Koori Prisoner Mental Health and Cognitive Function Study

FINAL REPORT

Prepared for the Department of Justice, Victoria

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The views expressed are those of the authors and do not necessarily represent the policies of opinions of the Department of Human Services or the Government of Victoria.

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PREAMBLE

Article 12(1) of the International Covenant on Economic, Cultural and Social Rights requires governments to "recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." To this end, concern about the wellbeing of the prison population has become an increasingly prominent issue in the criminal justice system, and this is particularly true for Aboriginal and Torres Strait Islander peoples who are over-represented within the criminal justice and prison system. Article 7(1) of the United Nations Declaration on the Rights of Indigenous Peoples[1] states that "Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person" (United Nations, 2007, p. 5). Article 24(2) provides that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right" (p. 9). Moreover the Declaration specifies in Article 24(1) that "Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and *persons with disabilities* in the implementation of this Declaration" (p. 9, italics added).

Research has consistently shown that the estimated rates of mental and cognitive disabilities among prisoners are significantly higher than those in the general population, both internationally and in Australia (Baldry, Dowse, & Clarence, 2011). Addressing the mental health needs of prisoners is important from clinical, ethical (social justice), human rights, and practical (prison management and reducing offending) perspectives (Ogloff, 2002).

With respect to clinical perspectives, prisoners with serious mental illnesses require mental health care to assist them in ameliorating the detrimental effects of the illnesses. From a practical perspective, given the strong link between mental health/cognitive disability and the risk of being incarcerated, addressing prisoners' mental health problems may contribute to a reduction in rates of and time to recidivism (Ogloff, Davis, River, & Ross, 2007; Simpson & Sotiri, 2004). From a social justice perspective, regardless of the offence risk, addressing mental health needs of the offender is their basic human right (Jones et al., 2002).

The issues pertaining to the needs of prisoners with mental illnesses and/or cognitive impairment are amplified for Aboriginal and Torres Strait Islander offenders given their significant overrepresentation in the criminal justice system (Australian Bureau of Statistics,

[1] Australia was one of four nations that voted against adopting the Declaration on the Rights of Indigenous Peoples.

2011), higher rates of recidivism (Allard, 2010), past injustices, and present socio-economic disadvantages. Nonetheless scant empirical attention has been paid to the mental health and cognitive status of Aboriginal and Torres Strait Islander prisoners in Australia. In a review of the mental health needs of prisoners in Australia commissioned by the Commonwealth Department of Health and Ageing, Mullen, Holmquist, and Ogloff (2003) wrote that "*the lack of commensurate mental health information on this population is nothing short of scandalous*" (Mullen, Holmquist, & Ogloff, 2003, p. 35). The need to collect better quality information about prisoner health was identified as an 'immediate priority' in the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (Department of Health and Ageing, 2007).

The Study arose from the policies and priorities articulated by the original Aboriginal Justice Agreement (AJA) released in 2000 to address Koori overrepresentation in the criminal justice system and the expanded AJA2 of 2006.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Project Outline

The Centre for Forensic Behavioural Science at Monash University (CFBS) and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) were engaged by the Department of Justice to examine the mental health, cognitive functioning, and social and emotional wellbeing of Koori prisoners in Victoria. The study arose from the policies and priorities articulated by the original Aboriginal Justice Agreement (AJA) released in 2000 to address Koori overrepresentation in the criminal justice system and the expanded AJA2 of 2006. The study was jointly overseen by Justice Health and the Koori Justice Unit.

A consultancy team comprising Professor James Ogloff, Dr. Karen Adams, Associate Professor Stuart Thomas, Dr Margaret Cutajar (later replaced by Dr. Jenny Patterson) and Mr. Chris Halacas undertook the consultancy. Advice was provided by Mr. Graham Gee (Psychologist), Dr. Ed Heffernan (Psychiatrist and Director, Forensic Mental Health, Queensland) and Ms. Kimina Anderson (Social Worker and Project Manager, Forensic Mental Health, Queensland).

The study was designed in collaboration with the project Steering Committee and a Project Advisory Group, the members of which provided feedback with regards to the design of the study protocols, questionnaire design, data analysis, interpretation of findings, and recommendations.

Aims

The project firstly sought to conduct a thorough assessment of needs from the perspective of Aboriginal and Torres Strait Islander prisoners in Victoria, and secondly, to gain an understanding of the service gaps and needs from the perspective of key stakeholders in Victoria. To this end, the aims of the project were to:

- Identify the Social and Emotional Well-Being (SEWB) strengths and needs of Aboriginal and Torres Strait Islander prisoners, including levels of psychological distress

- Identify the nature and extent of mental illness for Aboriginal and Torres Strait Islander prisoners and their associated needs
- Assess the cognitive functioning of Aboriginal and Torres Strait Islander prisoners and their associated needs
- Identify barriers to accessing services and other potential gaps in meeting identified needs
- Develop recommendations for improving current service systems and clinical practice

Methods

A literature was undertaken to explore previous research that has investigated the mental health, cognitive functioning and social and emotional well-being of Aboriginal and Torres Strait Islander prisoners.

A representative sample of Koori prisoners was interviewed. The questionnaire that was developed drew on concepts of Social and Emotional Wellbeing (SEWB) taken from two previous questionnaires used with Aboriginal and Torres Strait Islander people in Australia, neuropsychological and diagnostic tools and also included demographic questions that would provide a description of the sample. Collateral information on the prisoners who participated in the study was also collected from government databases to enable an exploration of the more complex relationships between SEWB, mental health, substance use and offending.

Interviews with Koori prisoners took place between January 2012 and October 2012. All remanded and sentenced Aboriginal and Torres Strait Islander prisoners from regional and metropolitan prisons Victoria-wide were approached to participate in the study. Aboriginal Wellbeing/Liaison Officers at each prison briefly informed eligible participants of the details of the study. Those prisoners interested in participating in the study then met with the interviewers who provided them with an explanatory statement.

Interviews with prisoners were conducted in teams consisting of a culturally trained mental health clinician and an Aboriginal and Torres Strait Islander research officer. Interviews varied in length from 50-240 minutes, depending on the prisoner's willingness to disclose information and the matters that arose.Key stakeholders were interviewed November and

December 2012 in a semi-structured format over the telephone to gain an understanding of the current service delivery models and gaps in service provision for Aboriginal and Torres Strait Islander prisoners

Main Findings from the Literature Review

- The review revealed that across their lives Aboriginal and Torres Strait Islander prisoners, particularly females, are exposed to high rates of social adversity, trauma and health problems.

- There is limited high quality research regarding the nature and types of mental health and cognitive functioning problems amongst Aboriginal and Torres Strait Islander people in custody. This may be due in part to the lack of culturally validated assessment tools.

- The available literature suggests that Aboriginal and Torres Strait Islander people in custody have high rates of complex mental health and cognitive functioning problems.

- Importantly, the review revealed that the bulk of the literature examined only illness aspects of mental health amongst Aboriginal and Torres Strait Islander people, with little attention given to positive life experiences that may act as protective factors for Aboriginal and Torres Strait Islander people's well-being.

Key Findings from the Study

Phase I: Koori prisoner interviews

A total of 122 Aboriginal and/or Torres Strait Islander prisoners participated in the study (107 males and 15 females). The participation rate was high and the sample obtained is representative of the broader Aboriginal and Torres Strait Islander prisoner population in Victoria. Given the small sample of females, caution must be exercised when considering the results pertaining to women.

The vast majority of participants were born and raised in Victoria. The age range of men was from 19 to 63 years and for women it was 19 to 50 years. The average age of men was 35 years (SD = 10) and for women it was 32 years (SD = 9). Participants were sampled from all prisons except for Beechworth and Tarrengower. Participants had relatively low levels of formal education, with the majority having a year 10 education or less. A small percentage (less than 3%) had obtained a technical trade or university degree.

Male and female sentenced participants had been convicted of a range of offences, with the majority being for crimes involving physical violence. Just over a quarter of men (28%) and one third of women (33%) were on remand at the time of the interview.

Mental illness and substance misuse

With respect to findings pertaining to mental illnesses (excluding substance misuse disorders), 71.7% of men and 92.3% of women had received a lifetime diagnosis of mental illness. The prevalence of all disorders, except psychotic illnesses, for both men and women were found to be significantly greater than what would be expected in a population of non-Aboriginal offenders based on previous research. The rates of all disorder, including psychotic illnesses, were dramatically higher than those found in the general community in Victoria.

For both males and females, the most prevalent illnesses included major depressive episodes and post-traumatic stress disorder (PTSD). Almost half (46%) of women, as compared to 14.7% of men, were found to have met the criteria for PTSD at the time of the interview.

