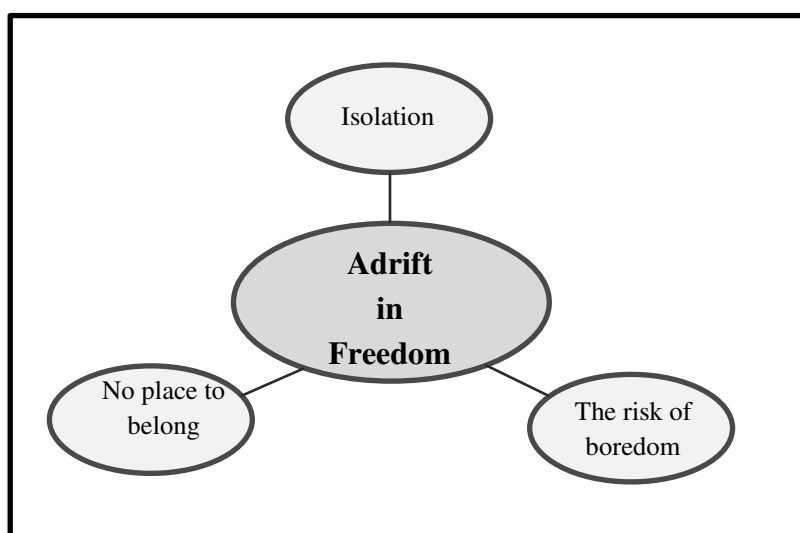


Figure 6: Adrift in freedom.

The first subtheme of “isolation” identifies the circumstances described by the majority of participants of being alone without support post-release. They linked this state to the multiple pressures on family and social ties prior to involvement in the criminal justice system and during imprisonment and transition. The second subtheme of “no place to belong” explores the sense of wanting, but mostly not being able to achieve, a place to belong in the community, particularly related to the lack of stable housing available on release. The third subtheme of “the risks of boredom” explores participants’ experience of being confronted with boredom and nothing meaningful to do when re-entering the community.

7.2 Isolation

Apart from the minority of participants who re-entered the community into structured environments such as living with family or spouse or in the drug rehabilitation centre, the dominant experience during transition was one of isolation. Participants described multiple pressures on family and social ties related to circumstances leading up to their involvement with the criminal justice system, which were then exacerbated by the experience of cycling in and out of prison. For the majority of participants, the pressure on family and social ties had begun with estrangement from their fathers in childhood, and continued with the drifting away of mothers and siblings, as the cycle of involvement in the criminal justice system deepened. The absence of their children in the lives of the participants was also apparent as they disengaged or lost contact during years of imprisonment. Absence of families and friends for most of the participants as they re-entered the community meant that they had no one to turn to, rely on, or trust during the transition phase:

Like, I've never had family people looking out for me. (RP15, pre-release)

One of the strongest underlying themes at the second data point was the sense of social isolation participants conveyed when discussing their lives post-release in the community, related to the amount of time they had spent in prison. Pre-prison social connections had been lost by many participants as a result of having spent so much time in prison. The 14 participants who had been in prison more than twice since age 17 reported that the longest average time they had spent continuously in the community was approximately 18 months (range 1–60 months) during their adult lives. It is likely, then, that one of the reasons the participants experienced isolation was a lack of continuous time in the community in which to establish themselves, either socially or materially, exacerbated by housing instability and the multiple complex health and social issues that they were dealing with.

One participant with a diagnosis of paranoid schizophrenia, a history of IV amphetamine use and nine episodes of imprisonment, was typical of this pattern. He summarised his experience thus:

I really haven't done nothing other than spend a lot of time in jail since I was a teenager, you know ... I am 34 years of age, I've been in and out of jail, I've been in every year ... (RP02, pre-release)

In contrast to the social bonds described by many participants when talking about their lives in prison, the experience of being in the community was frequently described as both unstructured and socially isolated:

In there you've got your mates around you 24/7, whereas out here you've got a lot of free time by yourself. (RP08, post-release 2)

Several participants demonstrated their capacity for individual agency when they spoke about actively pursuing a drug-free life in the community. They outlined their strategies, which typically involved staying away from drug-using friends, for example:

... all my friends use drugs so when I get out of jail I sort of got to try and stay away from it if I want to try and stay out, I've got to try and stay away from them. So really when I get out I've got no friends. I gotta keep away from them. (RP06, pre-release)

However, this put them in a double-bind regarding their social connections. Their friends in the community were mainly drug users and a desire to stay drug free post-release meant that they needed to avoid these old connections, resulting in self-imposed isolation in order to try and achieve their goals. The isolation resulting from trying to avoid old drug-using friends, however, put them at great risk in terms of relapsing to drug use, which in the past had led to criminal activity to support their drug habit:

Yeah, but I was completely abstinent from drugs and alcohol for quite a while, so I had to sort of make new friends who were doing the same sort of thing, which was hard sometimes. (RP05, pre-release)

Only two of the participants had a spouse at the time of the study, and there was a strong sense from many of the other participants of having missed out on the experience of marriage and children and feeling isolated from old friends who had chosen family life:

I had normal straight friends out here but they've moved on with their life now and have family and kids. (RP09, post-release 2)

Returning home to live with parents or a spouse, while appearing to be a protective factor in relation to homelessness to some extent, was not found to necessarily mitigate against social isolation in the community. For example, the only participant in this study who returned from prison to live with both of his parents was also extremely isolated from peers in the community:

I've got one friend [in the community] but I haven't seen him for a few years so I think he's got a kid and missus. So I don't keep in contact with him anymore. (RP01, post-release 1)

Another man, who was one of two participants returning to live with a spouse and the only participant who was returning to live with his children, also described a post-release life of relative isolation. He described his life with his spouse and four children as being without extended family support and with virtually no friends:

We just sort of stick to ourselves mainly and look after our own kids. (RP16 post-release 1)

Family featured strongly in all of the interviews in this study. The importance of family to participants and the striking lack of family support and connections were evident in the data for the majority of this group as they transitioned out of prison.

The following participant's experience was typical of those in the study who were estranged from family from a young age:

Me and my family don't speak to each other. We haven't spoken since I was pretty young. ... They didn't want to put up with me so they gave me to my father and my father is violent and nasty and I didn't want to stay there so ... I left there when I was 14. (RP12, pre-release)

Lack of hope and growing despair was evident in the stories of the participants as they relayed accounts of lost contact with family. Reconnecting with mothers, siblings and children was a strong motivator for many of the participants, who expressed a desire to turn their lives around so as to enable them to reconnect with family members and gain access to or provide support for their offspring. The extent of the family estrangement for most participants, however, was at a level that was not going to be resolved in the short term and unlikely for most in the longer term. The reality for the majority of the participants of the study as they were leaving prison was estrangement from family of origin and minimal contact with their children.

Post-release family support was perceived by all participants as a highly desirable factor in assisting with transition, and the experience of those participants who were estranged from family was in marked contrast to those few participants who were still receiving family support. For example, the only participant who returned from prison to live with both of his parents, while unemployed and socially isolated from his peers, believed he would have been much worse off without his parents' house to live in, and their support:

Well, I put it down to my family. If I didn't have a family to go to I'd be doing the same thing as what they are, in and out. Like it's really good to have a supportive family.... We sat down at the table and just talked about things Mum ... looks after me with my medications and stuff like that. (RP01, post-release 1)

Another participant who was interviewed at 3 months post-release at home expressed similar gratitude towards the parent he was living with post-release:

Just knowing I've got someone there to help me. Even if I don't need it [Dad is] there.... It's going to be hard to try and stay away from the things I used to do but my Dad helps me and my sister helps me. (RP05, post-release 1)

Other participants were making plans, prior to release, to try to rebuild connections with family:

That's my bigger goal. Get back into my family. Find my other sister, go and talk to her. Like ... try and get stuff sorted and then slowly, slowly build up a personal social circle outside my family. (RP03, pre-release)

The majority of participants in this study were not raised in secure family environments. More than half of the participants reported that their parents had separated when they were children ($n = 11$). While eight of the eighteen participants were completely estranged from all of their family of origin at the time of the study, only three of the remaining ten participants reported any contact with their fathers. One participant reported how his father committed suicide when he was a child, and another participant said his father was murdered when he was 9 years old. Two other participants had had no contact with their fathers for many years, one because his father had died when he was a teenager, the other because his father had been in prison since the participant was 14 years old. Four of the participants reported “violent” fathers, and one of the participants (RP03) made comments such as “he has been out of the picture for many years” and “he doesn’t care”, but did not elaborate further about specific behaviour.

Early childhood experiences of family disruption and disengagement, however, meant that there was a lack of trusting family and social ties early in participants’ lives before going to prison. With the addition of multiple pressures on these often-fragile family and social bonds, participants became vulnerable to extreme isolation in the transition phase. In contrast, there was a sense that friends who had been in prison could be trusted, that they understood and accepted what the participant had been through, and that this was something that couldn’t always be shared with others in the community. For example, one participant reminisced about his friends still in prison:

I had mates, people I used to call friends ... even though we were co-offenders. They were still friends, people I could trust that I could rely on 100%. (RP03, post-release 1)

For those participants who had experienced estrangement from their families in childhood or teenage years, the challenge of needing to re-establish themselves in the community each time they were released from prison was very challenging without a social network that they could rely on:

it's pretty tough because if you don't have family support or money saved up you get sort of Centrelink benefit for the first two weeks and that's not very much. You've got to find a house. You know, you've got to get your ID, identification, papers. Yeah, you've got to get bond and rent for a house or stay in a hostel somewhere. You've got to get your food and then get yourself to work somewhere, which can be tough if you haven't saved up money. (RP05, pre-release)

With an average of seven incarcerations for the participants in this study, the gradual falling away of family support had occurred as their involvement with the criminal justice system became

entrenched. This was often expressed by participants with great sadness and regret, but at the same time they conveyed a sense of the inevitability of the consequences of their behaviour. For example, one participant described how he had not seen his family for over 12 months, which he associated with his repeated incarcerations:

They're just getting a bit sick of it and they're getting a bit distant. They just think, oh here we go again.. he's out ... how long is he gonna last this time. Yeah, they're getting a bit sick of it and they're starting to keep their distance from me. (RP06, pre-release)

For those participants who were more recently estranged from mothers and siblings or had minimal contact, the estrangement had happened gradually and was reported by participants as a direct consequence of repeated imprisonment. Participants explained, for example, that while they were cycling in and out of prison, they had lost contact details of family members, which was exacerbated when both the participant and family member was itinerant. For example, one participant described his situation thus:

I'm not in contact with them [family]. I haven't been for a while. I was in contact with my mum for a while but then I lost contact with her ... I lost her phone number. Coming into jail last time my stuff was stolen so when I got out I didn't have her phone number.... I haven't seen her for 5 years. (RP07, pre-release)

For the fathers in this study, the desire to reconnect with their children, however realistic and/or late that might be, was a very strong motivator for change. Half of the participants ($n = 9$) were parents of children, all of whom were under the age of 18 at the time of the study, a total of 14 children. Only one participant was returning from prison to live with his children. A consistent theme for the participants who were fathers was expressions of guilt that they had not been present for their children, a fear that they were perpetuating intergenerational trauma, and a view that reunification or at least provision of support was their strongest motivator for change towards a more positive life direction. Nevertheless, it appeared that in many of the cases, circumstances surrounding the father and child relationship were seriously impaired and plans for reunification unlikely, despite the desperate hope of the participants for this situation to change on release. The following example illustrates this point:

I've done my time. It's time to wake up to myself and get a job and support my son. He's almost 16 now, living with his mother in [a distant city]. It's time to wake up to myself so I can one day see him. That's the plan. The last time I saw him he was 2 years old, that's a long time ago. I lost his number so I've got to somehow find the number. I don't know how I'm going to do that but I'll find a way. (RP04, pre-release)

From the stories of many of the participants, there was a strong sense that history was repeating itself:

I haven't seen my mum ... and my dad for 12 years.... I was taken away from my mum when I was six and made a ward of the State ... because her boyfriend flogged me so bad I was black and blue. The detectives took me away and put me in a foster home.... My plan is to try and stay away from drugs and go down to [another town] to see my [18-month-old] daughter ... I haven't seen her since she was born ... I'd love to see how she looks. See what she looks like. (RP15 pre-release)

Community support workers who could be trusted by participants and who they felt did not make judgements about them, were important to the men. One participant reflected back to his previous release and the role his mental health worker played in providing support:

I had a good mental health support team and even though I used drugs they didn't hold it against me. I felt free to go and talk to them and if I had any experience with drugs I'd go in and talk to him and he didn't hold it against me. (RP11, pre-release)

Overall, the participants in this study described themselves as experiencing extreme isolation and loneliness in the community, and a key component of being adrift in freedom was a lack of social and family connections. While happy to be out of prison, there were relatively few social anchors in the community, contributing to a high risk of a slide back to drug use and the social milieu of prison.

7.3 No place to belong

All of the participants in this study had experienced temporary or unstable housing at some point during their teenage and adult lives, including the three participants who were living with family during the study. The majority of participants had also experienced homelessness at various times. There was a strong sense from the majority of participants that their ambivalence about leaving prison and of being adrift in their freedom was related to a feeling of having no place to belong in the community. Apart from the three participants leaving prison to live with family and one of the participants returning to his spouse who he hoped was maintaining a flat, all other participants in this study faced uncertain living arrangements or homelessness. The following extract illustrates this point:

I actually found it very difficult because when I left I didn't have any support networks and I didn't have anywhere to go. I actually ended up on the streets there for a while when I did get released, until I found somebody I could move in with and I stayed at his place for a little while. (RP12 post-release 1)

Plans made in prison for accommodation frequently fell through after release. An address was required for parole conditions, and as the majority of participants did not have a permanent address, this was problematic. Post-release, RP02 could only stay with his grandmother for the weekend because, while she had supported him in the past, she did not want him living in her house long term again:

I'll be staying at me Grandma's to start with, that's just to get out, and then I'll be looking for me own place straight up, probably move in with a friend ... if she allows me, you know, then find me own place, save up a bit of cash ... (RP02, pre-release)

Post-release, the accommodation with RP02's friend did not eventuate and his mental health support worker was able to find him a room the next day in a small single men's boarding house located on the outskirts of an outer suburb of the city. It emerged during the post-release interview conducted at an outdoor table in the grounds of the hostel, that the participant was very unhappy with this accommodation:

It's shit, you've got to share toilets, you've got to share showers. The room's the size of a kennel. No room. Piss it off as soon as possible. (RP02, post-release 1)

This particular hostel provided a room only, with no meals or access to kitchen facilities, and it was a two-kilometre walk to the shopping centre where food options consisted mainly of takeaway fast food. The interview did not proceed well because the participant was irritable and impatient to be finished, whereas in prison he had been a very willing and articulate interviewee. It emerged that he hadn't eaten that day when the interview took place at midday, and he was waiting for a friend to come and pick him up "to go and get some food". This participant had a very small amount of money left over from his rent at the hostel, a large debt, no employment, and very little prospect of finding more suitable accommodation, which required a pre-paid deposit. The sustainability of this current situation appeared to be poor, due to its isolated location and lack of access to affordable meals.

One participant who was living with his children struggled to survive after his release, having just been told that they had to move from their accommodation:

Got to find a house.... One of my mates was living there with their dogs [while I was in prison] and we're not allowed to have dogs there. We hadn't been evicted, they're just not gonna renew the lease. So we got to find another accommodation. Like, I went to Housing Commission yesterday and put an application in for them and they said it would be a couple of years before they can do anything. (RP16, post-release 1)

At the second data point a week after this participant had left prison and returned to his family, it emerged that the children had been kept home from school because there was no food in the house for them to have breakfast. The participant explained his situation following release as follows:

Yeah, I'm broke because we were behind in rent so I paid \$660 rent. After that I was broke. Got a bit of bread and milk and the kids just eat it all. (RP16, post-release 1)

Participants frequently expressed their vulnerability in relation to maintaining security of their accommodation and possessions when in prison, as illustrated by one participant who described what had happened during his previous incarceration:

She [ex-partner] cleaned out my bank account, took all my clothes, took all my furniture, sold my car, ran up my credit card and took off with another bloke. (RP08, pre-release)

These experiences of loss of possessions and accommodation were described as extremely disheartening for participants:

Sort of do all that work to get somewhere and then ... you got to start from scratch again. (RP12, post-release 1)

While many of the participants had received help at some point from their community mental health support workers or other support agencies, maintaining tenure of the accommodation often proved to be difficult, resulting in reduced options such as staying at one of the homeless men's hostels or living on the streets. One participant was in prison for 8 weeks for breach of his parole conditions. He described his recent difficulty in maintaining accommodation, and on release he stayed at one of the homeless men's hostels:

I've been on the street for 12 months ... I've had a few different places of accommodation but I haven't been able to keep them. (RP14 pre-release)

Over half of the participants mentioned they had stayed at some time in a homeless men's hostel, and five of the participants during this study were released into these environments, or similar temporary boarding house arrangements. The following participant was leaving prison with plans to stay at one of these hostels on release:

I'll go to a men's hostel. I was in share accommodation before I got locked up. Yeah, so that's gone now. (RP13, pre-release).