Rates of substance abuse and dependence disorders were greatly over-represented with 92.9% of women and 76% of men found to have a lifetime substance misuse disorder. Most people with mental illnesses had a co-occurring substance misuse disorder.

Cognitive Functioning

With respect to cognitive functioning, none of the participants in the sample were found to have dementia or otherwise be grossly impaired. The level of non-verbal intelligence among participants was found to be roughly equal to other prisoners (mean Performance IQ = 93),

with only 4% of prisoners falling in the borderline IQ range. Almost 12% of participants were found to have some significant executive functioning deficits (e.g., poor decision making, concrete thinking).

Social and Emotional Well-Being

Seven areas of SEWB were evaluated: identification with their Koori community, connectivity with their Koori culture, knowledge about their Koori culture, positive coping, resilience, stressors, and distress. The vast majority of both male and female participants felt connected to their Koori community and culture. Almost two thirds reported having learned about their culture from their family and community. Most felt that they had the knowledge to teach younger members of their family about their culture. Unfortunately, many people felt that their opportunities to practice or live their spirituality were very limited. Many also felt unable to give to their family and friends over the past 12 months. On average, a significant number of participants were found to have had a high level of unmet needs and experienced stress. The majority of participants were found to have a positive level of resilience and more than half of males and 40% of females reported that they have not felt distressed in the past 12 months.

Relationship between Mental Illness and SEWB

Analyses were conducted to assess the extent to which elements of SEWB affected the prevalence of mental illness among participants. Generally speaking, the presence of stressors and distress were related to a higher prevalence of mental illnesses, although the specific relationships were complex. Those with greater levels of resilience were less likely to experience mood disorders (e.g., depression, bipolar disorder) and anxiety disorders (e.g., PTSD, panic disorder) but not psychotic illnesses. Similarly, greater numbers of unmet needs were related to an increased likelihood of having a mood disorder or anxiety disorder, but not psychotic illnesses.

Phase II: Stakeholder Interviews

Does your organisation have an Aboriginal and Torres Strait Islander Health Policy?

Most organisations had a policy or were in the process of developing a relevant policy in this area.

What are the main issues faced by Koori individuals when coming into prison?

A number of issues were identified including displacement, intergenerational trauma and grief, substance misuse and withdrawal, isolation from their country and mob. It was noted that many Koori prisoners have a distrust of the "system" and those who work in it. There is a lower level of engagement among Koori prisoners than that which is seen for most other prisoners. Stakeholders noted the presence of racism in the prisons and a lack of cultural awareness or planning. Also noted was a lack of integrated planning and communication between Koori-specific and mainstream services.

What are the main issues that impact on mental illness, cognitive functioning and social and emotional wellbeing for Koori men and women in prison?

It was believed that guilt and shame associated with crime and incarceration impacts prisoners' mental state and SEWB. Some Koori prisoners also demonstrate a lack of understanding of the importance of some health related behaviours. It was also noted that some Koori prisoners exhibit a degree of defensiveness that stems from negative experiences with non-Indigenous Australians. Factors such as frequent prisoner transfers and the over-assessment and relative under-treatment of Koori prisoners were reported to have detrimental effects. Moreover, Koori prisoners often have chaotic family lives, lack some skills, and experience feelings of hopeless about future opportunities.

What are the main barriers to Social Emotional Wellbeing and mental health service access for Koori men and women in prison, including transition services?

A lack of trust among Koori prisoners, a lack of interagency communication, and the time limited nature of services were all noted to impede mental health service access. It was reported that movement of prisoners can make follow-up and continuity of care difficult or impossible. There are long waiting lists for services and too many steps in the referral process before people actually make contact with a service provider. There are limited places in Koori-specific programs and they are not found in all prisons.

What are the main barriers to Social Emotional Wellbeing and mental health service delivery for Koori men and women in prison, including transition services?

A lack of understanding and training amongst professionals in Aboriginal mental health was identified; this is compounded by a lack of Koori mental health workers. The current model of mental health care provided in prisons is not embedded within a culturally sensitive context and may not be meaningful to Koori people. There is poor continuity of treatment from community to prison and back (i.e., frequent changes to medication regime, lack of communication between services). Adding to feelings of mistrust previously identified, the insufficient time available to develop professional relationships and rapport are seen as challenging. The pre- and post-release funding model is seen as too rigid and often results in an inaccurate assessment of prisoners needs. Significant concerns were raised relating to the lack of follow-up services upon release, raising the need for more preparation around post-release planning which should commence much earlier.

What works in the existing service delivery system?

A number of factors that may have success were identified. For example, healing programs were highlighted, but it was noted that too few are available. Other programs and services that place treatment in a context that is relevant to Koori people are helpful. Aboriginal Welfare Officers (AWOs) and Aboriginal Liaison Officers (ALOs) can be very effective. The mental health screening of prisoners coming into prison is seen as positive in identifying mental health needs in all prisoners, including Koori prisoners. Family contact may be helpful and there is a need for more opportunities to help prisoners re-connect to their families. It was noted that very high needs clients tend to receive better support and post-release planning because they tend to attract considerable attention. The informal system of

referrals which involves talking to other prisoners and AWOs helps to encourage people to attend services. A consistency in professionals is helpful; it was noted that all too often there are changes in staffing.

What else could work and is needed, but is <u>not</u> part of the current service delivery model?

A need exists for systematically detecting mental illness after prisoners are incarcerated. There is a need for more sophisticated psychological treatment to deal with trauma. The approach to mental health services needs to be holistic – not just about illness, but about resilience and other aspects of well-being. Coordinated release planning across agencies – including Koori services – is required. It was noted that services are required for non-acute needs.

Recommendations

Drawing on the findings from the study, the following recommendations were developed focussing on systems recommendations and recommendations pertaining to practice. The flow of services is depicted in Figure 1 that follows the recommendations.

Systems Recommendations

1. The Department of Justice should identify the mental health and well-being of Koori prisoners as an immediate priority for service development.

2. The findings from the Koori Prisoner Mental Health and Cognitive Function Study should inform an up-to-date action plan to underpin mental health service development and delivery for Koori prisoners. Once established, the action plan should be measured within AJA3's Monitoring and Evaluation Framework and monitored by the Aboriginal Justice Forum for five years to ensure it is implemented appropriately. The action plan should be linked to existing accountability processes for the Victorian Aboriginal Justice Action Plan, including Justice Health's Koori Inclusion Action Plan and Justice Health's Aboriginal Justice Action Plan.

3. The philosophy underpinning the development and delivery of a model of mental health care for Koori prisoners should be based on the Social and Emotional Well-Being (SEWB) model of mental health. A variety of specific delivery models should be considered for use, including enhanced culturally sensitive practice, the training and recruitment of Aboriginal mental health professionals and mobile Koori mental health care teams.
4. Mechanisms, such as scholarships and internships, should be investigated to increase the availability of Aboriginal mental health professionals in prisoner health and mental health services.
5. Justice Health and contracted health service providers require an overarching policy for mental health assessments and the delivery of mental health services to Koori prisoners. While establishing standards, the policies need to be flexible and responsive to local needs.
6. Increased availability of cultural and spiritual practices and supports are required to assist Koori people to participate in activities to enable them to connect with their culture and practice their cultural activities while incarcerated.
7. Any service delivery model or practices implemented for Koori prisoners must be evaluated to help determine their utility in addressing the needs of this population. An evaluation framework should be embedded in the service development and delivery model that ensures that Koori people are involved in data collection, analysis, and interpretation.
8. Objective, measureable, key performance indicators should be set for health providers to ensure that the health, mental health and social and emotional well-being of prisoners are being met.
9. The development of mental health and SEWB services should ensure continuity of care across the period of incarceration. To the extent possible, the service model should allow prisoners to have ongoing access to mental health professionals with whom they can build a trusting therapeutic relationship over time.
10. Culturally competent efforts to enhance mental health services for Koori prisoner must be linked to aftercare in the community, with emphasis on Aboriginal Community Controlled Organisations. There is a fundamental need for the continuity of care in mental health services provided to Koori women and men as they exit prison. The means to help Koori prisoners connect to health, mental health and social services in the

community should be explored since different approaches, such as in-reach models, the use of AWOs who work outside of the prison to provide support and assistance, might be appropriate.

Practice Recommendations

11. The Aboriginal concept of health is holistic and encompasses all aspects of health: physical, mental, cultural and spiritual. The assessment and treatment of mental health, therefore, should be conducted in the context of a broad Social and Emotional Well-Being framework that includes the following elements:

    a. Mental health assessments and the delivery of mental health services to Koori prisoners must be done in a culturally informed and culturally safe manner.

    b. Health and mental health staff should receive training to assist them to develop cultural competence in working with Koori people. Health and mental health practitioners and those responsible for the delivery of services should take into account the historical, cultural, and environmental experiences and contemporary circumstances of Koori people.

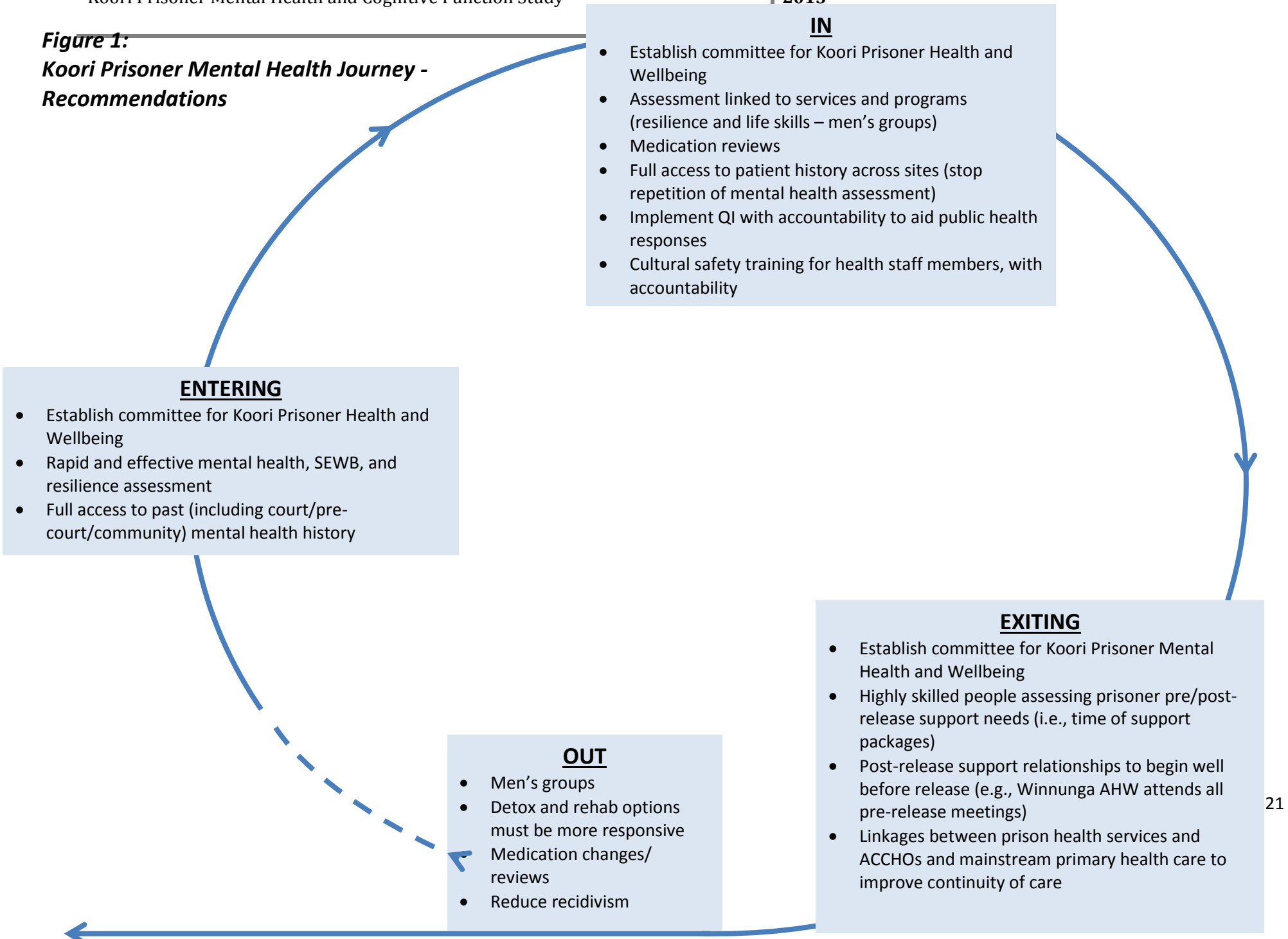
    c. Services should be provided to address elements of social and emotional well-being that impinge on mental health including the importance of connection to culture, ancestry, spirituality, land, family and community.

    d. Services should also help individuals build resilience (e.g., coping strategies, strengths), as the study revealed that men and women with higher degrees of resilience experience lower levels of most mental illnesses.

12. The study identified particularly high rates of anxiety (PTSD) and mood disorders among Koori prisoners, and revealed a relationship between these disorders and elements of social and emotional well-being including distress, stressors, and lack of resilience. As such, in addition to managing symptoms, services are required that address the underlying distress experienced by Koori men and women in custody. Given the high rate of mental disorder and social and emotional damage among female Koori prisoners, all Koori women should undergo a culturally appropriate mental health assessment upon incarceration. The assessment should be used to develop care plans for female prisoners that can help address their mental health and social and emotional well-being needs during their period of incarceration and into the community.

13. Although the rates of mental disorder and social and emotional damage are somewhat lower for male Koori prisoners, they are still significantly higher than what is found for other prisoners. As such, health and mental health professionals should be acutely aware of the heightened level of need for services that many male Koori prisoners may have to ensure that men in need of services are appropriately referred and treated.
14. Rates of substance misuse are high among both female and male Koori prisoners; therefore, culturally relevant intervention programs for substance use disorders, and co-occurring mental illnesses and substance use disorders are required. Interventions should include life building skills and the development of resilience to help address some of the underlying factors that may relate to elevated levels of substance misuse (e.g., grief, loss, trans-generational trauma, and psychological distress).
15. Although the estimated rates of cognitive impairment deficits among Koori prisoners do not appear to differ from rates for other prisoners, a small but significant proportion of Koori prisoners have intellectual disability and cognitive impairments that can impact negatively on their well-being. Appropriate evaluation and intervention are required where needed that take into account the cognitive deficits of prisoners.
16. Families may provide a support of ongoing support for Koori prisoners with mental health and social and emotional well-being needs; therefore, where appropriate, the role of the family in providing information and support should be considered in the mental health care of prisoners.
17. Given the diversity across Koori prisoners from different regions and mobs, attempts should be made to reconnect people to their mobs and enlist support of the mobs in providing prisoner care.
18. Aboriginal and Torres Strait Island prisoners sometimes come from other states and jurisdictions and staff should, therefore, consider their unique cultural issues and needs.

Figure 1:
Koori Prisoner Mental Health Journey - Recommendations



REVIEW OF THE LITERATURE

The literature review that follows will provide a brief overview of international and national research findings on the prevalence, nature and types of mental and cognitive disabilities in the general prison population. Following this, the unique aspects of social and cultural well-being of Aboriginal and Torres Strait Islander people in Australia will be presented. Finally, mental health and cognitive functioning assessment issues as applied to Aboriginal and Torres Strait Islander Australians will be discussed and relevant research involving Aboriginal and Torres Strait Islander prisoners will be presented.

Mental illness amongst the general prisoner population

It has long been known that a far greater proportion of prisoners have mental illnesses than people in the community – this is no longer even a question (Ogloff, 2002; Ogloff et al., 2007). Internationally, estimated rates of mental illness have been shown to be markedly elevated in prisons relative to those found the general population. For example, Fazel and Danesh (2002) reviewed findings of 62 surveys from 12 countries published from 1966 to 2001 and concluded that one in seven prisoners in Western countries had a psychotic illness (3.7% of males and 4% of females) or major depression (10% of males and 12% of females). According to the Health Care Needs Assessment of Federal Inmates Report (Correctional Service Canada, 2004), compared to the general Canadian population, prisoners were 4 times more likely to have a mood disorder, with schizophrenia 20 times more likely amongst female prisoners and 3 times more likely amongst male prisoners.

In one of the most well conducted studies internationally, Brinded and colleagues (2001) in New Zealand found markedly elevated prevalence rates of schizophrenia in the prison population (4.2% in women, 3.4% in remanded men, and 2.2% in sentenced men) compared to a community sample (0.1%). These increase in prevalence estimates were also mirrored with bipolar disorder, major depression, and post-traumatic stress disorder (PTSD).

The findings of research studies conducted in Australia examining rates of mental illness amongst prison populations parallel the international literature. In an extensive review of existing Australian epidemiological data Mullen and colleagues (2003) reported that 13.5% of male prisoners and 20% of female prisoners had reported having prior psychiatric admission(s). Further, up to 8% of males and 14% of females were diagnosed with a major mental disorder with psychotic features and the prevalence rate of

schizophrenia itself was estimated between 2% and 5%; while in the general population the lifetime prevalence rates for schizophrenia range from 0.3%-1% (Ogloff et al., 2007; Short et al., 2010).