At the second data point, this participant had been evicted from the homeless men's hostel and was presumed homeless. At last contact, the homeless mental health team were attempting to find this participant but had been unable to do so (personal email correspondence, December 18, 2011).

Several of the participants described how they had trouble avoiding drug use during their time staying in these hostels:

I went to live at [one of the homeless mens hostels] and that's how I fell into the drugs because while I was there I was smoking drugs all the time. I got caught for a dirty urine, so I'm back [in prison]. (RP15, pre-release)

However, for many of the participants, staying in a hostel and hoping that other options would become available, was preferable to being homeless. One participant described his experience of living on the streets:

I put my two suitcases on a skateboard and I dragged them along. I had nowhere to go. It's not fun [being homeless]. It's shit. You feel like a bum. I felt like a bum. When you're down and out and you got no one to help you and stuff like that it's just like I can see how hard it is to get back on your feet. (RP18, post-release)

The above examples illustrate how the majority of participants in this study, apart from the three participants who had left prison to live with a parent and the two participants who were residing in a long-term drug rehabilitation unit, were at constant risk of homelessness post-release. Participants experienced uncertainty and insecurity in their living arrangements, which compounded and accumulated as they cycled in and out of prison. The consequences of being adrift in freedom with nowhere to live and nowhere to belong for the participants was extreme vulnerability in terms of health, social and psychological impact during the transition phase.

7.4 The risk of boredom

One of the significant factors contributing to this population being adrift in their freedom was the issue raised by the majority of participants of being unemployed, with nothing to do in the community after release from prison. All of the participants in the study, with the exception of two who left prison to residential drug rehabilitation, were released to unemployment, and lacked anything meaningful to do with their time other than trying to survive on a practical level to maintain shelter and food. The sheer effort of starting again in the community after a stay in prison was often overwhelming for participants. They frequently left prison without any possessions, including clothes and shoes, and with no money other than to barely survive. For example, a 34-year-old participant with a diagnosis of paranoid schizophrenia and heroin dependence who had been in prison nine times explained his situation:

Yeah, well it's hard to try and get back into the community. Like, I could be in jail for two years and have nothing, cause over 2 years everything's gone — I'm flat out having a bag of clothes. So I get \$400 and then sort of kick on with it and try ... I've got to get straight into work and have an income and have something to do with my time. it just doesn't work. It's

hard to get out and just plod along on \$200 a week, and you got a car then you got petrol. You got food and rent all the rest of it. It's not easy. Without doing crime and getting more money through crime it's hard, it's pretty hard to have nothing, got no clothes. It's just really hard. (RP06, pre-release)

Leaving the highly structured environment of prison, where for most participants there was work and friends, was in stark contrast to the community where there were limited work opportunities and limited or no social contact. Many of the participants were very insightful about the risks of unemployment and the associated boredom and isolation in the community. When boredom was combined with poverty and a lack of an identity associated with work, discussed further below, they perceived themselves as being at high risk of returning to drug use and a criminal life:

... people get to the point where they haven't stable housing, stable employment, they don't have anything in place and money's tough. So boredom, not doing anything productive, on the drugs and it all goes to shit. (RP09, post-release 1)

While the majority of participants expressed that they experienced boredom at times in prison, the general view was that there was always something to do there such as “read, play sports, exercise, study” (RP05) and “just try to train and keep healthy” (RP06). The majority of participants had worked in prison when they were there long enough to sign up to a role, and in addition found that the prison experience provided the opportunity for physical exercise and activity. While living in the community post-release, however, participants described the contrast with prison, as illustrated by the following example:

Whereas out here you've got a lot of free time by yourself, a lot of free time as there's not as much to do out here as there is in there. You can always find something to do [in prison]. If you're bored you'll go and see your mate and have a cup of coffee and you end up doing a training session or playing a game of cards or something like that. (RP08, post-release 2)

Work and employment was found to be extremely important to the participants, playing a role beyond that of generating an income. The majority of participants expressed quite clearly that they wanted to work. Work was associated with having something to do in the community when participants left prison, in that it alleviated boredom, helped to gain and maintain stability, was a source of pride, provided a sense of purpose, and offered an identity. Typical comments about work linked having a job with stability, and was perceived by participants as an essential element of turning their lives around:

You know, I just want to go back to work, maintain a stable job, maintain a stable life, save a little bit of money. (RP02, pre-release)

Boredom in the community was perceived by the participants as one of their main risk factors in terms of using drugs and getting into trouble. Participants spoke about this risk, both prior to leaving prison based on previous experiences, as well as post-release while living in the community:

Boredom. Guaranteed number one worst enemy. That'll be my worst enemy. I get bored very easy with things. Now it's get out ... and try not to become incredibly bored and get work. That will help. (RP03, pre-release)

Do I prefer to work? Yeah. it keeps me busy and I don't think as much. Makes the days go quicker (RP13, pre-release)

My biggest problem is boredom, boredom is my biggest trouble (RP02, post-release 1)

The transition period was perceived by participants as a particularly vulnerable time to be bored and under-occupied. Several of the participants expressed the view that they would prefer a situation where they were released into the community and were assisted to move straight into employment. One participant, for example, was of the view that employment on his previous release may have been protective for him:

I'd done a lot of labouring and that sort of stuff. It's hard to get out and find work ... this [last release] I had a bit of trouble finding work. If I'd have got some sort of work it would've been a bit better, it would have helped ... I've got to get straight into work and start working and have an income and have something to do with my time. (RP06, pre-release)

Participants tended to associate work with mitigating boredom by keeping busy and thereby staying away from drugs and criminal activity:

Once I'm working I'll be right. I'll be busy, I'll stay out of trouble. (RP02, pre-release)

Participants also tended to use examples of having maintained employment as an indicator of their stability over a period of time, as described by the following participants:

Yeah, I thought I was finally working and I thought my life was going to go on track. (RP01, pre-release)

Last time that I left [prison] I kept studying and I started work and I started my own cleaning company and I was going okay for a long time ... (RP05, pre-release)

Being able to find employment and maintain it over a period of time was important to participants in terms of maintaining a level of stability in order to avoid relapse to drug use, involvement in crime and return to prison. However, mitigating boredom and accessing a regular income was only

part of the reason for this perceived link between stability and employment. It would appear that pride and a sense of identity were also factors related to the importance of work for this population. Comments were proudly made by participants in prison, such as “I work in the kitchen” or “I work in the woodwork industries section”, implying an identity associated with that role. Post-release, the most common response from participants in relation to identity was essentially “I am unemployed” or “I am on the streets”. For example, RP12, who was 27 years old and had a diagnosis of paranoid schizophrenia, a long history of intravenous amphetamine and other drug use, and had been estranged from his family for many years, spoke in the pre-release interview about his work in prison with great pride:

I've been working in here for the last four or five months ... I work in the woodwork industries section of the prison and we do cabinet making and cutting the boards for a couple of businesses and we work five days a week from 8 o'clock in the morning until 3 in the afternoon. (RP12 pre-release)

Post-release, several weeks later, this man was interviewed on a park bench, having left the temporary hostel accommodation he had moved to on release after 12 months in prison. His plan was to live on the streets because he couldn't afford the rent at the hostel after purchasing some clothes and essentials, having lost track of all his belongings while he was in prison. At 3 months post-release, this participant had lost contact with all mental health and other support services and was presumed to still be homeless. Despite his history of mental illness and accompanying social and psychological problems this participant was a relatively fit looking man when he left prison who had clearly been able to work quite successfully in the structured environment of prison, but without support he struggled with the most basic aspects of living in the community.

A further example of the role of pride and identity in employment was the experience of RP14, who had previously worked in various roles, including “for 2 years as a messenger just taking mail and delivering things”. This 38-year-old man with a diagnosis of paranoid schizophrenia and alcohol dependence described his experience of leaving prison approximately 18 times for minor offences, and finding himself homeless and begging for money on the streets:

I ask people on the street for money. It's not the best thing to fuckin' do ... I just ask people ... “Do you have any spare change?” ... I'm actually disgraced in the fact that I have to do that. It's fuckin' pitiful. (RP14, pre-release)

Having a criminal history and a history of imprisonment was experienced by many of the participants as being a problem when looking for a job post-release. While the language of stigma was rarely used by participants, it was evident that prolonged association with the criminal justice

system had significant impact on participants' capacity to successfully transition back into the community, particularly as it impacted on the opportunities for employment:

It is difficult as people see you as being a certain type of a person coming from jail so it's very hard to gain somebody's trust to get a job. It's very hard to find somebody that will open their doors and let you into their house.... It feels a little bit unfair that you make a mistake in life and people portray you as that type of a person who will continue to do the wrong thing. (RP12, post-release 1)

Despite difficulties associated with symptoms of psychotic illness and substance use disorder, the majority of participants had managed in the past to work in a wide range of predominantly manual but at times quite skilled and demanding employment. Participants described working in one or more of the following roles either in prison or in the community: baker, cleaner, ceramic floor tiler, roof tiler, tree lopper, shearer, station hand, labourer, kitchen hand, car mechanic, factory hand, messenger, cabinet maker, coffin maker, carpet layer, window glazer and brush cutter. In addition, two participants had been working towards a university degree, having first completed high school level education in prison; two participants had been working towards hospitality qualifications; and one participant had completed certificate level qualifications in prison for a forklift ticket, traffic control certificate and a first aid certificate. Yet, despite this range of skills and experience, there were no opportunities for participants to transition directly into work on release.

Finding and maintaining work once they were in the community was a challenging prospect for participants. One participant had a suggestion as to how this situation could be addressed:

It would be good if they could line a job up while you're in there and you come out and have a job. That would be great. That would help a lot having an income coming in and you'd be working so your time would always be busy. Yeah, that would be good. (RP16, post-release 1)

RP08 also had a suggestion as to how post-release employment could be addressed:

If there was like a support group out there that could help place day labourers. A lot of the boys in jail all have multiple skills like I do.... If there was a program that goes okay well you were doing this work in jail, we've got these companies out here that are looking for workers, when you get released you can go to one of these companies and get a job. (RP08, post-release 1)

It was clear from the above data that the majority of men who were interviewed in this study were capable of working, even in quite physically or technically demanding roles, given an adequate level of structure and support. It was also clear that the consequences of being adrift without anchors in the community with nothing to do to occupy the day and no opportunity to experience

feelings of pride and identity attached to a working life contributed to these participants being highly at risk of relapse to drug use and continuing on a cycle of involvement in the criminal justice system.

7.5 Discussion

The reality of trying to survive with limited resources, limited support and limited capacity to change their circumstances meant that while participants were free from prison, they were adrift in their freedom in the community. The transition period was perceived by participants to be a particularly vulnerable time, when they were leaving the structured environment of prison and returning to the community where the majority experienced social isolation, estrangement from family and children, unstable housing, unemployment, inactivity and boredom.

Participants emphasised that family was extremely important to them, yet despite this, nearly half of them were completely estranged from their family. The men who were estranged from their family described themselves as being very isolated, and they perceived that there was no one in their lives who cared about or believed in them, which meant there was no one who they could rely on and trust to turn to post-release. Visher and Travis (2003) assert that the role of families in transition is not well understood, that studies on recidivism have virtually ignored family dynamics other than identifying family attributes contributing to criminal activity, and that criminal justice agencies have paid little attention to social and family-related factors when prisoners are released. Recently, however, several studies have found that health outcomes, treatment compliance, quality of life and access to employment opportunities were all influenced by positive family support during incarceration and transition for both the general offender and those with a mental illness (Mills & Codd 2008; Naser & La Vigne 2006; Taylor, 2013; Wolff & Draine, 2004).

Most of the nine fathers in this study were estranged from their children, and it was evident from the data that there was little hope of this situation changing without significant support and assistance. It also meant that there was a risk identified by some of the men of repeating history and creating another generation of children who were chronically estranged from their family of origin. There is recent work discussing fathers who return from prison, with findings that suggest that stronger engagement between fathers and their children can play a protective role in terms of the transition experience (Visher, 2013).

A small minority of participants in the current study described being positively engaged with mental health support workers post-release, which they reported as very important to them, particularly when they lacked family support. Being treated “like a human being” was the way that one of the participants expressed this relationship. Given the apparent importance of family support, little

discussion was found in the literature on alternatives to family support during prison-to-community transition where none was available, or where family relationships were estranged beyond the point of no return, as appeared to be the case in the current study for nearly half of the participants. In an Australian qualitative study on women offenders during transition, the factor most strongly related to reduced offending was a positive client-worker relationship (Trotter et al., 2012). This included understanding the released prisoner's perspective, taking a holistic view of all of their concerns using a collaborative approach, and having an optimistic view of the possibilities for change. In addition, it was important that the worker was reliable and offered practical assistance. The findings by Trotter et al. (2012) resonate closely with the mental health recovery process (Deegan, 1998; Slade, 2009), especially having someone who believes in the person and the possibility that life will improve (Padgett et al., 2008; Ralph, 2000).

The economic impact of losing accommodation and possessions was perceived by participants as being a result of repeated incarceration, which meant that they needed to start again in the community after each release. This led to a downward spiral of cumulative disadvantage that progressively entrenched them in a life of crime and continued involvement in the criminal justice system. The notion of social capital has the potential to assist in understanding the underlying social dynamics for participants in this study (Draine & Wolff 2009; Wolff & Draine 2004). Within this construct, stocks of social capital can be depleted or mobilised during transition. Social capital means more than providing resources. It also involves emotional support and "gateway connections" to resources in the community so that the recipient can become more functional and independent (Wolff & Draine, 2004). Moreover, social capital in terms of prison to community has been conceptualised as involving both the individual and the community in a reciprocal relationship, where the community provides resources and the individual is encouraged to participate and give back to the community (Maruna, 2006; Wolff & Draine, 2005). The participants in the current study had very low stocks of social capital to draw on prior to their involvement in the criminal justice system, which was progressively depleted with repeated short-term incarcerations. This meant that the majority of participants had virtually no social capital stocks to draw on during prison-to-community transition, with no one to turn to or rely on after release.

Participants did demonstrate a capacity to articulate what they needed in their transition journey, to mitigate the sense of being adrift in their freedom. First, they were clear that they needed to access stable accommodation; and second, that they needed assistance for a seamless transition from prison to work. An opportunity to self-identify needs and have some control of modest expenditure in transition was found by Morani et al. (2011) to produce powerful results in terms of employment

and moderate results in terms of housing and substance use. In line with the needs expressed by the participants in the current study, participants in the study by Maruni et al. (2011) allocated their funds primarily to practical supports to assist them in starting again in the community. This is consistent with the mental health recovery framework where control, choice and inclusion are core elements both in terms of identifying treatment needs and social supports (Bradstreet, 2004).

Participants identified that boredom, which they associated with unemployment, was their greatest risk factor in terms of relapse to drug use and the associated problems that this behaviour caused, including return to prison. Paid employment has been found in numerous studies to be a protective factor for the general ex-prisoner population, as well as for people experiencing severe mental illness (Graffam et al., 2005; Latessa, 2012; La Vigne et al., 2009; Waghorn, 2009). Despite the debilitating psychological and social disadvantage associated with mental illness and substance use, almost all of the participants were able to describe their strengths associated with employment. This included the capacity to work, including in roles requiring technical skills, and also to maintain a social network either in prison, or when they had been in an environment in the past that provided those opportunities in a supportive way. Yet, none of the participants left prison to work, and there was no evidence that any of them were working in stable employment by the end of the study. They reported that they knew from previous experience that it was very difficult to get a job and go to work without stable accommodation, and one participant specifically talked about his need for work clothes and boots, which he could not afford. This is consistent with other research that has found that even when there has been a history of previous employment, having a criminal history, as well as practical problems such as lack of stable housing, and acquiring work attire, can hinder searching for a job (La Vigne et al., 2009).

Participants were clear, however, that they wanted to work for a range of reasons, including the generation of income and to give them something to do in the community, which they perceived as a protective factor in terms of isolation and drug and alcohol use. Accessing employment opportunities through family support and having a support network to vouch for the person looking for a job were found to be important considerations during transition by La Vigne et al. (2009). This was difficult for the participants in the current study, who tended to be socially isolated. There was also an underlying message from participants about the need for a sense of identity and pride that was missing in their lives in the community and that some of the participants had experienced through employment experiences, including in prison. This is in line with findings in the mental health recovery literature, where employment has been found to promote recovery in mental illness, reduce stigma, increase self-worth, improve social relationships and increase a sense of community (Latessa, 2012; Perkins et al., 2009). However, the “triple stigma” (Hartwell, 2004b) of a prison

record, severe mental illness and substance use disorder meant that the cohort in the current study was unlikely to find paid employment without considerable assistance and support.