Butler and colleagues (2005) examined mental illness in two NSW prisoner populations: new receptions and sentenced prisoners. Overall, 43% of prisoners screened had a mental illness, a rate some three times higher than the estimated prevalence in the community. Rates of specific diagnoses were also elevated, with 9% of all prisoners experiencing psychotic symptoms in the previous 12 months (compared to a community prevalence of 0.4%); 20% of prisoners diagnosed with a mood disorder (6% in the community); and 36% of prisoners diagnosed with an anxiety disorder (10% in the community). The study also found, as would generally be expected, that psychiatric diagnoses were more common amongst newly received prisoners than sentenced prisoners (46% versus 38%), with PTSD the most common disorder (26% of receptions and 21% of sentenced prisoners). A more recent study of NSW prisoners (Allnutt et al., 2008) also found that the 12-month prevalence rates of depression (15%) and anxiety disorders (35%) in the prisoner sample was higher compared to the general Australian community (11% and 9%, respectively).

Taken together these findings confirm that a substantially higher proportion of incarcerated individuals in Australia experience mental illness as compared to the general population. These results are particularly troubling given the lack of specialist mental health services in prisons and the complications that prisoners with mental illnesses present for managing them.

The elevated rates of mental illnesses amongst female prisoners relative to male prisoners are among the most consistent findings in the national and international literature (Ogloff & Tye, 2007). For example, in a study reported by Brugha and colleagues (2005), the prevalence rate of mental illness among female prisoners was found to be more than twice the rate of male prisoners. A report by Lewis (2006) is typical of the findings in relation to the representation of mental illness among female prisoners: PTSD – 40.8%, major depressive disorder and dysthymia (chronic low grade depression) – 40.8%, anxiety related disorders – 9.2%, schizophrenia/manic disorder – 6.5%. Similarly, Teplin, Abram, and McClelland (1996) estimated that the experience of PTSD in female prisoners was 3 times the rate in the general population. In Australia, Tye and Mullen (2006) reported alarmingly high rates of anxiety disorders (52%) and depression (45%) among Victorian female prisoners. Moreover, when compared to a community sample, the female prisoner group had

a significantly higher prevalence of all mental illnesses except obsessive-compulsive disorder.

While the findings for female prisoners are consistent with those for men, the reality is that the prevalence rates are even higher, suggesting that females are an additionally vulnerable population within the criminal justice system.

Substance Abuse/Substance Dependence Disorders amongst the general prisoner population

In addition to the research on the prevalence of mentally ill people in prisons, the rates of substance use and substance dependence disorders are also very high – certainly significantly greater than what one would find in the general community. Moreover, among prisoners with mental illness, substance use disorders are frequently comorbid (or co-occurring) conditions. High concurrence rates (comorbidity) have been reported between alcohol/illicit substance abuse and serious mental illness such as schizophrenia (59% and 42.1%, respectively) and major depression (55.8% and 25.9%, respectively) in prison populations (Abram & Teplin, 1991). Ogloff, Lemphers, & Dwyer (2004) found that almost three-quarters of mentally ill offenders had a co-occurring substance abuse or dependence Similarly, and more recently, Brinded et al. (2001) demonstrated the high level of comorbidity of substance abuse disorders with schizophrenia among New Zealand prisoners.

Furthermore, the available evidence suggests that female prisoners exhibit higher rates of substance abuse disorders than male prisoners (Ogloff & Tye, 2007); indeed according to the Grant and Gileno (2008) report, 80% of female offenders in Canadian prisons have substance abuse problems. In a Queensland study, 69% of female offenders had a substance abuse problem, and 60% had an alcohol abuse problem (Heffernan, Andersen, Dev, & Kinner, 2012). Moreover, substance abuse has been found to be the most prevalent mental disorder among female prisoners. For example, in a Canadian sample, Nicholls, Ogloff, and Douglas (2004) found that half of the female prisoners in their study had substance abuse disorders and Lewis (2006) reported that two-thirds of the American female prisoners sampled had a substance abuse disorder.

Similarly, in Australia, Tye and Mullen (2006) found that 63% of female prisoners in Victoria had a drug-related problem in the 12 months prior to imprisonment, which again was significantly higher than the estimated prevalence of these disorders in a community sample. Overall, Australian epidemiological data (Mullen et al., 2003) suggest that a third of male prisoners and over one-half of female prisoners report having been diagnosed with a

substance abuse disorder. Specifically, 10.4% of male prisoners and 8.7% of female prisoners reported having a alcohol abuse/dependence diagnosis, and 25% of male prisoners and 44.4% of female prisoners report having an illicit substance abuse/dependence diagnosis.

Returning to the study reported by Butler and colleagues (2005) that investigated the prevalence of mental illness in NSW, they reported a high rate of substance abuse disorders (54%) in the NSW prisoner sample. A high rate of alcohol problems has also been reported among NSW juvenile prisoners: 78% of respondents in a 2009 NSW Young People in Custody Health Survey indicated that they drank alcohol to risky levels (Indig et al., 2011[1]).

Cognitive Disability amongst the general prisoner population

Research indicates that individuals with cognitive disability, which includes Intellectual Disability (ID) and Acquired Brain Injury (ABI), are at greater risk of entering the criminal justice system than people without cognitive disability (Brain Injury Association of NSW, 2011). ID is distinct from ABI in that ID primarily affects learning abilities, whereas, individuals with ABI generally retain their intellectual abilities but have difficulty in controlling, coordinating and communicating their thoughts and actions (Brain Injury Association of Tasmania, 2007). People with ID are commonly found to be overrepresented in prison populations.

Community estimates of the prevalence of ID in Australia and internationally vary from 0.3% to 3%, in comparison to between 1.3% and 29% in prison populations (Corrections Victoria, 2007; Herrington, 2009). In Australia, the estimated prevalence of ID is particularly high among young offenders. The NSW juvenile justice health survey (Indig et al., 2011[1]) reported that around 44% of young people had a total IQ score consistent with the definition of ID (< 70) or borderline IQ (70-79). Although co-existing substance use problems have been reported among the intellectually disabled offender population (Hayes, 2005), there remains a lack of knowledge regarding the extent and nature of psychopathology among offenders with ID (O'Brien, 2002).

Similarly, compared to mental disorders and intellectual disability, the prevalence and impact of ABI in the criminal justice system has long been a neglected area of research and there are only limited data available both internationally and in Australia on this issue (Brain Injury Association of Tasmania, 2007). In Australia, only one study (by Corrections Victoria) has systematically examined ABI resulting from a wide range of causes in a prison population; the results indicated that 42% of male prisoners and 33% of female prisoners in the sample had ABI (Jackson and Hardy, 2011).

A number of studies have examined the prevalence of Traumatic Brain Injury (TBI) in prison populations. TBI can be defined as 'Acquired brain injury caused by external force applied to the head' (Rushworth, 2011, p. 4). Shiroma et al. (2010) identified 20 studies conducted in the USA, UK, New Zealand and Australia and calculated an average estimated prevalence of TBI in the offender population of 60%. In an Australian study in New South Wales, 82% of male prisoners reported a history of TBI, 43% had sustained four or more TBIs, and half reported that the problem was still ongoing (Schofield et al., 2006). While these rates appear high, it is difficult to make valid comparisons with the general population as there are little data about the lifetime prevalence of TBI in the general population (Rushworth, 2011). Of note here, the coexistence of substance abuse and TBI has been well-documented in the correctional settings, both internationally and in Australia (Colantonio et al., 2007; Schofield et al., 2006).

Despite considerable data on the prevalence of TBI in the criminal justice system, this data consists mainly of self-reports by prisoners and thus, is susceptible to participants' recall bias. Moreover, screening instruments used to assess TBI typically do not include questions about ABI that may result from stroke, brain infection, neurological diseases, or brain injury due to chronic alcohol or drug abuse (Rushworth, 2011). In comparison, the prevalence rate of ABI in the community has been estimated to be approximately 2.2% (Australian Bureau of Statistics, 2003). This therefore tentatively suggests that people with ABI may be overrepresented in the criminal justice system.

Why people with mental illnesses, substance abuse disorders and cognitive disabilities are at a greater risk of entering the criminal justice system?

Taken together, the existing body of research reveals that amongst the general prison population rates of mental illness, problematic substance use and cognitive impairment are all high. A number of contributing factors have been identified to explain the disproportionate number of people with mental illness in the criminal justice system, including the deinstitutionalisation of mentally ill people, an increase in the rates of substance use by people with mental illness, and the limited capacity of community-based mental health services to address the needs of mentally ill offenders (Ogloff et al., 2007).

The greater risk of entering the criminal justice system by people with cognitive disability has been linked to the nature of cognitive disability, namely, a person's reduced capacity to understand laws and societal norms, reduced impulse control, and diminished

decision-making abilities, which can lead to risk-taking behaviours and antisocial / criminal activities (Simpson & Sotiri, 2004). Although these contributing factors may also be valid for the Aboriginal and Torres Strait Islander prison population, as noted by the Australian Human Rights Commission (2008), any delineation of mental health problems and cognitive disability amongst this population must encompass recognition of the unique social and cultural context of Aboriginal and Torres Strait Islander mental health and well-being. Therefore, before proceeding to the overview of relevant studies in relation to mental health and cognitive functioning of Aboriginal and Torres Strait Islander prisoners, the following section will focus on the unique issues of social and cultural well-being of Aboriginal and Torres Strait Islander people.

Social and cultural well-being of Aboriginal and Torres Strait Islander Australians

It is commonly recognised that the conceptualisation of mental health differs between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander populations (Dingwall & Cairney, 2010). Amongst Aboriginal and Torres Strait Islander Australians, mental health is understood within a broader, more holistic, framework referred to as 'social and emotional well-being (SEWB)' (Dingwall & Cairney, 2010). Recognition and establishment of a national Aboriginal and Torres Strait Islander SEWB health framework would reflect a more encompassing notion of health in which the concept of wellbeing is conceptualised as representing a set of multifaceted and interrelated factors including spiritual, environmental, ideological, political, social, economic, mental and physical domains of living (Australian Human Rights Commission, 2008; Dingwall & Cairney, 2010). This framework, although similar in some respects to Westernised bio-psycho-social models, goes beyond an understanding of the individual and emphasises the significance of harmony for the individual in relation to the much broader issues of culture, spirituality, ancestry, family, community and connection to the land in the maintenance of mental health and wellbeing (Jones & Day, 2011; Zubrick, Kelly, & Walker, 2010). A brief overview of what are considered to be some of the most important culturally specific influences on Aboriginal and Torres Strait Islander social and emotional well-being will be provided below. For ease of access, these are divided into *protective factors*: 1) self-determination, 2) social cohesion, 3) connection to land, culture, spirituality and ancestry; and *risk factors*: 1) grief, loss and unresolved trauma, 2) acculturation stress, 3) identity issues, 4) separation, 5) socio-economic disadvantages (Jones et al., 2002; Jones & Day, 2011; Zubrick et al., 2010).

Self-determination

The concept of self-determination is not easily defined (Behrendt & Vivian, 2011). Broadly, it can be considered to include control over one's future destiny, though the precise areas that are encompassed in this concept are dependent on the aspirations of the individual or group involved (Behrendt & Vivian, 2011). In Victoria, The Charter of Human Rights and Responsibilities, which sets out freedoms, rights and responsibilities that are protected by law in Victoria, does not yet include self-determination (though the Charter is in the process of being reviewed). Despite continuing debate as to exactly what self-determination is, and how it can adequately be defined, a recent Canadian study (Chandler & Proulx, 2008) provided evidence for its benefits, finding a direct connection between the increased transfer of powers around decision-making (covering core areas including health, education, policing and seeking title to land) to Aboriginal and Torres Strait Islander communities and a decreased rate of youth-related suicide. This provides hope, therefore, that moving away from the traditional paternalistic model regarding Aboriginal and Torres Strait Islander people toward one of self-determination may well be protective and lead to enhanced health outcomes over the long term.

Social cohesion

The issue of social cohesion is of significant priority to Aboriginal and Torres Strait Islander culture. Social cohesion has been defined as the quality of social relationships with others, underpinned by the core tenets of trust and mutual respect (Wilkinson & Marmot, 2003). Enhanced perceptions of social cohesion both within and between communities have the potential to provide some level of protection when being faced with multiple stressful events.

Connection to land, culture, spirituality and ancestry

The importance of the land one belongs to is central to most aspects of Aboriginal culture, and maintaining a spiritual, physical and emotional connection to the land is inherent to many Aboriginal and Torres Strait Islander beliefs about mental, social and emotional well-being. As such, this may be conceptualised as acting as an additional protective factor in relation to the well-being of Aboriginal and Torres Strait Islanders (Zubrick et al., 2010).

The loss of social and cultural connection for Aboriginal men has been supported to be the prominent cause of depression (Brown, et al., 2012). In this qualitative study, Brown et al. argued that feelings of disconnectedness from the aboriginal life were not only detrimental to emotional health but also negatively impacted physical and the spiritual

health. It was the weakening of the spirit which directly impacted depression. The most common expression of depression was exhibited through great sadness, constant worriedness and the lack of hopelessness.

Grief, loss and unresolved trauma

The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2004-2005 found that just under half of Aboriginal and Torres Strait Islander adults reported that they lost a friend or family member within the year prior to completing the survey. The same proportion (47%) reported that they attended a funeral in that period (Australian Bureau of Statistics, 2006). Zubrick and colleagues (2010) reported that these experiences were additionally traumatic because the deaths were commonly of children and youth and therefore considered unexpected and ultimately preventable. The survey also found that eight percent of respondents had been taken away from their natural families and over 40% reported that a relative had been part of the stolen generation. It has been suggested that these traumatic experiences are likely to contribute to higher levels of mental health problems, in particular depression and PTSD (Raphael, Swan, & Martinek, 2008).

Acculturation stress

Sue and Sue (1990) defined acculturation as the process of adjustment that occurs when two cultures come together. The conflict with this process occurs as a result of the fact that it is generally the 'minority culture' which has to commit to the most significant changes so that it becomes more aligned with the majority culture. Given the wide reaching changes often required to be undertaken across really quite fundamental areas including language, education, social hierarchies and social justice, Jones and Day (2011) highlighted the real risk of 'acculturation stress' leading to an increased risk of psychological distress and, in some circumstances crisis (Jones et al., 2002).

Loss of identity

The issue of identify is central to how one perceives and positions oneself in relation to others in the community and the broader society. Aboriginal and Torres Strait Islander people have had to deal with a significant period of deculturation, losing their traditional knowledge and sense of connection to their culture. For example, the NATSIH survey mentioned previously found that more than one third of respondents who lived in urban

areas did not know the location of their traditional country (ABS, 2006). In addition, and severely compounding this issue, is racism; taken together Jones and colleagues (1999) suggest that these significant issues contribute to the lack of a positive sense of identify among Aboriginal and Torres Strait Islander people. Jones and Day (2011) suggest that racism can be conceptualised as impacting on mental health negatively at both interpersonal and systemic levels; at extreme levels this can lead some additionally marginalised Aboriginal and Torres Strait Islander people (e.g., offenders) to go as far as to deny their Aboriginality (Jones et al, 2002). More generally, evidence of systemic racism is found in relation to the acculturation processes and the disadvantage and limits on rights brought about by being a minority culture. At an interpersonal level, the extremely deleterious impact of racism can be witnessed in relation to poorer mental health (particularly depression and anxiety) and increased use of both alcohol and drugs (Jones et al., 2002; Paradies, 2006; Williams & Mohammed, 2009).

There is also some evidence from a study in New Zealand indicating that having an insecure cultural identity can be related to an increased likelihood of criminal offending (Marie, Fergusson & Boden, 2009). The research found that those offenders who did not clearly identify themselves as being either Maori or non-Maori had higher rates of offending.

Separation

Separation from land, family and culture has an immeasurable impact on Aboriginal and Torres Strait Islander people's social and emotional functioning (Jones et al., 2002). According to the Australian Institute of Health and Welfare (AIHW, 2008), the proportion of Aboriginal and Torres Strait Islander children aged 0-17 years on care and protection orders was 41 per 1000. This rate is seven times greater than it is for other children. The most common reasons for removal were parental substance abuse, mental health issues and family violence. This separation has been shown to be detrimental to the health and wellbeing of the children involved, with increased rates of mental disorder and problematic behaviour (Raphael & Swan, 1998). Moreover, Aboriginal offenders who have experienced separation have been found to be overrepresented among those who have died in custody (Royal Commission into Aboriginal Deaths in Custody, 1991).

According to the ABS (2011) report, Aboriginal and Torres Strait Islanders were 14 times more likely than non-Aboriginal and Torres Strait Islander Australians to have been incarcerated; risks are higher for those originating from remote areas. The incarceration itself all too often leads to an enforced geographical separation from family members, land

and, therefore, culture as the prisons are often situated long distances away from the remote communities from where the offenders come (Jones et al, 2002).