Returning from prison to unstable housing was the experience of the majority of participants in this study. The importance of stable accommodation for ex-prisoners is extensively discussed in the literature as a basic requirement for successful transition and community reintegration (Baldry et al., 2006; Visher & Travis, 2003). The provision of housing alone as an intervention, however, is unlikely to be helpful to these participants, as it may not address their social isolation (Rowe & Baranoski, 2011). Participants described their isolation in the community, even when living with family. The need for stable housing can be further understood by Giddens' (1984, p. 375) concept of "ontological security", which he associated with feelings of wellbeing and safety, allowing for identity development and self-actualisation when there is constancy in the social and material environment.

The participants in this study had experienced a level of ontological security when they were in prison with friends and a routine, but most did not experience that sense of security in the community. The need to avoid drug-using friends, combined with the loss of contact with previous friends as a result of cycling in and out of prison, as well as having more friends in prison than outside, all contributed to their social isolation in the community. Overall, the absence of family to rely on and someone to trust during transition meant that participants were vulnerable and highly at risk of not being able to survive well in the community. Adequate housing and employment were largely missing for the participants in this study as they were leaving prison; however, a place to belong, a social network and something meaningful to do to occupy time in the community were important to participants beyond just accommodation and a job.

Chapter 8: The slippery slope

8.1 Introduction

The “slippery slope” and its three subthemes (Figure 7) represents the struggle against relapse into drug use and crime. This struggle was exacerbated by the loss of contact with mental health support and treatment services, the lack of engagement with alcohol and drug agencies, and the system response to technical violations of parole. These factors, combined with previously discussed vulnerabilities associated with unstable housing, lack of employment and lack of family and social support, meant this population were highly at risk return to prison, despair and suicide.

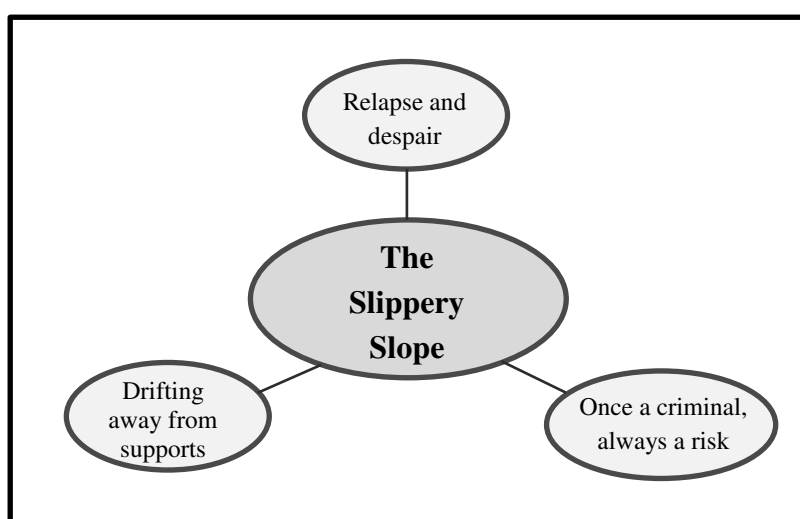


Figure 7: The slippery slope.

The seven participants interviewed at the third data point were the only participants who left prison to a structured and supported environment, either with a parent, to drug rehabilitation, or back to prison. They were also the only participants in the study who were still in contact with mental health services at the third data point. These participants were either living with one or both parents ($n = 3$), living in a residential drug rehabilitation centre ($n = 1$), had been returned to prison ($n = 3$) or had not been released as anticipated ($n = 2$). All of the remaining participants ($n = 9$) were lost to follow-up by their mental health service. The state-wide mental health information system indicated that they had not been engaged by another service in the state during the study. The data informing the theme of the “slippery slope” were extracted from the interviews with these seven participants, as well as from the pre-release interviews, where all participants relayed their experience of “the slippery slope” after previous releases. Given that only four of the 18 participants conveyed any sense of stability in the community at the third data point and three participants had been returned to

prison during the study, the dominant experience, in combination with reported experience of transition from the recent past, was interpreted as a slide into relapse and despair, hence “the slippery slope”.

The first subtheme of “drifting away from supports” discusses the experience of participants’ loss of contact with mental health treatment and support services post-release, despite positive engagement in prison and facilitation of links with community mental health services. The second subtheme of “once a criminal, always a risk” discusses the system impact related to parole practices as well as community level stigma during transition. Participants perceived themselves as being labelled as a risk to community safety, including when they had not committed another offence. The third subtheme of “relapse and despair” explores relapse into substance use and crime, the lack of engagement with alcohol and drug interventions, and the accompanying despair participants disclosed when discussing suicide attempts during prison-to-community transition.

8.2 Drifting away from supports

For many of the participants, the slippery slope of returning to drug use and crime was accompanied and exacerbated by loss of contact with mental health support and treatment services after leaving prison. This was despite the fact that all study participants received mental health treatment in prison and the majority discussed their strong engagement with the prison mental health team. Prior to release, all participants reported that they had been referred to and linked with mental health services in the community.

For one participant, the level of support he received on his previous release was relatively new because he reported that for a number of years, the only place he had received psychiatric medication was in prison or in hospital, but not in the community:

Well, it's not like I have now, where it's [mental health support agency] — no one came to me with any of that. I didn't go to see any doctors. My medication stopped as soon as I walked out the door, that sort of thing, and eventually I became ill again. They're hooking me in with my mental health team outside. They're taking me to appointments, helping me get to appointments and stuff. If I'm feeling crook they'll come around and talk to me ... like keep me company sort of thing. See if I'm doing all right, that sort of thing, check on me. Just helping me with all the things I need to hook into outside. They're good for that and that's great. I need that help. (RP03, pre-release)

Homeless participants had also been linked into mental health support in the community. One participant spoke about his contact with the homeless mental health team during his previous release:

Yeah, had Mental Health, Homeless Outreach Team that see me every fortnight, all that sort of stuff. I had a lot of support, and um, yeah I had a lot of support so I just kicked on with it. (RP04, pre-release)

Participants who spoke about their mental health team all appreciated the support they had received. It was apparent that regular contact, practical support for accommodation and continuity of care such as ongoing access to medications were important to many of the participants, as the following extracts convey:

R. [mental health worker] was calling me every couple of days to see how I was going. She helped me fill out paper work. I spoke to her up until I got arrested again. (RP06, pre-release)

Mental Health has been coming to see me and they have been giving me good support, asking me about having an address and to help me get my own place when I get out and I'm on high doses of medication now ... and I have to make sure I come and get my medication off the mental health out there. (RP09, pre-release)

It's [mental health service has] given me a lot of support in the community, like if I wasn't going to mental health and I didn't have medications to go back on I would have been heading down the exact same path as what I had before then ... going back to doing the exact same things. I haven't just flipped out ... for a while now. (RP08, post-release 2)

Consistently, participants referred to the assistance they were receiving from their mental health supports that was delivered with a positive and supportive message and that recovery gains were possible. In the following extract, the participant clearly attributed part of his early gains in his recovery to the quality and level of support he was receiving from his mental health service provider in the community:

Well, the support's pretty good, they support me well ... they ring me up and tell me that it's time for injection in case I forget, and my case manager, he is a good case manager.... He talks to you like a normal human being. He's a good talker. It's important to me because I like to know where I stand with case managers and stuff like that. Like if they're friendly ... and that. (RP01, post-release 1)

It was apparent that this participant, while appreciating the practical support he was receiving from the case manager, also valued the sense of normality that was conveyed and that he felt valued as a “normal human being”.

One participant in the study who showed real prospects of making significant changes was living in a drug rehabilitation centre, participating in programs and had returned to his tertiary studies. Again, this participant had mental health support, which he acknowledged as follows:

Mental Health has been coming to see me and they have been giving me good support, asking me about having an address and to help me get my own place when I get out [of rehab], and I'm on high doses of medication now ... and I have to make sure I come and get my medication [from] the mental health [team] out there. (RP09, post-release 2)

The extent of mental health support offered to participants, as described above, was perceived by them as largely adequate. This result was expected because the sample was drawn from a population of men who were engaged with mental health services in prison that linked them with mental health services in the community. The prison-to-community transition experience was characterised overall, however, by a drift away from mental health treatment and support in the first 3 months post-release, with only the participants who were living with a parent, or resident in drug rehabilitation, or in prison, were still in contact with a mental health service by the end of the study.

While it was important to the participants to have adequate mental health care in prison and links with community mental health services, it was only one component of the transition support required by them. Mental health care alone did not achieve very positive outcomes for this group and by the end of the study only those living in a structured environment were still engaged. While all of the circumstances of the participants who were lost to follow-up are not known, their accounts given pre-release of their experiences following previous releases strengthens the interpretation of the “slippery slope” as the dominant transition experience of this cohort.

8.3 Once a criminal, always a risk

Participants indicated that the message they perceived from the criminal justice system (i.e., police, courts and parole) was that that they were a risk to community safety, that they were not to be trusted, and that they could not and would not change. Participants believed that this message undermined their hope for a normal life, conflicted with the messages received from mental health supports that there was hope for recovery, and contributed to the slide into relapse and despair.

The reason for imprisonment for nearly half of the participants in this study was for a breach of parole conditions. This group tended to have experienced multiple, short-term incarcerations associated with breaches, often referred to as “technical” violations, where no new offence had been committed, but rather they had broken the rules of their parole conditions. While mainly the breach of parole was related to drug use such as traces of marijuana or amphetamines found in a urine drug test, at other times the breach was related to mental illness or social circumstances, including missing an appointment with the parole officer, or not taking medication. For example, the following extract conveys the recent history of breaches for one participant:

I was out for two, three months and then breached parole order again by failing to report to interview. Then the time before that was for dirty urine and I'm doing five weeks full time. This one was a breach, last one was a breach and the one before that was a breach as well, I was on home detention. I got a breach and come back in.... I moved house and then I missed an appointment and then I rang up and they said "there is a warrant out for your arrest" and they arrested me the next day. Yeah, I was arrested the next day. (RP04, pre-release)

While participants expressed insight into the inevitable consequence of robbery and other similar behaviour that they described in their attempts to obtain money for drugs, it was harder for participants to accept being identified as a risk when it appeared to be mainly as a consequence of being entrenched in the criminal justice system. One participant described a situation where his parole was breached immediately for an alleged offence:

I got out on parole and I was only out for three weeks and they charged me with an old burglary that they said I done like last year, December last year, and I didn't do it and they breached my parole straight away and sent me back into custody until the outcome of court. I'll get out and I'll do another year or 2 years then I'll get out and I'll come back for another 2 years — it's just kept on going. It just seemed to never end. (RP06, pre-release)

In this study, the trend of repeated breaches appeared to be cumulative and related to the number of imprisonments. The participants who had been in prison more than three times as adults ($n = 13$) were more likely to describe a deteriorating situation where they would be returned to prison immediately on contact with police. A participant who reported that he had been in prison nine times, each for less than 1 year, illustrated this point with his comment:

It doesn't take long before they catch you, you know ... and with me there's no more bail, they always lock me up.... Like I was locked up for 12 months right, and then I was in hospital for three months, I was only out of hospital for two weeks and [then back in jail on breach of parole]. (RP02, pre-release)

Participants tended to be not only entrenched in the criminal justice system, but they were also in a complex relationship with the mental health system. Several participants who were in prison on a breach of parole described their experience in terms of being directly related to their mental illness and non-compliance with treatment, as the following example illustrates:

I got breached the first time for not taking my medication and dirty urine. The second time for not taking my medication, public nuisance and something else I can't remember ... and this time, because it was part of my parole conditions to stay on all my medications and to see my psychs and follow their directions, and I stopped taking one of my medications ... because it was making me sick. (RP08, pre-release)

A further complication of being caught in the criminal justice and mental health systems were the delays three of the participants described in waiting for assessments by psychiatrists before they could progress their case. One participant waited for months in prison for this to occur:

You know, I've just done 4½ months for a fineable offence, and cause of mental health, holding things up, means I had to stay in jail..... I was already on a forensic order and a forensic patient getting charged cannot plead until he is been assessed by a psychiatrist [to say] if I'm fit or unfit ... so I had to stay in jail ... (RP02, pre-release)

Being held on a fineable offence that would not normally result in prison time due to delays in psychiatric assessment was very disheartening for these participants and was a further example of system-related discrimination that tended to undermine hope and lead to despair. As one participant commented:

I feel like I am being pushed further down rather than being helped up. (RP12, pre-release)

In combination with all of the psychological and social problems the participants in this study experienced, the addition of being perceived during the transition phase as “once a criminal, always a risk” contributed to progression down the slippery slope. Participants perceived that the systems they were dealing with during transition did not provide concrete opportunities to break out of involvement with the criminal justice system. Indeed, participants perceived that in many ways they were being pushed down rather being helped up.

8.4 Relapse and despair

Extreme risk of relapse to drug or alcohol use was the most significant component of the slippery slope for participants during transition. The majority of the participants who were in prison on a breach of parole explained that it was related to drugs being detected in the regular urine samples that they were required to produce while on parole.

All participants expressed in various ways that if they were able to abstain or significantly reduce their drug or alcohol use, their chance of breaking out of the cycle of involvement with the criminal justice system would considerably improve, as would their health and overall recovery. However, participants conveyed that they lacked confidence that they would be able to achieve abstinence. Relapse into drug or alcohol use and then subsequent involvement in criminal activity was the trajectory that the majority of participants expected would await them on release. For all of the participants in the study, this had proved to be the case after each previous incarceration. While there was some discussion about drug use in prison, most of the participants described abstinence as much easier while they were inside, and they were mainly confronted with the temptation to resume drug or alcohol use on release:

Yeah, its easy to lose focus on what you've got to do ... if your mind is crowded, if you think of drugs ... then you want to go and get on and stuff like that ... yeah, [then] you're off doin' stupid stuff. (RP01, pre-release)

During this study, only six of the thirteen participants who were interviewed within 2 weeks post-release reported that they had actively remained drug and alcohol free up to that point in their transition back into the community. Three of these participants were in a drug rehabilitation centre at the time, one was at home with both parents, and the remaining participant had returned home to his wife and children. This last participant was pleased that he was able to resist smoking marijuana with his friends:

My mates come around the other day, a couple of old mates, and they had a [smoke of marijuana] at my house and they offered me one and I said no I don't want it.... I thought it was going to be hard but it was easy once I said no, it felt good and they didn't offer me anymore and they haven't come back around since. (RP16, post-release 1)

The remaining seven participants at the second data point reported that they had not remained abstinent. At the third interview, 3 months post-release, only three of the seven participants interviewed reported that they had successfully remained drug and alcohol free. A fourth participant, while maintaining that he was not using amphetamines, was evasive about whether he was smoking marijuana.

While it is difficult to be conclusive on this point, by the end of the study there was no evidence that 13 of the 18 participants were successfully dealing with their substance use, and a further two participants had not been released from prison as initially expected. This meant that only three participants out of eighteen appeared to have been actively dealing with their substance use problem in the community. Various sources of data contributed to this conclusion. There was direct evidence that at least nine of the participants had recommenced their use, either because they discussed it during the second interview, or after being rearrested and re-interviewed in prison. One participant was intoxicated when visited at home for a second interview, and another participant spoke only briefly as he said he had been out drinking all night and was suffering from a hangover. A further two participants who were lost to follow-up were presumed homeless by their mental health service. Both of these men had a long history of dependent substance use, and there was no evidence that their substance use had discontinued.

For some participants, the threat of returning to jail was enough to hold back relapse for a short period of time. The following extract illustrates this point:

I don't [want to use drugs] when I first leave because the memory of jail is clear in my head but then I forget and that's when I start going off the rails. Most people that go to jail go to

jail because of drugs and alcohol — 80% — so that's what happens, is that they relapse ... (RP07, post-release 1)

For other participants, the temptation to use drugs seemed to become more pressing over time.

Because last time I got out I thought I was well enough. Like, I worked for 2 years and I just kind of started using drugs again and made me sick and sicker in the head. (RP01, post-release 1)

Several of the participants described how when they knew they were returning to prison, due to a breach of parole or the pending outcome of a court process, they would use drugs again quite heavily even when they had achieved a period of abstinence. This had led to more charges, further complicating their legal situation, and further entrenching them in the criminal justice system:

I just wanted to escape from reality for a little while, you know, knowing that I am going back to jail, so I may as well enjoy myself ... and escape from reality for a bit. (RP02, pre-release)

In discussing their post-release experiences that had occurred in the past, the slippery slope was described by all of the participants as being directly related to drug or alcohol use. For some participants, the relapse into drug use post-release was rapid and severe:

It was only, I think it was about 70 something days between when I [was released] and [when I] got arrested, things I used to do, drug use whatever ... like if I went and got something I'd go to excess. I'd have big shots. I'd use lots. (RP03, pre-release)

For those participants who described alcohol as their main drug of dependence, the rapid reinstatement of their use was similar to those participants returning to amphetamines:

... out of the whole year I've only been out for a month ... I'm always in jail and if I'm not in jail I'm always drunk. (RP10, pre-release)

Participants considered the transition phase to be a particularly vulnerable time for relapse, yet their substance use disorder remained largely unaddressed. Apart from the three participants in the study who received drug treatment after release, the remaining participants, despite the severity of their diagnosed substance use disorder, provided little evidence that they had received any drug and alcohol education, motivational counselling or treatment while in prison or post-release. All of the participants were asked if they had participated in these activities while in prison, and only three responded that they had participated in small amounts of education but not any motivational counselling or treatment. Participants reported explanations for this that included: not understanding the relevance for them of alcohol and drug interventions in prison while they were abstaining; the

lack of availability of alcohol and drug education or treatment in prison; and when programs were provided, the lack of access to these as short-term prisoners.