Socio-economic disadvantages and health

Current socio-economic inequalities experienced by Aboriginal and Torres Strait Islander populations have reinforced the view expressed in most Aboriginal and Torres Strait Islander reports that the impact of colonisation continues up until the present day. Central to these debates is the argument around social inequalities and social-economic disadvantage.

The current significant disadvantage of Aboriginal and Torres Strait Islander health is well recognised; for example, the life expectancy of Aboriginal and Torres Strait Islander Australians is approximately 17 years lower than for non-Aboriginal and Torres Strait Islander Australians and premature death rates (from accidental injury) are nearly three times higher (ABS, 2008). Aboriginal and Torres Strait Islander Australians are also more likely to experience a range of chronic disease such as diabetes, cardiovascular, respiratory, and kidney diseases than non-Aboriginal Australians (ABS, 2006). However, and of particular note here, in a report on the burden of disease and injury for Aboriginal and Torres Strait Islander Australians (Vos et al., 2007), mental disorders were ranked second only to cardiovascular disease. The high prevalence disorders of anxiety, depression and alcohol misuse, along with diagnoses of schizophrenia, contributed in excess of 75% of the total burden of disease.

Despite little investigation into the rate of cognitive deficits among the Aboriginal population, rates are likely to be elevated compared to non-Aboriginal Australians due to the widespread exposure among Aboriginals of known correlates of acquired brain injury, including substance abuse, violence, head trauma, malnutrition, chronic illness and foetal alcohol syndrome (Dingwall & Cairney, 2010). Furthermore, the estimated prevalence of dementia in Aboriginal and Torres Strait Islander Australians aged over 45 years from the Kimberly region has been reported at 12.4% -- a rate more than five times higher than those of the same age in the general non-Aboriginal Australian population (Smith et al., 2008).

Aboriginal and Torres Strait Islander disadvantage is also apparent according to other social indices, including overcrowding (Parker, 2010), income (ABS, 2006), completion up to year 12 education (Parker, 2010), and, therefore, unemployment. The latter is perhaps of particular significance, as Jones and colleagues (2002) suggest that the association between unemployment and criminal offending is particularly strong.

Taken together, the plethora of unique SEWB issues that affect Aboriginal Australians doubtless affect the matters related to the Koori Prisoner Mental Health and Cognitive Function study. That is, it is possible that the SEWB deficits may lead to decreased mental health, increased cognitive damage, and increased offending amongst Aboriginal and Torres Strait Islander Australians. In the next section, we turn to a discussion of the over-representation of Aboriginal people in the criminal justice system and the factors that affect them.

Aboriginal and Torres Strait Islander people in the criminal justice system

Aboriginal and Torres Strait Islander people continue to be disproportionally represented in the criminal justice system, both internationally and in Australia. In Canada, Aboriginal people comprise 17.3% of federally sentenced offenders, while the Aboriginal population comprises just 2.7% of the total Canadian population (Correctional Service Canada, 2010). In New Zealand, the male prison population (both remand and sentenced) comprised just under 50% Maori men and more than 50% of Maori women, despite only 14% of New Zealanders being Maori (Brinded et al., 2001). Contemporary Australian figures (ABS, 2011) suggest that more than one in four current prisoners is Aboriginal and Torres Strait Islander, compared to a community prevalence of just 2.5% (1 in 40) of the Australian community. This overrepresentation is even higher among women prisoners (Bartles, 2010) and among the younger age groups; with one recent study suggesting that the rate of incarceration of Aboriginal and Torres Strait Islander young people is nearly 28 times higher than non-Aboriginal and Torres Strait Islander young people (Taylor 2011). Victoria is the state with the lowest percentage of Aboriginal inhabitants (0.6%); however, even in Victoria, Aboriginal people make up approximately 6%-8% of the prison population – at least 10 times more than expected based on their relative proportion of the population (Mullen et al., 2006).

Mental health and cognitive functioning assessment issues

It is difficult to obtain reliable estimates of the prevalence of mental and cognitive disabilities for Aboriginal and Torres Strait Islander people in prison settings, mainly because prison data are rarely stratified according to Aboriginal and Torres Strait Islander status. In addition, there are specific complications around the appropriateness of using assessments of mental illness that are not validated for use with Aboriginal Australians

(Jones & Day, 2011). For example, for Aboriginal and Torres Strait Islander Australians, mind, body and spirit are inherently linked and illness can be perceived as a normal reaction to spiritual forces or a curse (Burdekin, 1993). For example, in non-Aboriginal and Torres Strait Islander cultures it can be normal to speak the name of a deceased person but in Aboriginal and Torres Strait Islander Australian cultures such behaviours may be considered grossly inappropriate and distressing because they violate strict cultural rules (Westerman, 1998).

Mental illness may manifest in different symptoms between Aboriginal and non-Aboriginal Australians. For example, anger may represent a culturally specific symptom of depression for Aboriginal and Torres Strait Islander Australians (Thomas et al., 2010). This has led some to comment upon the cultural appropriateness of standardised assessment tools and procedures which may not accurately estimate the prevalence rates of major mental disorders (Australian Human Rights Commission, 2008). As such, the differential meaning and experiences of mental health problems for Aboriginal and Torres Strait Islander Australians compared to non-Aboriginal and Torres Strait Islander Australians implies that distinct methods for their assessment are actually required (Dingwall & Cairney, 2010).

Similarly, current cognitive assessment tools are based on skills that are valued by non-Aboriginal cultures, such as verbal memory for example. In contrast, Aboriginal and Torres Strait Islander Australian culture may place less value on verbal memory and more on spatial memory as the ability to know directions, space and place is essential for survival in much more remote, harsher environments (Department of Education and Children's Services South Australia, 1995). Furthermore, mental and cognitive functioning assessment tools generally rely on questions and answers for which the standard response is obtained from the general population (Burdekin, 1993); this may render test interpretation for Aboriginal and Torres Strait Islander Australian problematic as Aboriginal and Torres Strait Islander norms are rarely available.

At this point in time there remains a very limited number of culturally fair and appropriate, and scientifically validated tools relating to the assessment of mental disorders and cognitive impairments for use specifically with Aboriginal and Torres Strait Islander Australians. These significant shortcomings mean that the true rates of mental and cognitive disabilities for Aboriginal and Torres Strait Islander people, including those in the prison population, currently are not known with any degree of certainty (Australian Human Rights Commission, 2008). That being said, it is argued that there may be some benefit to utilising the widely used validated tools and using additional collateral information from the

responders to consider possible lower and upper confidence limits of prevalence estimates taking into account at least some of the pertinent cultural considerations. For example, validated assessment measures have been found to be effective in the large New Zealand prisoner mental health study (Brinded et al., 2001) and other studies conducted with Aboriginal and Torres Strait Islander people in Australia (e.g., Butler et al., 2007) and internationally.

Mental illness

Compared to the general prison population, there are limited studies available on this issue in relation to Aboriginal and Torres Strait Islander people in custody. Heffernan, Andersen, and Kinner (2009) identified only eight published studies in relation to the mental health of Aboriginal and Torres Strait Islander people in custody in Australia. One of the most systematic of these studies by Butler et al. (2007) compared the mental health of a sample of 226 Aboriginal men and 51 Aboriginal women incarcerated in NSW prisons. Notwithstanding the aforementioned issues around the culturally appropriate ascertainment of mental disorder, the study found a population exhibiting a high prevalence of mental disorder and psychological distress.

While the differences between Aboriginal and non-Aboriginal men differed little apart from rates of depression, rates for Aboriginal women were particularly elevated compared to non-Aboriginal women. Twelve-month prevalence rates of mood disorder were reported as 13.1% for males and 43.1% for females; while for anxiety disorders, rates were recorded as 34.4% for males and 58.6% for females. The most common anxiety disorder was Post Traumatic Stress Disorder, which was identified in almost 20% of males and 50% of females. A further 6.6% of males and 20.3% of females screened positive for psychosis. Just under half of the males and more than 5 out of every 6 Aboriginal and Torres Strait Islander females assessed reported medium or higher levels of psychological distress. In a more recent Queensland study (Heffernan et al., 2012), Post Traumatic Stress Disorder was also the most prominent Anxiety disorder, which affected around 12% of males and 32% of females. Furthermore, a higher rate of psychotic disorders in females was also supported; 8.1% of males and 25% of females qualified as having a psychotic disorder.