Two of the participants in the study reported success in the past in staying away from drug use by participating in opioid replacement programs in the community. However, these participants reported that the treatment was not available in prison. The following participant, for example, had managed to remain abstinent from drug use when he was previously on an opioid replacement program in the community, and recognised the risk of relapse after release while he was organising to be re-established on the program:

No, they won't give it to us ... it would be good to be on a dose and then be released on a dose so you were constantly on it. (RP06, pre-release)

Several participants reported barriers to transitioning from prison to a drug rehabilitation centre. One participant reported that the drug rehabilitation centre required an application to be lodged after release, as well as a lack of availability of beds, requiring a wait in the community before being able to enter the rehabilitation service. This participant, who was highly motivated to return to the community drug rehabilitation centre where he had previously been successful in achieving abstinence, resided in the homeless men's hostel for over a week while he was waiting for a bed in the rehabilitation centre. During that time, he said he felt extremely vulnerable to drug use and reported a minor relapse that nearly prevented his entry to the centre:

It could have been better if I had of got here on the day I was released. There needs to be a bit more interaction between places like this [drug rehabilitation centre] and prison. Like, maybe a worker that comes in here and works with the [rehabilitation program] and goes into the prisons and that ... You know what I mean? It would have meant that I wouldn't have used pot and got caught with it. It would have meant I wouldn't have been susceptible to using drugs and left in a hostel waiting to get into [the rehab]. It would have meant I'd be here straight from prison. From one routine to another instead of being left to my own devices with all that freedom and that feeling of just coming out and left to my own devices. (RP07, post-release 1)

Those participants who had not been exposed to alcohol and drug treatment, counselling or rehabilitation, appeared to fill the gaps in their experience with imagining what rehabilitation would be like; for example:

I don't like rehab. I never been there but it's one of those places I never want to go to.... It'd be just like jail so I don't want to go there. (RP04, pre-release)

Several participants reported previous negative experiences with drug rehabilitation centres that had put them off the idea of trying again, even though some of them commented that it was most likely

what they needed to do to get their lives back on track. One 27-year-old participant with 15 incarcerations had been to drug rehabilitation twice and was expelled the last time:

I snuck out one night ... [we were] camping ... I waited until everyone went to sleep and snuck out and went down to another tent, they had smoked [marijuana] and that so I smoked and went back and felt guilty next morning so I told them I snuck out last night and they kicked me out. So I haven't been back to rehab since. (RP15, pre-release)

The above discussion and other remarks, such as that drug rehabilitation is 'just like going to church' (RP10), illustrate that the programs being offered were perceived by participants as divorced from the worlds they inhabited and were unlikely to meet their needs. These findings are important when exploring the transition experience. While participants clearly identified that their greatest risk to their recovery and breaking out of the cycle of involvement in the criminal justice system was continued drug use, their exposure to opportunities to address their substance use problems was minimal, with many barriers in the way.

For the three participants who did go to a drug rehabilitation centre, it was largely a positive experience. Thus, RP05, who was paroled to the residential drug rehabilitation centre on his previous release, was choosing to go back there again:

I went to [residential drug rehabilitation centre] last time I was paroled which is a rehab in [an inner city suburb] and the program there was for two months and I had previously been there before and they accepted me from jail and I completed the program. (RP05, pre-release)

I guess it's like you've got counsellors and psychiatrists there and there's doctors and if you want to be clean and learn about what makes you use drugs and all that sort of stuff then it's a good place to go, and there's lots of support networks there so you can stay clean if you want to ... you can go for walks, do programs, find out why we use drugs and all that sort of stuff. There's many things you can pick up in here. (RP05, post-release 1)

Apart from the small minority of participants who were starting to make positive changes in their lives, a striking aspect of the accounts given by participants of the "slippery slope" of living in the community post-release was the extreme level of despair described by many of the men. Participants particularly associated despair with their struggle with mental illness, relapse to drug use and the subsequent spiral downward in their circumstances during the transition phase. Thoughts of suicide and attempts to do so were mentioned by six of the participants during the interviews. Four participants described serious suicide attempts and two participants spoke of having thoughts of suicide. For example, one of the participants expressed his despair about his situation and ideas of suicide:

I feel like I'm trapped in the criminal way of life. I just want to get out of it. I've been really depressed by it, even thinking of suicide. (RP07, post-release 1)

Four participants reported attempting suicide in the previous 2 years, either in the lead-up to a release or within days after release. One participant (RP09) tried to hang himself in his prison cell several weeks before being due for release in response to his then untreated symptoms of mental illness. He spoke about it in the pre-release interview:

I was freaking out in the units here because I was hearing voices ... that's why I hung myself. I was put in a safety unit.... I've only just got out last week. The first time in my life that I've ever had a self-harm history or anything. (RP09, pre-release)

This participant had been subsequently identified by mental health services in the prison, given a diagnosis of schizophrenia and commenced on medication. By the time of the interview, his symptoms had settled and he was feeling more positive. He was subsequently released into a community drug rehabilitation centre and by the end of the study he was progressing quite well with his recovery.

Another participant (RP03) disclosed a serious suicide attempt within days after his previous release. He explained how he was homeless on release and had been taken to live in a hostel where there was a large group of mentally unwell men:

I got out of jail March just gone. Three days later I tried to kill myself ... I went to a boarding house. This was when I tried to kill myself few days later.... It just started in on me straight away. As soon as I got there ... when people went to bed I could hear people talking and it was just like a catalyst and it just kicked off and got worse to the point where I said I've had enough.... Trying to kill myself, that's the first time I done that. (RP03, pre-release)

Shortly after this pre-release interview, the participant was released from prison, again into temporary hostel accommodation. Within 2 days he experienced a severe psychotic episode and was admitted to the mental health unit of the metropolitan hospital where the second interview took place. On release from hospital several weeks later he was lost to all follow-up, telling a community support worker that he was going to another city. At 39 years old, he had minimal family support and few life skills. He relayed that after 15 trips to prison:

She's [mum's] had enough. She pretty much said "you're on your own now". (RP03, pre-release)

The irony of this case is that when he was interviewed in prison with adequate treatment he presented as an articulate, well-presented man who appeared to respond well to medication:

I was really ill. That's how bad things were ... but now I've been stable and I've been medication compliant for quite awhile now. This is the longest I've been clear for as long as I can remember. (RP03, pre-release)

Although articulate and mentally well while in prison, on the last two occasions that he left prison this participant reported lack of supports and lack of stable accommodation as being the main precursors to a plunge into despair and suicidal thoughts, which had resulted in at least one serious attempt on his own life.

The six men who disclosed suicidal ideation or suicide attempts represent one third of the participants of the study. The suicide attempts or serious thoughts about suicide were all just prior to release or soon after release, indicating extreme vulnerability during the transition phase. The despair evident in these men when they disclosed their suicidal thoughts and feelings was also present at certain points in the interviews for many of the participants as they discussed their recent and past experiences of leaving prison. With hopes that life might be different this time, followed by awareness in the community that they were unlikely to achieve their goals, with drug use and continued involvement in the criminal justice system the most likely outcome, participants described the despair of the slippery slope settling in.

8.5 Discussion

The slippery slope for participants in this study was characterised by a slide away from mental health treatment despite strong engagement while in prison, the impact of systemic factors such as parole practices that tended to undermine rather than enable hope for recovery, and a lack of exposure and access to alcohol and drug treatment and counselling. Extreme despair manifested by thoughts of suicide was identified by one third of participants who raised this in discussions of their transition experiences.

Engagement with mental health services in prison was largely positive for participants, who consistently reported they were responding well to the medication and support they were receiving from the prison mental health service. Yet, despite this, all of the participants who were not living in a structured environment post-release had lost contact with mental health services by the end of the study. Low levels of engagement with community mental health services was found in a recent UK study for people with severe mental illness leaving prison (Lennox et al., 2012). The study involved 137 participants and 30% of the cohort had received no discharge planning. Of the 70% of the cohort who did have a discharge plan, only 20% of participants made contact with the community mental health team post-release (Lennox et al., 2012).

The challenges of continuity of care for this population appear to extend far beyond the provision of referrals from prison into community mental health. The combination of lack of structural supports and untreated substance use disorder may have contributed to the men in the current study being unable or unwilling to sustain their contact with mental health services post-release. One of the contributing factors in loss of continuity of care in the current study appeared to be that although the mental health service in prison was involved in transition support such as assistance with accommodation, for example, these supports functioned as only short-term solutions to avoid “primary” homelessness, such as living on the street (Chamberlain & MacKenzie, 1992). Participants indicated that their longer-term support needs remained unaddressed. Research in the United States has found that relapse to drug use after prison often occurred in the context of poor social support and lack of financial resources (Binswanger et al., 2012) and that practical considerations for released prisoners tend to come before mental health and drug treatment and rehabilitation needs (Davis et al., 2011). Interventions such as longer-term stable housing, transition to employment and family support have consistently been identified in the literature as essential to successful transition for this population (Davis, et al., 2012; Graffam et al., 2005; La Vigne et al., 2009; Petersilia, 2005). Lennox et al. (2012) summarise:

Therefore discharge planning should be holistic, focussing not only on mental health, but also on wider determinants of social stabilisation, such as substance misuse, housing and employment rather than on mental health treatment services. (p. 73)

Relapse to drug use and crime was identified by almost all participants as the major risk facing them in the community, yet despite this, excluding the three participants who went to a drug rehabilitation centre post-release, very few of the other participants engaged with alcohol and drug treatment or motivational counselling during the transition phase. While there is ongoing unresolved debate in the literature as to the relationship between untreated mental illness and criminal justice involvement (Greenberg et al., 2011), there is a high level of consensus that co-occurring mental health and substance use disorders place individuals at high risk of reoffending and reincarceration (Drake et al., 2008; Messina et al., 2004; Proctor & Hoffmann, 2012; Swartz & Lurigio, 2007).

Challenges such as avoiding drug-using friends and moving from prison to a homeless shelter where there was high levels of exposure to drugs made it difficult to avoid relapse for the participants in the current study. Binswanger et al. (2012) also found that “the environments to which participants returned immediately following prison made it difficult to avoid relapse due to ubiquitous triggers to use” (p. 5). Rhodes (2002) is emphatic that harm reduction related to drug use has tended to centre on individual risk behaviour that is “context-free” (p. 86) rather than a

recognition of risk environments impacting on relapse and drug use. This encourages one-to-one interventions that focus on individual behaviour change, rather than a broader understanding of socially situated nature of drug use and relapse during prison-to-community transition.

Participants reported their perception of a lack of integration between alcohol and drug services in the prison and the community, and limited services provided in correctional facilities, even for those participants who were ready for treatment or rehabilitation. This also meant that those participants who were still ambivalent about their drug use had very little exposure and encouragement to review their beliefs about drug and alcohol rehabilitation. There is a growing consensus in the literature that participation in substance use treatment reduces substance use and offending (Chandler & Spicer, 2006; Cleary et al., 2009; Drake et al., 2008), that effective substance use treatment programs focus on tailored programs provided both before and after release (Kinner et al., 2013; Kurlychek & Kempinen, 2006; Kurlychek, Wheeler, Tinik, & Kempinen, 2011) and when mental health and substance use treatment is provided simultaneously by the same provider (Chandler & Spicer, 2006).

Participants perceived that the message they received from the criminal justice system was “once a criminal, always a risk”, particularly in terms of breach of parole and delays in prison related to waiting for a psychiatric assessment. This is consistent with Farrall et al. (2010), who equates breaches of parole for minor offending as sending a message to the person of “you can’t change” (p. 560) and to the staff that “this person is not to be trusted and won’t change” (p. 561). Robinson (2002) noted that approaches to risk management by parole practitioners “are not imbued with rehabilitative or transformative optimism” (2002, p. 10). Research in the United States and the United Kingdom has identified that parole officers are more likely to revoke the parole of people with a mental illness than non-mentally ill parolees for technical breaches of the rules (Eno Louden & Skeem, 2013; Grattet, Petersilia, Lin, & Beckman, 2009; Kennealy, Skeem, Manchak, & Eno Louden, 2012; Steen et al., 2013). One study suggests that parole officers tend to have an increased perception of risk regarding people with a mental illness, and that revocation is sometimes inappropriately used to manage emotional crisis (Lynch, 2000).

The accounts about self-harm and suicide attempts by six of the participants illustrated the level of despair this cohort experienced and indicated how much at risk they were to self-harm if they continued along the same path. There is a large and growing body of literature that exposes the risk of suicide post-release in the general offender population (Coffey et al., 2003; Kariminia et al., 2007; Merrall, 2010); however, no studies were found that specifically examined post-release suicidal ideas of released prisoners with co-occurring disorders. It is possible that this group are at

an even higher risk with the additional vulnerabilities they experience (Kinner et al., 2011). The participants in the current study speaking about their suicidal ideas and experiences further confirms the findings from previous studies of the risk of the potential for self-harm in the released prisoner population. It would appear that the despair of being trapped in a downward spiral of involvement with the criminal justice system was a major contributing factor for these participants, especially when combined with symptoms of mental illness. This state of despair is in stark contrast to the hopes and dreams of the cohort in the pre-release phase of transition. Even though the strong desire to change individual circumstances was tempered with awareness and at times expectation that it would be very hard to achieve these changes, the state of extreme despair expressed by these participants illustrates the extent that personal agency was restricted in these men, with suicide being perceived as a solution. In Snyder's (2000) hope theory, people lose hope when they are blocked from attaining their goals and when they don't have enough "hope resources" to overcome the blockage. Zournazi (2002) suggests that despair is the "other side" of hope.

While participants described a hopeful but in the end largely bleak and pessimistic picture of their previous and impending experience of transition from prison to community, there were glimpses of "what helped" woven throughout the stories. A small minority of individuals displayed a sense of agency in terms of making choices to engage with available supports and using these resources to remain motivated to maintain their footing, despite a strong pull down the "the slippery slope" of relapse and reincarceration. Moreover, what can be viewed as structural considerations, such as supportive relationships, stable accommodation and continuity of care, were the factors making a positive difference to some participants in aiding the transition experience.

Chapter 9: Discussion and implications

9.1 Introduction

This is the first known qualitative study in Australia to focus on the prison-to-community transition experience of prisoners with severe mental illness and co-occurring substance use disorder after repeated short-term imprisonment. The aim of the study was to understand the transition experience, from preparation for release through to 3 months post-release. Specifically, the focus was to understand the needs and challenges of participants during this high-risk time, and the impact of systems and structures on the individual experience of transition. The conceptual framework illustrated that individual dimensions interacted with four components of the structural risk environment (Rhodes, 2009). The theoretical lens of Giddens' (1984) structuration theory was employed to understand the interplay between the individual and structural dimensions for this cohort during transition.

Prior research has established the multiple challenges facing prisoners with severe mental illness during prison-to-community transition, such as poor housing, unemployment, social exclusion, barriers to adequate mental healthcare, and multiple short-term incarceration (Baillargeon et al., 2009; Baillargeon et al., 2010; Hartwell, 2004a, 2010; Kinner, 2006; Weisman, Lamberti, & Price, 2004). There have been few attempts previously to gain an in-depth understanding of the complexity of the prison-to-community experience of this population, particularly in understanding how individuals perceive the influence of systems and structures on their experience. This qualitative study adds rich understanding of the multifaceted dynamics associated with the transition experience by privileging the voice of participants. It highlights the multiple and complex challenges this population face from the perspective of their lived reality and adds weight to previous research calling for reform and development of transition support services (Borzycki & Baldry, 2003; Baldry, 2008; Binswanger et al., 2011; Hartwell 2010; Kinner et al., 2009).

Three themes were developed from the analysis of interviews: "hoping against hope", "adrift in freedom" and "the slippery slope". The experiences of participants in this study were marked by transition from hope to despair. Participants described the many times they left prison as moving from a routine and predictable environment, where they hoped for a better life after release, to an uncertain and unstable existence in the community. On release, the majority began a downward spiral of drug use and offending and drifted away from mental health services. Taken as a whole, the findings highlight three major points about the transition experience of the participants.

First, as “ambivalent agents”, the majority of participants found prison preferable in some ways to the difficulties facing them on release. It was not the case that most of the participants actually preferred prison; rather, there was a complex web of interrelated issues contributing to ambivalence about leaving. The disruptive economic impact and emotional consequences of repeated short-term imprisonment contributed to the ambivalence for participants. Their primary friendships were in prison, yet they wanted what they imagined to be a normal life in the community. After an average of seven incarcerations, participants were suspended between the worlds of prison and the community, with a sense of “non-belonging” in either world.

Second, while it is not suggested that they were innocent bystanders, with no responsibility for their own individual risk behaviour, participants perceived that the systems surrounding them tended to perpetuate and compound the risks related to their mental illness and substance use problems rather than address them. From the findings as a whole and reference to Giddens (1984), it is proposed that risk was “structured” in three important ways for participants. The first indication of the “structuration” of risk was in terms of the system response to technical breaches of parole, with the consequence of short-term incarceration, which had the impact of leading to further entrenchment in the criminal justice system. The second indication was the continuous disruption to mental health continuity of care as a result of multiple short-term episodes of custody. The third indication of the structuration of risk was that despite participants identifying substance use as their main “criminogenic” risk factor, they experienced a lack of access and encouragement to participate in drug treatment programs during transition.

Third, it was apparent that participants negotiated multiple and competing identities. Despite their complex problems, they displayed surprising insight into their needs and risks during transition. In prison, participants described identities associated with their friendship group and their work, whereas the most frequently available identities in the community were of ex-prisoner, criminal and estranged member of a family. Participants also had multiple risk identities during transition. On the one hand, the “risk agenda” (Farrall et al., 2010) positioned them as “a risk” (Stanford, 2010) to public safety; and on the other hand, the multiple structural disadvantages that limited their opportunities and relationships during transition could be viewed as positioning them “at risk” (Stanford, 2010).

Despite hoping for a better life while in prison, post-release, participants were constantly on the edge of relapse and despair, the “slippery slope” of transition. Furthermore, their capacity to engage in utilising the limited support that was available was constrained by the social, economic, policy

and physical “risk environments” surrounding them that undermined their hope, exacerbated their ambivalence and ultimately set them up to fail in their prison-to-community transition.

9.2 The ambivalent agent

Ambivalence characterised the transition experience as a whole. As “ambivalent agents”, participants hoped for a normal life in the community, while at the same time they wanted to remain with their friends in prison. Life in the community that participants imagined and hoped for, was different to what they had experienced in the past, and given their lack of stable accommodation and enduring social disadvantage, was unlikely to match what they were facing in the future. Most participants had a history of repeated short-term incarceration, and they knew from experience that the economic and emotional consequences of the “revolving door” (Howerton et al., 2009) accumulated over time. Participants were suspended between the two worlds of prison and community, with a sense of “non-belonging” and not being able to settle in either world. This analysis supports and builds on Baldry’s notion (2010, p. 261) that short-term prisoners were “neither fully in the community nor fully in the prison” but rather they were “betwixt and between” mainstream community and prison.

A major factor contributing to ambivalence about leaving prison was participants’ experiences of lack of access to adequate housing post-release, with the majority leaving prison to unstable accommodation. In contrast, they perceived accommodation in prison as “stable” and relatively supportive. The acquisition of stable housing is considered a crucial starting point for any successful prison-to-community transition for this population (Baldry et al., 2006; Greenberg et al., 2011). Most of the participants had not experienced continuity and security in their accommodation for many years, if ever; so this was a long-term problem for them, exacerbated each time by their release from prison. While they had very few social and family connections prior to going to prison, over time, repeated episodes of incarceration tended to exacerbate the pressures on any existing family and social ties, leaving them with progressively fewer supports on each release, a scarcity of people to trust or turn to, and nowhere to belong in the community. The findings are consistent with Halsey’s study (2007) that found that for some young men interviewed in prison, “lock-up was narrated as not only a home away from home so much as one’s only home ... where the sparseness, routines and authoritarian ethos nonetheless rate as preferable to life on the outside” (2007, p. 343). While it has been observed that finding prison a “peculiar kind of sanctuary” may be common in prisoners (Halsey, 2007), it has been rarely discussed in the literature. This is possibly because “it could easily be exaggerated and misappropriated that prison is too easy ... that prison should be more punitive” (Howerton et al., 2009, p. 456). This view is contested with the following comment:

This type of sentiment is understandable given that prisoners quickly go from total institutionalization with absolute routine, to life on the outside with no discernible structure and often without a transitional period to prepare them. (Howerton et al., 2009, p. 451)

The provision of secure housing as a single intervention, however, was unlikely to be helpful to participants in the current study. The need for secure housing for participants went beyond just a need for a place to sleep and eat. They indicated that they needed a place to belong, where they felt safe, supported and cared for. The men spoke of their risk of social isolation, in combination with boredom and a lack of meaning and purpose in their lives in the community, after leaving the relatively social environment of prison. It has been suggested that “a house is not a home” and that vulnerable individuals can remain socially isolated and at risk even when housing is provided (Rowe & Baranoski, 2011; Tsai et al., 2012). Many of the participants in the current study found themselves in a lonely world in the community post-release and therefore had a “tolerance” (Howerton et al., 2009) to the idea of returning to prison because it meant they would see their friends again.

Relationships were of central importance to this cohort and prison, despite its drawbacks, was the most socially inclusive environment available to the majority of participants. The men expressed a strong need to interact with peers, and there was a stark contrast between how participants spoke of their sense of belonging to a group of friends in prison and the expression of despair when talking about lack of family support and no home to go to in the community. The feeling of safety and wellbeing provided by secure accommodation has been linked with Giddens’ (1984) concept of “ontological security” by Padgett (2007):

the feeling of wellbeing that arises from a sense of constancy in one’s social and material environment which, in turn, provides a secure platform for identity development and self-actualisation. (p. 1926)

Finding a place to live where they felt comfortable was the first priority for participants in the study, and they indicated that they could not really focus on anything else until that basic need was met. Yet, finding and then maintaining tenancy in suitable accommodation is challenging for this population. People with severe mental illness have a much higher risk of homelessness and housing instability than people without a mental illness (Padgett, 2007). Moreover, several studies have identified that the more complex the needs of the person are in terms of co-occurring disorders, the higher the rates of difficulty in maintaining tenancy, often resulting in evictions (Baldry, Dowse, & Clarence, 2012; Greenberg & Rosenheck, 2010).

The emotional turmoil of repeatedly leaving and returning to prison was prominent for participants in this study and further contributed to ambivalence. Emotional turmoil during transition is an important factor to explore as to whether it has relevance to the high levels of self-harm in this

population (Binswanger et al., 2011). One third of the participants in the current study discussed their suicidal thoughts that had occurred during the transition phase. They described their euphoria on leaving prison, and for some men on release this was followed by a rapid plunge into despair and suicidal thoughts. This is consistent with several studies that found that prisoners frequently have high expectations about their pending life in the community and then experience frustration, disappointment, fear and anxiety on release (Binswanger et al., 2011; Cobbina & Bender, 2012; Howerton et al., 2009; Shinkfield & Graffam, 2010). The emotional response to cycling in and out of prison can be further understood by reference to Giddens (1984, p. 61), who proposed that when accustomed routines are suddenly disrupted with a “critical situation” — for example, leaving the structured environment of prison — responses can include “rapid emotional oscillation between depression and elation” and “a concentration on immediate events and loss of any long term perspectives”, related to the impact of anxiety and fear.

The disruptive impact of repeated short-term imprisonment contributed to ambivalence about leaving prison. Participants described having been unable to fully establish themselves in either prison or the community because they did not settle in either place long enough. When they had made small gains in the community — for example, such as finding accommodation or a job — these positive steps were disrupted, by returning to prison for short periods. Participants expressed frustration after release, associated with needing to continually start again, often having lost their accommodation and any remaining possessions. Ambivalence in short-term prisoners has been found in previous studies and has been understood as being associated with institutionalisation (Baldry et al., 2008; Howerton et al., 2009). Participants in this study could also be viewed as institutionalised (Goffman, 1961), in that they were familiar with the routine of prison and they understood their function and social role in that environment. Institutionalisation also occurs in short-term prisoners, according to Baldry et al. (2008), in a similar way to long-term prisoners, but more like “serial institutionalisation”, from serving repeated short sentences. In the current study, although participants did report difficulties with lack of experience, confidence and skills for living in the community, the major factors impacting on their ambivalence appeared to be their unsettled emotional state and economic problems, including lack of stable accommodation and employment exacerbated by repeated cycling in and out of prison.

This study adds depth to the understanding of ambivalence during prison-to-community transition beyond the concept of institutionalisation. The majority of participants were caught in a cycle of disruptive short-term imprisonment, suspended between the two worlds of prison and community without a home or job to go to. The complex state of ambivalence experienced by participants can be understood by considering the impact of a range of dynamics related to the frustration and

emotional turmoil of repeated short-term imprisonment, as well as being intimately connected with a need for a stable place to live, a sense of belonging and a social network to rely on.

9.3 The “structuration” of risk

It is proposed that individual risk behaviour was “structured” (Giddens, 1984) for the participants in this study. This means that the “risk environment” (Rhodes, 2009), which consisted of a variety of factors separate to the participants, tended to erode the capacity to settle in the community and perpetuated and compounded the risks of relapse and reincarceration. The participants were involved in or on the constant edge of individual risk behaviour that was produced and reproduced in the interplay with the risk environment (Giddens 1984; Rhodes, 2009). For Giddens (1984), “structuration” means that human agency and social structure are in a reciprocal relationship with each other.

The structuration of risk occurred in three main ways. First, technical parole violations such as relapse to drug use, missed parole appointments or mental health related concerns, such as non-compliance with medication, resulted in the disruptive strategy of returning participants to prison for repeated short-term stays. This system response to technical violations of parole had the unintended consequence of disrupting settlement in the community, which in turn increased participants’ risk of remaining entrenched in the criminal justice system. The punishment response to behaviour where participants perceived no new offence had been committed gave them a message of “once a criminal, always a risk” and left no space for recovery. The impact of these practices was to undermine hope to the extent that most of the participants were unable to imagine extracting themselves from ongoing entrenchment in the criminal justice system, and this contributed to the despair that was evident as part of “the slippery slope” back into drug use and risk behaviour.

The risk message operated on two levels. On the one hand, participants were very aware that their cycles of relapse to drug use combined with mental illness and episodes of mostly low level offending behaviour did place them in a situation where they became a legitimate risk to themselves and to community safety. There was a degree of acceptance that the subsequent offending behaviour would be punished. On the other hand, participants conveyed that they continued to receive the message that they were perceived as a risk, even when they had been living in the community and trying to cease their drug use and offending. They expressed that they were constantly at risk of attention from the police and that minor transgressions related to their parole conditions would be punished and they would be sent back to prison. Rhodes (2009, p. 196) makes a link with the iatrogenic effects of surveillance-orientated “carceral drug policy” contributing to a

“cycle of risk production and reproduction”. This occurs, according to Rhodes (2009), as marginalised drug users actively participate and become complicit in their own “structural subordination”, which is reproduced in their interaction with the criminal justice system.

The second example of the structuration of risk was the way that continuity of mental health care was continuously disrupted by repeated short-term incarceration. On the one hand, the chaos participants reported in their lives on return to the community, related to lack of stable housing and unemployment, tended to disrupt any continuity of care that had been achieved through engagement with prison mental health services. The study participants reported adequate mental health support in prison and linkage to community mental health contacts, with attempts by the mental health support workers to facilitate emergency housing needs. However, participants perceived the most basic need for secure stable housing as largely unmet. Those participants who were living on the streets or in the homeless men’s hostel immediately after release, for example, were understandably more concerned with gathering some basic possessions such as clothes and shoes, and finding somewhere safe and secure to live, than they were concerned with attending to their mental healthcare or dealing with their drug dependence. It was not surprising then that mental health care and substance use treatment competed with other priorities, leading participants further into the “slippery slope” of relapse and the risk of reincarceration.

These findings are consistent with those found in an ethnographic study of access to treatment and continuity of care needs of prisoners returning to the community in the United States. Blank (2006, p. 106) identified that while her participants were confronted and frequently overwhelmed with “all of their needs at once” on release from prison, it was the practical considerations of food, clothing and accommodation that came first. It was only once these and other needs such as social contact and support were met, that considerations of treatment for mental illness and substance use disorder were considered. Davis et al. (2013) also found that released prisoners found accessing mental health and substance use treatment post-release was secondary to economic needs such as housing and employment. The participants in this US research, however, had additional problems to their Australian counterparts, due to lack of access to mental health care in prison as well as eligibility for care in the community, related to the different structure of health services (Blank, 2006; Davis et al., 2013).

On the other hand, participants reported that when continuity of care had been achieved on return to the community after previous releases, it was disrupted by return to prison, particularly by short-term incarceration from breach of parole. The majority of participants reported that their mental health and substance use issues were identified in prison rather than in the community, either during

the custodial episode related to the study or during previous imprisonment. Yet for those participants who had then engaged with community mental health supports following previous releases, the process of returning to prison — for example, for drugs detected in a urine sample or non-compliance with reporting requirements — disrupted that connection. This observation is in line with a UK study evaluating the *Care for Offenders: Continuity of Access (COCO) project* (Byng et al., 2012), where the key finding was that “passage through the various elements of the criminal justice system provides both the potential for initial access to healthcare and also the disruption of the existing care” (2012, p. 3). The drift away from mental health services by the participants in the current study further supports the increasing concern in the literature about the complexity of continuity of care between custody and community. For example, a recent study in the United Kingdom found that only 20 of a cohort of 137 prisoners with severe mental illness receiving psychiatric care in prison had been linked to a community mental health team, and only 4 of that 20 had made contact at 6-month follow-up (Lennox et al., 2012). It has been proposed that services that commence in prison and provide continuous care into the community “seem to be the key feature” of successful transition for all forms of health care, according to Kinner (2010, p. 1555). However, it is also clear from the literature and the findings from this study that the problems encountered by this population during prison-to-community transition extend beyond the need for mental health treatment in prison and linkage to community mental health supports.

Finally, the lack of availability and access to substance use treatment for participants in this study, despite the centrality of drug and alcohol use to their offending, is the most important indication of the structuration of risk identified in this study. All participants were diagnosed with co-occurring substance use disorders, and all of them identified substance use as their greatest risk factor for remaining involved with the criminal justice system and for undermining their hope for a normal life. This is consistent with the results of a mixed method study involving 39 male prisoners about to be released and then followed up post-release, including data from their (ex) partners. Souza, Lösel, Markson, and Lanskey (2013) found pre-release expectations in relation to drug use significantly predicted post-release difficulties. It was concerning, therefore, that despite recognition of the problem by participants, one of the most outstanding unmet needs reported by them was the striking absence of interventions to address their substance use problems.

Five important points in relation to this finding were identified from exploring the experience of drug and alcohol treatment and rehabilitation with participants. First, there was little evidence in the interviews with participants of drug and alcohol education, motivational counselling or treatment either in prison, post-release or during the transition phase. Reasons given by the participants were partly related to ineligibility for them to participate in programs as short-term prisoners, and partly

related to their perception of the lack of availability and integration of services between prison and the community. Second, according to several participants, there was no opioid replacement program in prison. Those who described positive results from this treatment during previous releases explained that they faced a gap between leaving prison and re-enrolling in the program, which they perceived as greatly increasing their risk of relapse. Third, participants who wanted to make the direct transition to drug rehabilitation described waiting in the community post-release for a bed to become available, exposing them in the interim to what they perceived as unsafe environments in terms of drug availability, such as the homeless men's hostel. This suggests that there may be insufficient liaison between the prison and local drug rehabilitation programs. Fourth, those participants who had not been exposed to drug and alcohol rehabilitation in the community filled the gaps in their experience by imagining that rehabilitation would be "just like jail" or just like "going to church", neither of which were attractive options for them. Participants reported that they were not exposed to any information or experience during transition that challenged their beliefs about drug rehabilitation centres. Fifth, those participants previously enrolled in drug rehabilitation but expelled for reportedly minor transgressions were reluctant to try again. There was no indication that any of these participants had been approached to reconsider drug rehabilitation after prison.

These findings of the apparent lack of availability and access to substance use treatment, despite its centrality to offending behaviour in this population, is consistent with the literature discussing the lack of prison and post-release alcohol and drug services for this population during transition (Baldry et al., 2012; Hartwell, 2004a, 2004b; Lurigio, 2011). Psychiatric symptoms are often complicated by substance use and it is imperative that this population receive appropriate alcohol and drug treatment. Treating one problem without the other has been found to be less effective than treating both simultaneously (Thylstrup & Johansen, 2009; Wilson, Draine, Barringer, Hadley, & Evans, 2013). Little attention has been paid in the literature to the more subtle dynamics that appear to impact on the men's reluctance to engage with drug rehabilitation providers; for example, beliefs about what drug rehabilitation would be like, and the reluctance to "try again" after previous negative experiences. The stories of participants in this study indicate that interventions addressing beliefs about drug rehabilitation and facilitating exposure to an alternative view of these programs is likely to be an important strategy when focusing on recovery and criminogenic risk. The findings in this study raise important concerns in terms of whether the known community safety or the recovery benefits of drug treatment are being realised in the current context as a result of lack of access, lack of integrated services and lack of strategies to motivate and encourage participation.