Another important NSW study by Lawrie (2003) examined the mental health of Aboriginal and Torres Strait Islander women in prison. A quantitative survey in this study was conducted by five female Aboriginal researchers. At the time of the survey there were 104 Aboriginal and Torres Strait Islander females in custody and 50 (48%) of these were

surveyed. A total of 16% reported that they had been diagnosed with a mental illness; half reported that this was schizophrenia. Nearly three-quarters of the women reported that they had been victims of child abuse, mostly sexual abuse, and 78% reported being victims of violence as an adult, which additionally highlights trauma as a prominent experience among Aboriginal and Torres Strait Islander women in custody.

Substance abuse/dependence

Most of the data on this issue are available in relation to Aboriginal and Torres Strait Islander female and juvenile populations. In a female prisoner's health status survey in Queensland (Hockings et al., 2002), 25% (212 women) of the sample was identified as Aboriginal and Torres Strait Islander. Their findings indicated that the proportion of Aboriginal and Torres Strait Islander women who were harmful drinkers (53.8%) was four times that of non-Aboriginal and Torres Strait Islander women (13.2%). In terms of seeking treatment for substance use problems, Aboriginal and Torres Strait Islander women were less likely than non-Aboriginal and Torres Strait Islander women to have sought help for a drug or alcohol problem. In the previously noted study by Lawrie (2003), most of the Aboriginal women reported regular drug use and two thirds reported drug use at the time of their offending.

Similarly, in Canada, substance abuse has been reported as a major health problem among Aboriginal women prisoners. For example, according to Women in Prison Facts Sheet, 94% of Aboriginal women prisoners indicated that they have a problem with alcohol, 60.4% admitted drug abuse in their childhood, and 57.9 % admitted to early alcohol abuse in their childhood (Correctional Service Canada, 2010).

Higher rates of substance abuse among Aboriginal and Torres Strait Islander young people compared to non-Aboriginal and Torres Strait Islander young people were also reported in the 2009 NSW juvenile health survey (Indig et al., 2011). In the survey, 83% of Aboriginal and Torres Strait Islander respondents (compared with 73% non-Aboriginal and Torres Strait Islander) indicated that they drank alcohol at risky levels, and 72% of Aboriginal and Torres Strait Islander young people (compared with 58% non-Aboriginal and Torres Strait Islander) used drugs weekly prior to custody. Aboriginal and Torres Strait Islander young people were also more likely than non-Aboriginal and Torres Strait Islander young people to have a diagnosis of substance abuse disorder or dependence and to have parents who also had drug and alcohol problems. Substance abuse was also prominent in a sample of Aboriginal and Torres Strait Islander young people (aged 10-17) surveyed in a

youth detention centre in Queensland (Stathis et al., 2008), with 59% being identified as having drug and alcohol problems. This particular study used a screening tool developed for an American population. It is likely that differences in culture, language and schooling will impact on the validity of the results. Moreover, the findings were not stratified by sex and in the absence of comparative data for those not screened, it is impossible to assess the representativeness of the findings.

Cognitive disability

There are currently limited data on the prevalence rates of intellectual disability and/or acquired brain injury among the Aboriginal and Torres Strait Islander prison population. The core complication on identifying cases and whether rates were overrepresented or not in closed environments was aptly articulated by Simpson and Sotiri (2004) who identified four key complicating factors in answering the question: (1) the lack of data on the estimated prevalence of cognitive disability in Aboriginal and Torres Strait Islander non-incarcerated populations; (2) the lack of reliable data on the rates of cognitive disability in the criminal justice system; (3) culturally specific differences in framing and understanding what cognitive disability was; and (4) the distinct possibility that cognitive disability could be masked by other socio-economic indices. Nevertheless, there are some limited data suggesting high rates of cognitive disability among Aboriginal and Torres Strait Islander prisoners.

In a study (NSW Law Reform Commission, 1996) of the prevalence of intellectual disability among people appearing before two courts in NSW, the majority of the participants (73.9%) were Aboriginal and Torres Strait Islander. Of the whole sample, more than one third were considered to have had an intellectual disability (full scale IQ < 70), while 1 in 5 were in the borderline range (full scale IQ between 70 and 79). It should be noted that although an attempt was made to employ culturally-fair assessment tools in this study, it was acknowledged by the authors that it was possible that the Aboriginal and Torres Strait Islander people were disadvantaged by the assessment tools used.

In another study (NSW Department of Juvenile Justice, 2003), based on a reportedly culturally fair estimate, 10% of the Aboriginal and Torres Strait Islander young people in custody were classified as having an intellectual disability. It was concluded that Aboriginal and Torres Strait Islander young people in contact with the juvenile system were between 4 and 5 times more likely to have an intellectual disability than the general population.

In a more recent study (Corrections Victoria, 2007), Aboriginal and Torres Strait Islander people comprised 16.7% of prisoners who were classified as having an intellectual disability and only 4.9% of prisoners who did not have an intellectual disability. Similarly, in the 2009 NSW Juvenile Health Survey (Indig et al., 2011[1]), Aboriginal and Torres Strait Islander young people in custody were more likely than non-Aboriginal and Torres Strait Islander young people to have a full scale IQ less than 70.

Current recommendations include the need to consider an indication of adaptive behaviour as part of a more comprehensive assessment of intellectual disability; indeed doing so can have a dramatic impact on estimated prevalence rates that are reported. The cultural appropriateness of such measures is not known.

Research with the specific focus on ABI among Aboriginal and Torres Strait Islander prisoners is non-existent. The only study that bears some relevance on the issue was reported in the recent 2009 NSW Inmate Health Survey (Indig et al., 2011). Aboriginal and Torres Strait Islander respondents in the survey reported higher rates of head injury with loss of consciousness; more incidents of multiple head injuries; and more frequent, and unresolved, sequelae involving 'personality change' than non-Aboriginal and Torres Strait Islander prisoners. While the estimated prevalence rates of ABI in Aboriginal and Torres Strait Islander communities are suggested to be up to three times higher than that of the rest of population, these estimates are also potentially considerably compromised by the lack of culturally appropriate, standardised cognitive assessment tools (Rushworth, 2011).

Conclusion

Available literature suggests that Aboriginal and Torres Strait Islander people in custody have high rates of complex mental health and cognitive functioning problems. The literature also suggests that Aboriginal and Torres Strait Islander prisoners face high rates of social adversity, trauma and health problems outside the prison settings. One of the concerning and more consistent findings is the extent of these problems among Aboriginal and Torres Strait Islander women; Young Aboriginal and Torres Strait Islander people in custody also emerge as a particularly vulnerable group. This review has also highlighted the marked shortfall in both quantity and quality of scholarly research regarding mental health and particularly cognitive functioning of Aboriginal and Torres Strait Islander people in custody.

The currently available data are piecemeal at best and there is very limited information about the nature and types of mental health and cognitive functioning problems

for Aboriginal and Torres Strait Islander people in custody. The lack of culturally validated assessment tools is particularly problematic. Moreover, nearly all of the published research focuses on the illness aspects in relation to mental health of Aboriginal and Torres Strait Islander people; positive life experiences that may act as protective factors for Aboriginal and Torres Strait Islander people's well-being are noticeably absent. There is a clear need for future studies to incorporate a focus on social and emotional well-being of Aboriginal and Torres Strait Islander people in custody, complement quantitative research methods with qualitative approaches, and employ culturally informed methods to help us start to better understand the true nature and extent of vulnerability among this additionally disadvantaged population.

RATIONALE FOR THE STUDY

The current study was designed in collaboration with the project steering committee and an Indigenous Advisory Group to address the following key research aims:

- Identify the Social and Emotional Well-Being (SEWB) strengths and needs of Aboriginal and Torres Strait Islander prisoners, including levels of psychological distress
- Identify the nature and extent of mental illness for Aboriginal and Torres Strait Islander prisoners and their associated needs
- Assess the cognitive functioning of Aboriginal and Torres Strait Islander prisoners and their associated needs
- Identify barriers to accessing services and other potential gaps in meeting identified needs
- Develop recommendations for improving current service systems and clinical practice

METHODOLOGY

The data presented in this report were based on an interviewer-administered questionnaire for Koori prisoners and telephone interviews with key stakeholders. The following sections outline the process undertaken in the development of the interview questionnaire for Koori prisoners and stakeholder interviews, and also provide details of the sampling and recruitment protocols for each phase of the study.

Ethical Approval

The study protocol relating to the Koori Prisoner interviews (Phase I) was reviewed and approved by the Department of Justice Human Ethics committee. The stakeholder interviews (Phase II) protocol was reviewed and approved by the Monash University Human Research Ethics Committee.