9.4 Competing identities

Participants in this study negotiated multiple and competing identities during prison-to-community transition that had the impact of constraining their agency during this process. Participants perceived themselves as having little control over their circumstances, due to their individual limitations, their mental health and substance use problems, and their lack of experience of successfully living in the community. At the same time, the systems surrounding participants appeared to further constrain their sense of control over their lives by failing to provide adequate opportunities to find positive identities and a sense of belonging in the community.

Despite their complex psychological and social problems, the majority of participants in this study showed insight into their own needs during transition, even when they knew from previous experience that only limited support was available to them. They were also able to articulate the risks associated with returning to contexts and settings that were similar to the previous times they had left prison. As such, one of the identities that can be ascribed to participants in this study is similar to Giddens' (1984) "knowledgeable agents", "who know a great deal about the conditions and consequences of what they do in their day to day lives" (p. 281). As "knowledgeable agents", participants were aware of the multiple benefits they had experienced from employment in the past, and linked their lack of access to employment during transition to self-identified risk factors for drug use, boredom and social isolation. Participants also conveyed the importance of work in terms of a positive identity that they had experienced from work, both inside prison and previously in the community. Despite their problems, participants had previously worked in a range of employment settings, including roles that required some technical knowledge. They associated their work role with regularity, obligations, stability and a sense of identity and pride. The role of employment for participants can be further understood in terms of Giddens' (1984) concept of "position-practice", which refers to the idea that certain behaviours are expected appropriate to a role:

Social identities, and ... position-practice relations ... are...associated with normative rights, obligations and sanctions which, within specific collectivities, form roles. (pp. 282–283)

Consistent with Giddens' (1984, p. 86) ideas on social identity and role, which he linked to routines, trust and a sense of security, the positive impact of work or meaningful activity has been identified as a strongly protective factor for people with a severe mental illness and for the general prisoner population (Drake et al., 2008; Graffam et al., 2008; Latessa, 2012; La Vigne et al., 2009; Waghorn, 2009). Yet there is evidence that people leaving prison both with and without severe mental illness experience high levels of unemployment and difficulty in finding a job. In addition, research has established that without stable housing and family networks, the prospect of finding

employment is negligible without considerable support (Borzycki & Baldry, 2003; Graffam et al., 2008; Graffam et al., 2005; Visher et al., 2005). Highly supported work opportunities clearly have the potential to offer this population new roles, responsibilities and social identities (Slade, 2009).

Agency was further constrained for participants because they were negotiating competing risk identities during transition. On the one hand, participants were positioned as “a risk” (Stanford, 2010) to public safety, and non-compliance with the rules of parole and relapse to drug use was viewed as evidence of continued deviance (Wolff, Frueh et al., 2013). Participants demonstrated insight in that they recognised that at certain times, such as when they were using substances, they were “a risk” to themselves, other people and property. Indeed, the majority of participants in this study would be categorised as at “high risk” of recidivism, according to the criteria developed by Andrews and Bonta (2010), which views substance use as a key criminogenic risk factor. Participants also spoke of other behaviours that would fit criminogenic risk criteria, such as being caught in a criminal life, having more friends in jail than outside, being disengaged from family, and being unemployed. The consequence of the “risk agenda” (Farrall et al., 2010) operating in the criminal justice system, however, was to support interventions that repeatedly returned them to prison for short periods of time, with no apparent gain in the view of participants. This was demonstrated by accounts of multiple breaches of parole when no new offence had occurred, resulting in repeated, disruptive, short-term prison stays.

On the other hand, multiple structural and chronic disadvantage limited participants’ opportunities and relationships during transition. This could be viewed as positioning individuals as primarily “at risk” (Stanford, 2010). Participants in this study were “at risk” of multiple complex and interrelated problems, such as social isolation, suicide, homelessness, enduring unemployment, and continuing involvement in the criminal justice system. While recognition of this population as “at risk” (Stanford, 2010) is important in addressing social disadvantage, a purely deterministic view is in danger of minimising individual agency and the development of elements of recovery that were important to participants in this study, such as hope, belonging, and identity. Participants were not entirely without agency. They actively and knowingly participated in risk behaviour, yet their agency was constrained by the rules, resources and lack of opportunity within the structural risk environment. Hence, the responsibility for transition can be seen as shared between individuals and the systems surrounding them.

Relationships were important in terms of identity and wellbeing for this cohort. The men were clear that they had a strong need to interact with peers whom they trusted and there was a sense of loss of identity as a member of a social network when they left prison. They identified with and relied on

their friends in prison; however, they knew that their wellbeing depended on staying away from these friends. In contrast, when participants returned to the community, they struggled to survive without family support and friends, and the most frequently described identities available to them in terms of relationships were as estranged members of their family or as an absent father to their children. According to Slade (2009), close relationships are vital in that they shape identity, contribute to wellbeing and promote hope. The irony for participants was that their friends in prison were often their most trusted peers, yet they recognised that these relationships were one of the factors that put them most at risk in terms of relapse to drug use and crime in the community. Participants needed connection with people that they trusted and in the absence of family and friends, they were in a double bind of either being with their friends in prison or avoiding their ex-prisoner friends in the community, leaving them very isolated. Wolff and Draine (2004) observed that when prisoners identify more with the norms of prison culture, rather than with their family or other community supports, it is likely to impact on social networks and affect the stock of social capital available on transition to the community.

9.5 Implications for theory

The conceptual framework utilised in this study facilitated an understanding of how the structural risk environment constrained individual agency, but at the same time was a product and adaptation of agency. Moreover, it highlighted how the political, social, policy and prison risk environments produced and reproduced individual risk behaviour in a reciprocal relationship. This lens encourages a new way to conceptualise the prison-to-community transition experience, and indicates a need for a shared responsibility between individuals and the systems supporting them during transition.

It was apparent in this study that individual risk factors were interrelated with and compounded by structural and systemic constraints. The men in the study were both knowledgeable and active participants in terms of their individual risk behaviours, as well as subject to their position in the systems, structures and risk environments surrounding them. The literature revealed a polarised view of the impact of individual factors versus social and structural factors, on the barriers and obstacles facing people in prison-to-community transition. The tension between agency and structure remains current in the sociology literature, alongside the corresponding debate about the impact of individual or environmental influences in public health. A similar tension is played out across the literature discussing the prison-to-community transition experience, where there are polarised views that either emphasise the individual factors impacting on the transition experience or place emphasis on structural factors (LeBel et al., 2008). Williams and Popay (1998) note:

the existence of an unhelpful dichotomy in which either everything is blamed on the system, or everything is blamed on the subject. Whilst the first view tends to operate according to the assumption “subject good, system bad”, the second view tends to locate responsibility for social deprivation firmly at the door of the “fallen” and corruptible subject. (p. 157)

Baldry and Maplestone (2003, p. 1) comment that prisoners and ex-prisoners “have been treated as if their problems were entirely due to individual failings and pathologies and the remedies have been equally based on individual treatments and crisis interventions”. Travis (2005) has argued that this approach promotes acceptance of a punishment model with the assumption that the criminal justice system has no responsibility for the experience or behaviour of the ex-prisoner post release, beyond the role of supervision (Austin, 2001). An alternative premise suggests that there are primarily systemic or structural factors impacting on this population, suggesting a responsibility for the “system” to provide support and intervention during the transition phase. However, this approach has been criticised as underplaying the role of agency and the potential and capacity for action of people who are engaging in risk behaviours (Fitzgerald, 2009).

Structural features and systemic constraints related to the physical risk environment impacted on individual agency in this study. The prison and post-prison risk environments contributed to undermining confidence about managing in the community, leading to ambivalence, loss of hope, and despair. Participants were both enabled by their knowledge of their needs during transition, as well as constrained by their individual limitations, particularly those related to their complex mental health and substance use problems. The impact of institutionalisation, in combination with anxiety about being able to build a life in the community with limited material and social support, meant that participants were “prison tolerant” (Howerton et al., 2009). They were ambivalent about leaving prison and returned with a sense of inevitability that at least it was time out from the hardships of community living.

The “structuration” of risk for participants in this study can be partially understood by the interplay between individual risk behaviour and the political/macroeconomic risk environment. There was little evidence that the systems surrounding participants in the study were creating an enabling environment for positive change and hope for a different future. Nor did the systems appear to be operating from a place of understanding of the context of the individual risk behaviours and how environments can structure risk. Participants perceived that they were viewed as “once a criminal, always a risk”, with the implication that they were entirely “choosing to commit crime” (Fenton, 2012). As such, they were held entirely responsible for their own behaviour, and the system response was to punish them for their risk behaviour. This approach is consistent with a neo-liberal philosophy, according to Kemshall (2010) and Fenton (2012), who have been highly critical of political agendas driven by “law and order” concerns at the expense of a welfare response.

Similarly, the interplay between individual risk behaviour and the social/cultural risk environment was apparent in this study. For example, participants reported self-medicating with substances during their teenage years in the context of dealing with their undiagnosed mental health problems, frequently in environments of family breakdown and highly unstable circumstances. The notion that individuals can “embody” their oppression and the impact of “structural violence”, resulting in oppression illness which they medicate by drug use, has been discussed by Rhodes (2009). As adults, the impact of repeated short-term incarceration meant that participants experienced ongoing “structural violence” in terms of a cluster of poverty, unstable housing, unemployment, social isolation and stigma (Kelly, 2005; Rose & Hatzenbuehler, 2009), which may have contributed to their ongoing drug use and associated risk behaviours. It is clear that the participants in this study experienced low levels of social capital prior to their involvement in the criminal justice system and that the impact of repeated short-term incarceration contributed to a depletion of any social capital that they were able to achieve in their brief periods of living in the community.

In terms of the policy/organisational risk environment, an analysis of the competing paradigms of risk and recovery that are driving contemporary policy and practice for the population being studied is relevant to this discussion. There are compelling reasons for the need to understand the recovery framework in terms of this population in prison-to-community transition. The core notion of hope for a rich and fulfilling life despite complex disability is central to the recovery approach (Anthony, 1993; Deegan, 1988; Slade, 2009). It has been established that hope was prominent for participants in this study. Yet hope remains an elusive, inaccessible and abstract concept that has been under-theorised in the recovery literature, and the relevance of hope has not been explored in the population being studied. This is important, because it has been recognised elsewhere that the values and philosophy of recovery are not shared between the mental health arena and the “penal culture”, where “risk thinking” (Baldry, Brown et al., 2011) pervades. Currie (2013), for example, apologised for discussing the role of hope in criminology theory because it “sounds a little hokey” (p. 8). Epperson et al. (2011) identified that criminal justice staff, when taking a recovery approach with mentally ill prisoners were seen as “soft on crime”, attracting labels such as “hug-a-thug” (p. 29).

Hope is a central concept in the mental health recovery framework, and further conceptualisation of the importance of hope in prison-to-community transition may be assisted by combining knowledge from the criminology literature, which has begun to quantify the extent of hopelessness in this population (Wolff et al., 2013), and the recovery literature, which has built on insight from lived experience about hope (Anthony, 1993; Slade, 2009). The notion, for example, of informal and formal support people, including peer supports taking on the role of “hope carriers” (Darlington &

Bland, 1999) to assist people to “live a good life” (Ward & Stewart, 2003) when they leave prison may be relevant for this cohort in enabling their motivation. Moreover, the centrality of the principles of partnership and mutuality in the relationships between service providers and service users in the recovery framework and the idea that service users need to provide choices rather than solutions to problems, may be important in promoting and strengthening hope in this population (Slade, 2009). This approach is supported by Angell (2014), who suggests that prison-to-community transition programs need to be “relational savvy” (p. 10) in their engagement of people with a mental illness leaving prison, by working side by side with clients and paying attention to providing emotional support and building trust while advocating for resources in the community. There is also increasing focus on the role of hope in the criminal justice setting. For example, Currie (2013) comments on hope in terms of prisoners and ex-prisoners:

Hope is important because in its absence people can feel that what they do or don't do doesn't matter ... [it is] the opposite of the sense of hopelessness, the sense of not giving a damn. (p. 8)

It has been identified in this discussion that participants' hope for recovery was undermined by the message of “once a criminal, always a risk”, which conflicts with a message that recovery is possible despite complex disability associated with mental illness and substance use disorder. While it is essential that there is some reconciliation between the risk and recovery paradigms when considering the population being studied, it is unlikely that the problems of conflicting language and mixed messages can be reconciled by simply combining the two approaches into one framework. Without addressing the issues that have been raised, it is likely to be counter-productive in terms of transition support and lead to paralysis rather than a way forward.

A fully comprehensive recovery-based system of care, incorporating a focus on structural supports, has received virtually no attention in the recovery literature, including for the population leaving prison with co-occurring severe mental illness and substance use disorder. (Hopper, 2007) comments, for example:

Material deprivation is largely ignored [in the recovery literature], although poverty and shabby housing bulk large in the lives of many persons with severe mental illness ... [and] prized prospects like a decent job ... are either disregarded or casually remarked as if their provision were either unproblematic or of lesser concern to individual reclamation projects. (p. 871)

Thus, a new framework needs to challenge and expand both the recovery and risk paradigms, the recovery paradigm in terms of the relative neglect of structural considerations, and the risk paradigm in terms of the relative absence of hope.

A focus on individual risk factors, at the exclusion of social and structural risk environment considerations, combined with “moral panic” about mental illness and offending (Howarth, 2013; Wolff, 2002), obscures a more rational understanding of this population, who are likely to benefit, as this study and the broader literature has indicated, from improved support during transition, potentially addressing both health and social outcomes as well as political “law and order” concerns. This is not to suggest, however, that criminogenic risks do not require assessment and attention. Substance use, for example, is a central, if not the most important risk factor for this cohort (Epperson et al., 2011) both in terms of “a risk” and “at-risk” identities. Paying attention to criminogenic risk factors for people with severe mental illness and criminal justice involvement, beyond the provision of mental health treatment, is receiving considerable attention in the literature, although precisely how this should be approached within the risk-recovery context remains contested (Barrenger & Draine, 2013; Prendergast, Pearson, Podus, Hamilton, & Greenwell, 2013; Roberts & Bell, 2013; Wyder, Bland, & Crompton, 2013)

The interconnectedness of agency and structure as understood in structuration theory (Giddens, 1984) allows movement beyond macro level structural considerations or micro level individual experience and facilitates the development of an expanded understanding of the transition experience in this study. Rather than reducing the experience of transition to social-psychological or deterministic structural factors, it instead gives “proper weight to both structure *and* agency in continuous interaction” (Bottoms et al., 2004, p. 372). If opportunities and adequate social and structural supports had been made available to participants, they could potentially be reconceptualised as capable of knowing what their needs are and achieve some level of recovery despite their complex disabilities. Without significant support and opportunity, however, this population are likely to remain in a cycle of intractable involvement in the criminal justice system, continuing to experience prison as a “peculiar sanctuary” (Halsey, 2007) serving the role of respite, to recuperate from life in the community, before the next attempt at trying to succeed.

9.6 Implications for policy

Knowing is not enough; we must apply. Willing is not enough; we must do.

Johann Wolfgang von Goethe (1749–1832)

The literature examined, supported by the findings in this study, indicate that currently there may be incongruence between the central principles espoused in national policy documents that aim to drive practice in mental health and substance use services in Australia and the experience of prison-to-community transition for people with co-occurring disorders. It is notable that in the national and state mental health policies and standards that promote recovery as a fundamental principle, the

transition support and recovery needs of people with a serious mental illness who are repeatedly cycling in and out of prison do not appear. Mental health policy in Australia is underpinned by the idea that the person with mental illness can hope for a life that is useful, satisfying and meaningful (Anthony, 1993); and that they would be supported by services that meet “individual need” (Commonwealth of Australia, 2010, p. 31) and “achieve the best possible outcome in terms of their recovery” (p. 14). Indeed, the term “recovery” appears “on almost every page” of the *Third National Mental Health Plan* (Australian Health Ministers, 2003), according to Meadows et al. (2012, p. 63), and appears as the first priority in the current *Fourth National Mental Health Plan (2009–2014)* as “Recovery and social inclusion”. The transition support and recovery needs of prisoners with a mental illness are also omitted in a leading Australian community mental health textbook, which has introduced considerable material on recovery in the third edition (Meadows et al., 2012). While recovery principles permeate Australian mental health policy and literature, it would appear that these principles remain rhetoric rather than reality for people with a mental illness who are leaving prison, including those who have committed relatively minor offences attracting short-term imprisonment.

There is also incongruence between the philosophy of harm minimisation espoused in the *Australian National Drug Strategy 2010–2015* (Ministerial Council on Drug Strategy, 2011), with the practice of automatic violation of parole in response to a positive drug screen, which nearly half of the participants in the current study reported. This point is supported by Halsey (2008), who made the following observation regarding his research with juvenile offenders in South Australia who were repeatedly reincarcerated for violating their parole conditions often for minor drug use:

the high rate of recidivism ... should not solely be viewed in terms of the behaviour of risky ... offenders, but instead in the context of risky ... systems of post-release rules and administration to which young men are subjected when trying to start again. (p. 1209)

The principle of harm reduction is to reduce the health, social and economic consequences of drug use without necessarily requiring total abstinence (Hughes, 2004). Given that drug use is illegal in Australia, this presents a policy dilemma in relation to the population being studied. Without making a moral judgement for or against drug use, a more pragmatic approach to this issue is warranted, given the unhelpful consequences of repeated short-term imprisonment from technical violations of parole for the current study participants.

The incongruence between current approaches in relation to the transition support and recovery needs of study participants and national policy can be partially explained by understanding that they are located between two conflicting policy perspectives. The recovery and harm minimisation perspectives appearing in national social policy are based on research evidence and academic

theory, whereas the approaches to risk management discussed in this study are primarily located with a political “law and order” agenda that focusses on crime reduction through punishment. Current approaches to the population being studied would suggest that the later perspective is dominant and the former perspective is largely silent. The challenge is to reconcile these perspectives through careful analysis, in order to meet the complex needs of the population being studied, as well as address community safety concerns.

This study clarifies that increased policy congruence in relation to the population being studied would mean paying attention to both “at risk” and “a risk” identities at both the individual and systems levels. This would mean providing interventions that are based on the belief in the person’s capacity for recovery, despite their multiple and complex problems as well as providing a range of carefully targeted interventions and adequate community supports. Contemporary scholars in the field tend to focus either more strongly on the need for comprehensive community supports for this population (Barrenger & Draine, 2013), or on the need for increased attention to criminogenic risk, while still attempting to embrace the recovery philosophy, but without emphasising structural supports (Osher, 2012; Wolff et al., 2013). The findings in this thesis indicate that attention should be paid to all of these concerns simultaneously, within the context of understanding the complex interplay between risk and recovery and the individual experience and broader social and structural factors.

This study adds weight to the notion that the needs of this population, while intimately related to their complex mental health and substance use problems, extend far beyond the reach of the current approach in Australia of providing mental health services in prison followed by only limited transition support that is largely focussed on community mental health linkage. Study participants in Queensland had relatively good access to mental health services in prison, access that is not always present in other international jurisdictions, according to several studies (Binswanger et al., 2011; Howerton et al., 2009; Lurigio, 2011). Despite this access, participants in the current study experienced similar problems and levels of broader unmet need to their international counterparts on transition (Baillargeon et al., 2009; Cloyes et al., 2010; Hartwell, 2003). The issues during transition in the current study clearly went far beyond the mental health concerns of participants, indicating that the provision of prison mental health services alone, while extremely important, may indeed be making very little positive contribution to the transition experience for this population in Australia.

By conducting an in-depth exploration of the experience of participants during transition, the complex dynamics of continuity of mental health are further highlighted in the Australian context.

While there have been several recent studies in the United States (Davis et al., 2013; Sabbatine, 2008) and the United Kingdom (Byng et al., 2012; Lennox et al., 2012) dealing with continuity of care for this population, these studies have been largely focussed on measuring the extent of the problem rather than focussing on the qualitative experience of participants in order to understand the dynamics that may be impacting on loss of continuity of care. There continue to be outstanding questions as to whether by addressing a holistic range of social stabilisation determinants such as housing, employment and substance use, the continuity of mental health care for this group could be improved.

Nevertheless, there is an urgent need in Australia for a policy approach that supports the growing evidence in the literature for adequate structural and social support during prison-to-community transition, and recognition that a carefully enhanced response has the potential to make a difference to the psychological, social, health and risk outcomes of the population being studied (Duwe, 2013; Lewis et al., 2007; Robst, Constantine, Andel, Boaz, & Howe, 2011). Provision of stable housing to this population would have an impact on the risk of transition to homelessness and begin to address the associated health and social needs associated with the transience of this group. Paying attention to the emotional consequences of the sudden disruption on release from the structured predictable environment of prison to an unstructured environment in the community could potentially be addressed by further attention to staged approaches to transition with a focus on stable accommodation. Stable housing may also assist in stemming the drift away from mental health services post-release if this basic human need is satisfied. “Housing first” models have shown some success with this population, where supportive housing is provided without requiring treatment compliance first (Somers, Rezansoff, Moniruzzaman, Palepu, & Patterson, 2013; Tsemberis, Gulcur, & Nakae, 2004). These models have potential for this population and need to be further investigated.

For many of the participants in this study, being “adrift in freedom” with nothing to do was the precursor to the “slippery slope” back into substance use and prison both during this research and following previous releases. While there are many complexities to the literature, there is a strong consensus that work is important for people with a severe mental illness, including those with a history of offending (Draine & Herman, 2007; Drake, O’Neal, & Wallach, 2008; Frounfelker et al., 2011; Waghorn et al., 2012). Apart from the value of earning an income, which was clearly an important factor for participants in terms of ameliorating poverty, paying for accommodation and food and providing a means to support dependents, employment has been found to promote recovery in mental illness, reduce stigma, increase self-worth, improve prosocial relationships and increase a sense of community (Latessa, 2012; Perkins, Raines, Tschopp, & Warner, 2009).

Studies have identified that returning prisoners tend to rely on networks of friends and family to find employment (Latimer et al., 2006; Visser & Lattimore, 2008; Visser & Travis, 2003), and for those participants who did not have these networks, their employment prospects were negligible. The population in this study, of whom most were without family support, would require highly supported employment programs. Collaborative approaches involving local community support and employment organisations, mental health services and temporary housing programs have had good results with employment for homeless people (Marrone, 2005). Other features of successful employment programs for marginalised people and returning prisoners have used wraparound planning and supports with a focus on the whole person and rapid job entry, rather than extended job preparation training (Latessa, 2012; Marrone, 2005). Assistance to move from prison into immediate employment or meaningful activity would not only provide the multiple benefits of employment such as income and a sense of identity, but also help to mitigate the risks of drug use associated with boredom identified by the study participants.

Participants' stories indicated that the policy and practice related to drug rehabilitation for this cohort was not meeting their needs. More effective approaches to substance use treatment for this population would arguably make a difference to psychological, social, physical and mental health outcomes during transition, as well as addressing the most pressing "criminogenic risk" of substance use. Binswanger, et al. (2011) has advocated for the need to address health and substance related problems during prison-to-community transition to facilitate adherence to parole conditions and access to employment. For more than a decade there has been substantial evidence and strong advocacy in the literature for integrated mental health and substance use programs to improve treatment and support for people with co-occurring disorders during transition, as well as for substance use programs that commence in prison and flow into community programs (Burnett, 2010; Inciardi, 2004; Inciardi, Martin, & Butzin, 2004; Kinner, Lennox et al., 2013; Wolff, Frueh et al., 2013). It is well established that integrated services reduce substance use and improve mental health outcomes, especially when delivered by the same team of providers in prison through to the community during transition. Outcomes have been found in several studies to be enhanced if programs use a multidisciplinary approach (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Chandler, Peters, Field, & Juliano-Bult, 2004; Drake, Mueser, Brunette, & McHugo, 2004; Essock et al., 2006). Additionally, opioid and other related illicit drug substitution programs have strong efficacy in this population, particularly when commenced or continued in prison and maintained during the transition phase (Kinner, Moore, Spittal, & Indig, 2013; Stallwitz & Stöver, 2007; Wickersham, Zahari, Azar, Kamarulzaman, & Altice, 2013). It has been identified that most drug-involved prisoners return to the community without having received substance use treatment

(Taxman, Cropsey, Young, & Wexler, 2007; Taxman, Perdoni, & Harrison, 2007), yet evidence-based treatment programs have consistently demonstrated successful outcomes (Inciardi et al., 2004; Prendergast, Hall, Wexler, Melnick, & Cao, 2004; Taxman, Perdoni et al., 2007).

The provision of wrap-around family support, aimed at addressing family unification where possible and appropriate, would begin to address issues of social isolation and the risk of enduring intergenerational family estrangement in the population being studied (Mezey et al., 2010). Although no comprehensive studies were located on the role and impact of social and family supports in the transition from prison for people with mental illness (Hartwell, 2012), evidence from studies in the mental health and psychology literature suggest that social support can buffer stress and trauma, reduce strain and impact on environmental stability (Listwan, 2010). Further research is required to explore the nature and extent of social support that would assist in the transition of this population in the Australian context (Siskind, Harris, Buckingham, Pirkis, & Whiteford, 2012).

Review and reconsideration of parole policies in terms of people with co-occurring disorders and a history of repeated short-term imprisonment is required in order to reduce repeated short-term imprisonment for this population, particularly when no new offence has been committed. It has been acknowledged in the literature that parolees with severe mental illness and co-occurring substance use disorders have a range of differing needs from those without mental illness, and require specialised supervision that includes mental health treatment, assistance in complying with conditions of parole, and extra attention for their substance use problems (Epperson et al., 2011; Skeem et al., 2003; Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2009). It has also been proposed by Lurigio (2011) that technical violations of parole by people with a mental illness should trigger a medication review and consideration of interventions such as relapse prevention, rather than return to prison. A firm but fair approach and collaborative problem solving, rather than threats of revocation of parole, have been found in several studies to be more effective strategies for people with a mental illness and criminal justice involvement (Epperson, Canada, Thompson, & Lurigio, 2014; Lurigio, Epperson, Canada, & Babchuk, 2012; Skeem et al., 2003; Skeem et al., 2009).

9.7 Implications for practice

Practitioners can have an important impact on the transition experience of this population, even though it is recognised that practice is bounded to a great extent by policy and funding decisions. Participants consistently conveyed their need for supportive relationships, and in the absence of family and friends they relied on the social bonds that were forged in prison. A relational approach is central to the recovery framework where there is an awareness that recovery happens within the

context of relationships (Slade, 2009). Belief that the person can live a meaningful life, despite their mental illness, addiction problems and criminal history, has the potential to foster genuine hope and the possibility of the development of goals and pathways towards a sustainable life in the community. Davis et al. (2013) found that the quality of the relationships between staff and people with severe mental illness who were difficult to engage was central to maintaining contact and improving continuity of care. This notion is supported by Wolff et al. (2013, p. 7), who recently suggested that the philosophical orientation taken towards prisoners and ex-prisoners with mental illness, including a focus on recovery, is more relevant to outcomes than any other specific intervention.

While it has been argued that the main focus for this population needs to be on structural supports, the interrelatedness of agency and structure has also been discussed. Hence, individual strategies routinely used in mental health services may have potential for this population and need to be further explored, such as motivational interviewing, shared decision making, problem-solving techniques and relapse prevention programs (Rosenberg & Rosenberg, 2013, p. 10).

In this study, there was little sense of participants being surrounded by people who believed in them, other than their friends in prison. Research has indicated that mental health staff can exhibit a “culture of low expectations” (Happell, Scott, Platania-Phung, & Nankivell, 2012) in terms of expectations of people with a mental illness, including their capacity to form positive relationships (Slade, 2009). Further, it has been suggested that rehabilitation frameworks within the correctional contexts can have low expectations of this population and:

trains vulnerable people to navigate what are often chronically marginalised lives and stunted opportunities [aiming] at best for relatively minor changes to what are very often deeply disadvantaged, stressed and troubled lives. (Currie, 2013, p. 6)

It is not uncommon for people with severe mental illness to report having no friends (Davidson et al., 2001) and to feel hopeless (Darlington & Bland, 1999). There were few “hope carriers” (Darlington & Bland, 1999, p. 22) for participants in this study, especially as they drifted away from positive mental health supports after release. Given the majority of participants in this study reported an absence or gradual loss of family engagement, the role of service providers as “hope carriers” and to facilitate positive socialisation (Listwan, 2010) is an important component of transition support. It has been found that expectations can improve markedly when workers see improvements as a result of their positive and proactive interventions (Sommer, Lunt, Rogers, Poole, & Singham, 2012).

Peer support models are developing high levels of efficacy in mental health settings by reducing social isolation and increasing hope and confidence for recovery (Davidson et al., 1999; Moran et al., 2012; Solomon, 2004). Blank (2006, p. 88) points out, however, that there is tension in the idea of peer support models within the criminal justice system, as criminal associations are discouraged because they may facilitate future criminal involvement. Little attention has been paid to this approach with the population being studied, and the potential for peer support models in this context needs to be further explored.

This thesis supports the need for the reconciliation of the competing and conflicting paradigms of risk and recovery in order to advance the provision of transition support services to this population, and more effectively support the transition process. There needs to be recognition of the importance of risk assessment and management using a collaborative approach between the consumer and the practitioner, while at the same time promoting and supporting choices where possible. Self-determination needs to be encouraged, unless there are carefully considered and persuasive risk related grounds to the contrary. Attention needs to be paid to the importance of human dignity and that human needs are attended to, even in a restricted environment (Coffey, 2006; Simpson & Penney, 2011). Transition support services have the opportunity to move beyond some of the polarisations that have been identified in this discussion, to open the way for hope and recovery for the cohort in this study.

In light of the above discussion, there is an urgent need to develop an approach that more closely resembles the evidence in the field to address the needs of this population during prison-to-community transition. A shared responsibility for collaborative planning at both the whole-of-government policy level and practice level, involving all stakeholders potentially involved in transition support, is indicated in order to explore and resolve the existing tensions and contradictions inherent in the provision of these services (Eppersen et al., 2011; Borzycki, 2005; Borzycki & Baldry, 2003). Planning needs to start by acknowledging that the “goals of punishment and rehabilitation are not necessarily compatible” (Miller et al., 2010), and by identifying the inevitable tensions between “care and control” (Telfer, 2000) that impacted on the transition experience of the men in this study. Collaborative planning and the development of clear policies and standards to guide practice will require consensus about identified problems and solutions in order to enhance successful implementation. While further research investigating cost-effective and evidence-based interventions to support transition for this population is required, there is substantial opportunity for progress using existing knowledge and understanding in order to move transition support services closer towards meeting the needs of the population in this study.

9.8 Strengths and limitations of this study

Undertaking this research presented a range of ethical and logistical challenges, which may account for why so few studies of this population have been carried out in Australia and internationally. Difficulties encountered in this research included: gaining approval to record interviews inside prison, physical access to prisons, interviewing participants inside prison, and follow-up of participants post-release. Despite these challenges, a total of 38 interviews were conducted with 18 participants who fulfilled the selection criteria. A repeated in-depth interview design was utilised to facilitate a fuller understanding than would have been possible with a cross-sectional study. Although the sample for this study was modest, limiting the findings in terms of generalisability, the qualitative research design facilitated an in-depth analysis of the complexity of the transition experience for this cohort that supports and extends the existing knowledge and understanding of this population in Queensland.

The sample was recruited using purposive sampling from one prison mental health program that the researcher had been involved in developing. Nevertheless, it is the first study of its kind in Australia, and represents a start to qualitative exploration of this population in this setting. The bias in the sample selection is unknown, both in terms of whom the clinicians approached to participate, given that one of the criteria was being considered “well enough” to take part in the research and what motivated the men to participate, as opposed to those who refused participation. This raises questions about whether the sample was typical in terms of the target population. The sample may be skewed by participants with a particular experience or motivation for participating in the research, although this is unknown. Nonetheless, the consistency of responses from participants and the strong themes that emerged strengthens confidence that the findings in this study will increase understanding about the transition experience of this cohort. The value of the understanding needs to be further explored in qualitative research with a larger, potentially more diverse sample, with particular attention on mechanisms to improve longer-term follow-up.

One of the limitations in the data was the loss of follow-up of participants for the second and third interviews. This is common for longitudinal studies with this population (Kinner et al., 2013; Shinkfield & Graffam, 2009; Visher & Travis, 2003) and has been explained in terms of itinerancy post-release, as well as research participants wanting little to do with anyone involved in the correctional system once they were free (Howerton et al., 2007). The development of a written agreement with the non-government agency funded to provide follow-up care to this cohort assisted in locating some of the participants who were interviewed post-release. Information about the suspected whereabouts of other participants who could not be located was also provided. Given that recovery in mental health and substance use and desistance from criminal involvement is frequently

understood as an iterative process (Slade, 2009), the brief contact with participants in this study cannot reliably predict or gauge the outcomes for participants, even in the relatively short term. The intention, however, was to explore the transition experience as reported by participants at the time of the interviews, and this aim was largely achieved.

9.9 Future research

There has been little research on the prison-to-community transition experience of this population in Australia. It is unclear exactly how many prisoners are released in Queensland or Australia each year and what proportion of released prisoners have a severe mental illness. Data remain scarce on the post-release health, mental health, substance use and social circumstances of this population. High quality, reliable data are required to further understand the dynamics that are impacting on the transition experience, in order to facilitate evidence-based planning of transition support services. A larger, more diverse sample with increased attention to follow-up processes would facilitate greater understanding. Kinner et al. (2013), for example, have combined longitudinal research with record linkage, and this method may prove useful in future research on prison-to-community transition. In addition, little is known or understood about the prevalence data or problems associated with mental illness or comorbidity in the parole population in Australia, and both quantitative and qualitative research would be beneficial to assist in understanding any unique dynamics operating in this context and whether there are reasonable alternatives to the immediate return to prison for technical violations of parole in this population, for example.

One of the major limitations in this study was the retention of research participants. Attrition of research participants post-release has been frequently reported as a common problem for researchers in the field (Kinner et al., 2013; Shinkfield & Graffam, 2009; Visher & Travis, 2003). It has been hypothesised in this thesis and elsewhere that this may be occurring due to complex interrelated reasons including the broader impact of social exclusion, itinerant and chaotic lifestyle post release, lack of anchors in the community such as housing and employment and the desire to cut ties with anyone associated with the criminal justice system. Hence a major challenge for future research is to investigate mechanisms to retain participants in research projects with this population, particularly post release, in order to gain further insight into the dynamics of social exclusion during the transition phase, that are potentially the same factors excluding them from the research. One approach could include qualitative research involving ex-prisoners who remain in contact with agencies, as well as with staff working in the field, to specifically investigate reasons for the attrition and to generate strategies for remaining engaged with newly released prisoners.

Large gaps remain in the knowledge of the nature and extent of social support that would benefit the transition experience for this population, and this area requires considerable research attention in the Australian context. There are a range of evidence-based interventions that have been discussed in this thesis and careful selection and implementation followed by rigorous evaluation studies are required to ascertain their suitability to the Australian environment. It was identified in Chapter 3 that there has been more research on the prison-to-community transition experience of women in Australia than with people with severe mental illness and some of the findings on women may be usefully applied to the later population. To determine this will require careful investigation.

The role of families for individuals with severe mental illness both prior to and after incarceration is under-researched (Visher & Travis, 2003). Peer support models show potential in other similar populations particularly where family support is scarce (Moran et al., 2012) and need to be investigated. Direct transition to supportive housing and employment has been shown to improve outcomes for both mentally ill and non-mentally released prisoners, and these interventions should be trialled in the Queensland setting, including research on the cost effectiveness of these approaches in comparison to repeated short-term imprisonment.

The direct impact on the target population of parole policy and practice, such as immediate revocation of parole and return to prison in response to minor drug use, or for breach of regulations such as failing to notify change of address or failing to attend appointments, requires further research. Mixed method investigation to analyse the extent of incarcerations for people with severe mental illness related to parole breaches in comparison to their non-mentally ill counterparts, the specific reasons for the breach and the perception of parolees and parole staff would provide further insight into the impact of these practices on the transition experience.

It has been identified in this thesis that the almost complete absence of appropriately targeted, integrated mental health and alcohol and drug services available to this population is a significant barrier to successful transition. Qualitative work needs to be undertaken both with the target group and service providers to investigate barriers and facilitators to service provision in this arena. Paying attention to criminogenic risk factors for people with severe mental illness and criminal justice involvement is receiving considerable attention in the literature; however, precisely how this should be approached within the risk-recovery context remains unclear and requires further careful investigation.

9.10 Conclusion

This research has provided a deep understanding and a rich insight into the prison-to-community transition experience from the perspective of men with multiple and complex mental health and

substance use problems leaving prison in Queensland after short-term incarceration. Despite the fact that participants engaged in risk behaviour, they strongly expressed hope for a normal life. Participants perceived that the current approach to the provision of support was inadequate to meet their needs and was in many ways working against their recovery and successful transition into the community. Hence, participants were hoping against hope for a normal life as they imagined it to be. It was apparent from participant accounts that prison mental health services were providing adequate treatment and support in prison and initial linking of participants into community-based services. Yet it was clear from the study that the provision of mental health services alone was manifestly insufficient in addressing the complex needs of this population, and a significantly more enhanced response was required. The conceptual framework facilitated an understanding of how the political, social, policy and prison risk environments produced and reproduced individual risk behaviour in a reciprocal relationship and encourages a new way to conceptualise the transition experience, indicating a need for a shared responsibility between individuals and the systems supporting them. The challenge is for a whole-of-government approach to reconsider policies related to structural support, as well as sentencing and parole management strategies that enable the opportunity for this population to establish themselves in the community without the disruptive impact of repeated short-term imprisonment, while still holding them accountable for their offending behaviour. Consideration must be given to the provision of interventions, including stable supportive housing and direct transition to employment, to provide the best opportunity to settle in the community and remain engaged with treatment and support services. The provision of comprehensive integrated support and treatment services during transition, particularly focussing on enhanced substance use programs that specifically target the individual needs of this population are essential evidence-based strategies (Baillargeon et al., 2010; Barrenger & Draine, 2013). Together, these initiatives would provide this population with the best chance of realising their hope for a normal life, provide them with an opportunity to develop a stake in the community, while at the same time potentially addressing community safety issues.

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Appendix A: Participant information sheet



The School of Social Work
and Human Services
Head of School
Professor Howard Karger
Deputy Head of School
Dr Rose Melville
CRICOS PROVIDER NUMBER: 000269

INFORMATION for PARTICIPANTS

Back on Track : A study of the transition from custody to community for people with a mental illness

Who is doing the study ?

Michelle Denton is a Registered Nurse and a service manager who works for Queensland Health. She is involved in the management of mental health services for people who are in contact with the criminal justice system. She is also a student at the University of Queensland undertaking this research as part of her PhD. Michelle is interested in talking with people about their experience of leaving custody and returning to the community so that she can better understand this experience and use this information to suggest ways of improving services.

What is the study about ?

The study is about the experiences that people have when they leave prison and return to the community. For example you would be asked about: what are you planning to do when you get out; what sort of services and support you think you need; what helped and what were the challenges when you went back into the community. You won't be asked any personal questions or about why you were in prison.

What will I be asked to do?

The study involves talking to the researcher 3 times. Once before you leave the centre, about a week after you are released and then in 3 months time to see how you are going. Agreeing to speak with the researcher the first time while you are in prison does not mean you agree to speak to her again in the community. You will be asked again whether you are willing to talk to her. The interviews will take about 1 hour but you can stop at any time.

What are my rights if I decide to participate?

Information you provide will be confidential and will be identified by a number only. No names will be used. The information you provide will only be accessible to the researcher involved in the study, or if necessary those involved in your medical treatment. The information will be stored on a computer protected by a password and in a locked filing cabinet in a Queensland Health Building. Access to both will be limited to the researcher and her supervisors from the University of Queensland. You have the right to choose not to take part in the study and can withdraw any time. Your usual or requested treatment will not be affected by your decision.

This study has been cleared by one of the human ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council's guidelines. You are of course, free to discuss your participation in this study with the researcher on 32718729. If you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Officer on 3365 3924.

Appendix B: Information for clinicians involved in recruitment

RESEARCH PROJECT. Michelle Denton PhD candidate

Information for clinicians. February 2011

Project governance: The study will be undertaken by Michelle Denton, who is a PhD candidate at the University of Queensland. The project has the full support of The Prison Mental Health Service (QH), Queensland Corrective Services and academic supervisors at the University of Queensland. Full ethics approval has been received from each of these institutions.

Design: A repeated interview design will be employed for the study. This will involve interviewing young men with a serious mental illness at three points during their transition from custody (within 8 weeks pre-release, 1–2 weeks post-release and 3 months post-release).

Participants will be recruited through the PMHS transition support service. Participants will include:

- young men age 18–40 years
- diagnosis of a psychotic illness made or confirmed by a psychiatrist while in custody
- diagnosis of a substance use disorder made or confirmed by a psychiatrist while in custody
- assessed by their PMHS psychiatrist as suitable for the study
- current incarceration is expected to be less than 12 months duration
- currently incarcerated in the Brisbane area.

Exclusion criteria:

- assessed as not suitable for the study by the PMHS psychiatrist due to mental health status or risk
- identified by their psychiatrist as having intellectual or cognitive impairment
- assessed by their psychiatrist as lacking the capacity to give informed consent or are too unwell to participate
- identify as Indigenous
- do not speak English.

Location: It is anticipated that the centres involved in the study will be AGCC, Woodford CC, BCC and Wolston CC.

Data collection: Data will be collected in three face-to-face interviews with each participant during the transition phase. Only the first interview will take place in custody. The second and third interviews will be undertaken in the community.

Approval has been gained from QCS to use a digital recorder to tape the interviews in custody with participants consent.

The health centre within the correctional centre or other designated appropriate confidential area negotiated with QCS and PMHS staff would be the preference for the first interview in custody in order to ensure privacy and confidentiality for the participant.

It is estimated the interviews will take between 20 mins–80 mins (anticipated average time 40 minutes).

The interviews will be focussed on participants' experience of community integration. The first interview in custody pre-release will explore plans and preparation made by the individual for post-release. The interviews in the community will explore the post-release experience in detail in relation to what services were accessed, how the services helped, what other services would have been useful and how the participant negotiated these services.

Data analysis: A thematic analysis will be conducted for the purpose of elucidating the dominant themes related to the experience of community reintegration and to understand commonalities and differences among the participants. The findings will be used to make recommendations on further development of transition support services for people with mental illness in Queensland and Australia

Recruitment: Recruitment will begin in **March 2011**. Potential participants will be identified (according to the inclusion criteria) by the TC team.

Step 1: Does this client fit the criteria? (outlined above)

Step 2: TC discuss with psychiatrist the suitability of the identified client for the study (according to mental health status and/or risk)

Step 3: Discuss with client as to whether they are interested in participating in the study

Step 4: If any interest, or uncertain, give information sheet to client.

Step 5 : If the client is interested in participating in the study contact Michelle (3139 7200 / 0413 933 384/ GroupWise). The formal signed consent process occurs in Step 6 and will be negotiated by the researcher if the client expresses interest in participating in the study. It is important to explain to the client that they can withdraw from the process at any point and that this will not affect their PMHS treatment.

Step 6: Organise with Michelle to meet client. Michelle will make a visit and go through study information and seek formal signed consent.

Step 7: Interview one (pre-release) will proceed at this step or later as negotiated.

Appendix C: Consent to participate

CONSENT TO PARTICIPATE

Back on Track : The transition from prison to community for people with a mental illness

RESEARCH PROJECT

NAME OF INVESTIGATOR: Ms Michelle Denton: Principal Investigator, PhD candidate, University of Queensland, Manager Forensic Mental Health Service, Queensland Health. Ph 3271 8729.
michelle_denton@health.qld.gov.au

I, _____ consent to participate in the above project

I understand that my participation in this project involves:

- Participation in interviews and this has been explained to me
- I authorise the investigator to conduct the interviews and collect information referred to above
- I authorise the researcher to audiotape the interview

As a participant in the project I acknowledge that:

- I understand that the project is related to the study of the experience of people with a mental illness when they leave prison and return to the community;
- The risks, inconvenience and discomfort of participating in the study have been explained to me;
- I understand the attached information sheet and the general purpose, methods and demands of the study;
- I understand the project will benefit people with a mental illness leaving custodial settings but that there is no direct benefit for myself;
- I have been informed that I am free to withdraw from the project at any time and to withdraw any information supplied;
- I am satisfied with the explanation given in relation to the project in so far as it affects me and my consent is freely given;
- I am aware that I can obtain overall results of the study;
- I have been informed that the research information obtained from me will be confidential, but that intentions or threats to harm myself or others may be subject to reporting to my doctor
- I have been informed that, according to law, any information that I reveal concerning the protective safety of children is subject to reporting to relevant authorities;
- I agree that the data gathered during the course of this project may be published providing that identifying information is not used,
- I can request that a support person be present at any time during the interviews
- This project has been approved by The University of Queensland Medical Research Ethics Committee (MREC) and The West Morton South Burnett Health Service District Human Research Ethics Committee.

Participant Signature: _____

Date: __/__/____

Witness signature: _____

Date: __/__/____

Witness name: _____

Appendix D: Semi- structured interview guide

INTERVIEW GUIDE

The interviews will be focussed on participants' experience of community integration.

Pre-release interviews will consist of three phases:

Phase 1: Introduction, written and verbal information about the project and consent process.

a) The researcher will explain the project in the following way;

“This is a research project about the experience of people leaving custody and returning to the community. The aim of the research is to determine what experiences people have when they leave custody and to ask you what you think helps or gets in the way. This information will be used to improve ways of providing services. I will be asking you questions about your plans and preparations for returning to the community and then meeting up with you two times after your release to see how you are going.

I would like to interview you before you leave custody if you agree to participate. Agreeing to this interview does not mean you have to agree to the interviews in the community. You are free to withdraw from the study at any time without consequence.

All data is confidential and your name is not stored with it. It is completely voluntary and you do not have to participate. If you choose to participate I will talk with you for about 40 minutes each time we meet. You can choose to leave at any time during the interview, even if you agreed at the start. You can choose not to answer any of the questions. The information provided by you will not have your name attached to it and it cannot be traced to you. There is no penalty for not participating in the interviews. The Information Sheet gives a clear description of the project and sets out the contact details for people responsible for the research.”

If consent is given, signed and witnessed, the first interview will be arranged at a time convenient for custodial and health staff and the participant.

Phase 2: Semi-structured interview (see questions below).

Phase 3: Closure (The individual will be provided the opportunity to ask questions and discuss aspects of the interview with the researcher).

1. Pre-release interview

a) Exploring pre-release preparation and planning, for example:

- Have you talked with anyone about your preparation for release (for example, your PMHS worker community support worker/someone from QCS)? Have you made plans for when you are released, such as:
 - What you will do on the first day of release?
 - Where you are going to live?
 - Where you will get money from?
 - Where you can see a psychiatrist or mental health worker?
 - Where you can get your medication?
 - How you will get around the city?

b) Expectations and plans for post-release, for example:

- Do you have any family or friends who will help you when you are back in the community?
- What do you think will be the biggest challenges when you get back out?
- What sort of help do you think you will need when you leave here?
- Is there anything else that you think would help you in settling down in the community?
- I am trying to understand what it is that helps, or gets in the way of, people settling back into the community. Is there anything else you would like to tell me about that?

2. Post-release interview (within 1–2 weeks)

a) Discussing first day of release, for example:

- What happened on the first day of release?
- Where did you go?
- Was there anything you needed that wasn't available?
- What has been the biggest challenge/ hardest thing you have done since you left?

b) Negotiating and using services after release, for example:

- What services did you use after you left prison?
- How did you know about these services?
- Did the services you used help you with settling back into the community?
- Were there any other services that would have been useful, for example, to help with:
 - finding accommodation or a better place to live?
 - your general health?
 - your mental health or emotional support?

- managing your life?
- finding some training or getting a job?
- working things out with family or friends?
- legal or financial issues?
- Why do you think some people end up back in prison?
- I am trying to understand what it is that helps, or gets in the way of, people settling back into the community. Is there anything else you think I should have asked you about? Or that you would like to tell me?

3. Post-release interview (approximately 3 months)

- What has been happening since you were released from prison?
- What has been the biggest challenge/hardest thing you have done since you left?
- Who have you received help from?
- Are you happy with where you are living?
- What sorts of things do you do during the day?
- Are there other things you would like to be doing?
- Have you used any services since you left prison?
- How did you know about these services?
- Did the services you used help you with settling back into the community?
- Were there any other services that would have been useful?
- What else could services do that would be helpful for people who come out of prison?
- I asked you last time we met “Why do you think some people end up back in prison?” Has your answer changed since last time we talked?
- I am trying to understand what it is that helps, or gets in the way of, people settling back into the community. Is there anything else you think I should have asked you about? Or that you would like to tell me?

Appendix E: Ethics approval



THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form For Experiments On Humans
Including Behavioural Research

Chief Investigator: Ms Michelle Denton

Project Title: Back On Track: Transition From Custody To Community For People With A Serious Mental Illness

Supervisor: Prof Robert Bland, Dr Michele Foster, Dr Edward Hefferman

Co-Investigator(s): None

Department(s): School of Social Work and Human Services

Project Number: 2010001288

Granting Agency/Degree: Queensland Corrective Services, Queensland Health

Duration: 30th November 2012

Comments:

Expedited review on the basis of approval from the Darling Downs West Moreton HSD HREC, dated 06/10/2010.

**Name of responsible Committee:-
Behavioural & Social Sciences Ethical Review Committee**

This project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research* and complies with the regulations governing experimentation on humans.

**Name of Ethics Committee representative:-
Dr Jack Broerse
Chairperson
Behavioural & Social Sciences Ethical Review Committee**

Date

12/10/10

Signature