Research Design

Post-data collection, staff from the Victorian Aboriginal Community Controlled Health Organisation and the Centre for Forensic Behavioural Science met to discuss further data analysis. The first stage of the analysis was comprised of descriptive statistics. The second stage was comprised of inferential statistics which looked at the relationship between measures. The third stage of the analysis was comprised of regression analyses conducted to investigate the association between mental health and social and emotional wellbeing.

Oversight of the Project

As the project was conducted under contract to the Department of Justice (Justice Health and Koori Justice Unit), the project was overseen by a Project Steering Committee, the membership of which is provided at the outset of this report. As seen in the figure below, the project was managed by Justice Health and the Koori Justice Unit with the oversight of the Project Steering Committee and the advice of the Project Advisory Committee.

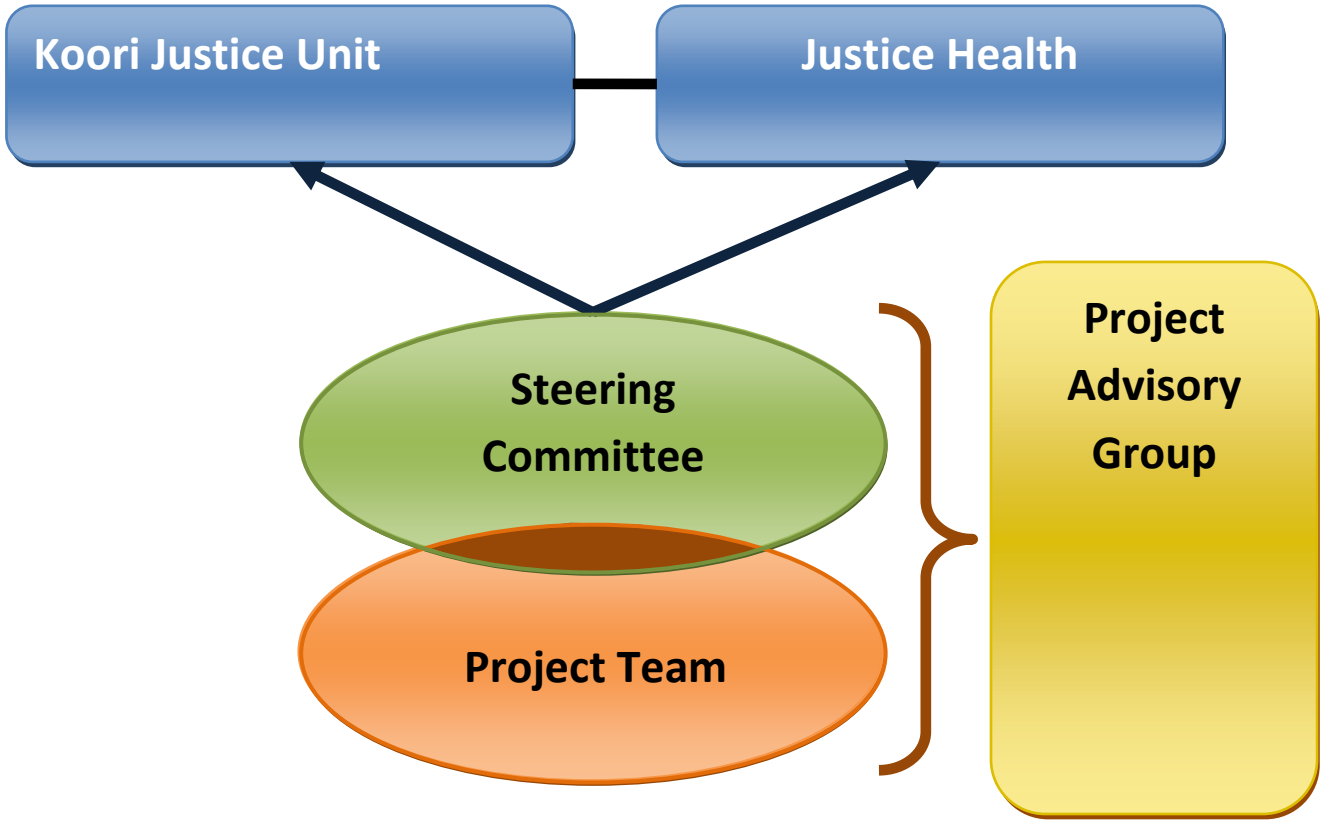


Figure 2. Oversight of the Study

The Steering Committee provided oversight of every aspect of the project from the commencement of the project. The study design, study measures, procedure, data analyses and interpretation, and draft recommendations were reviewed and approved by the Steering Committee. In addition to the Project Steering Committee, the assistance of the Project Advisory Committee provided guidance and support for the project. Membership of the Project Advisory Committee is listed at the outset of this document and was drawn from Aboriginal and Torres Strait Islander organisations, relevant government departments, and health professionals. A series of workshops were held with the Project Advisory Group to receive advice regarding the approach of the study, the findings from the participant interviews, the findings from the stakeholder interviews, and the draft recommendations.

Phase I: Koori Prisoner Interviews

Sampling

Data collection took place from January 2012 until October 2012. All remanded and sentenced Aboriginal and Torres Strait Islander prisoners from regional and metropolitan prisons Victoria-wide were approached to participate in the study. Insufficient numbers of prisoners at Tarrengower, Beechworth and the Judy Lazarus Centre meant that no prisoners were recruited from these sites. In relation to exclusion criteria, participants were required to have their Aboriginal and Torres Strait Islander status formally registered with prison services. Also, participants placed in management at the time of interviews were not eligible to participate in the study. Over the course of recruitment, two prisoners declined to participate in the study once the researcher had explained the study to them.

Materials

Questionnaire Design

The development of the questionnaire used in the interviews with Koori prisoners involved close consultation with the steering committee and advisory group. It was also reviewed by an Aboriginal psychologist with research expertise, as well as an Aboriginal psychologist with neuropsychological experience and a clinical neuropsychologist. The final questionnaire was an amalgamation of questions based on feedback received from these groups and the following two surveys:

The questionnaire utilised in the Queensland 'Inside Out' project that assessed Mental health of Aboriginal and Torres Strait Islander people in custody (Heffernan et al., 2012).

- National Aboriginal and Torres Strait Islander Health and Social Surveys (Purdie, Dudgeon, & Walker, 2010).

The final semi-structured questionnaire covered five key areas:

Participant Details

This section related to the collection of basic demographic details including, gender, date of birth, Aboriginal and Torres Strait Islander status, education level, offending information, employment and prior living.

Social and Emotional Wellbeing

In this section details about cultural identification, cultural knowledge, positive wellbeing, life experiences and life stressors experienced by participant and their family, and anger were recorded.

Service usage

Information pertaining to services used (e.g., psychiatrist, GP, traditional healer) in the 12 months prior to custody and barriers to such access was obtained in this section. The perceived helpfulness of services to meet a number of needs currently (over past month) and at the time of the offence was identified with the Camberwell Assessment of Need - Forensic Short Version (CANFor SV). Post release plans were also explored and participants were given the opportunity to make suggestions about the types of services needed within the prison and community.

Mental Health

Participants were asked about past suicide attempts and current suicidal thoughts. The presence of current and life-time mental disorders of mood, anxiety (including PTSD), psychosis and substance use was assessed using the relevant sections of the Mini International Neuropsychiatric Interview which is a structured clinical assessment tool.

Cognitive Assessment

The neuropsychological screen included a mix of language-based and non-verbal measures. The assessment measures included the Kimberley Indigenous Cognitive Assessment (KICA) which is a culturally relevant cognitive screen that assessed global cognitive functioning. Selected components of the WASI and WAIS-IV were also used including: Matrix Reasoning, Block Design and Digit Span. These tests broadly assessed non-verbal intellectual functioning and spatial reasoning. The Trail-making Test from the D-KEFS was used to assess executive functioning and mental flexibility.

Procedure

Recruitment

In the first instance Aboriginal Wellbeing/Liaison Officers at each prison briefly informed eligible participants of the details of the study. Those prisoners interested in participating in the study then met with the interviewers who provided them with an explanatory statement. Interviews were conducted in teams consisting of a culturally trained mental health clinician and an Aboriginal and Torres Strait Islander research officer. At the commencement of the interview, the Aboriginal and Torres Strait Islander research officer verbally reviewed the explanatory statement with the prisoner and provided an opportunity for the prisoner to ask questions. Prisoners who wished to take part in the study were asked to sign a consent form acknowledging their understanding of the following information: that the information collected from the interview would be held in the strictest of confidence; that confidentiality may need to be breached if the participant gave details of abuse they had suffered or serious offences they had committed for which they had not been charged; their participation was voluntary; they could not be individually identified in any published material; they could choose not to answer any question; and the interview could be terminated at any time.

Interview

The interview was conducted in two parts: the Aboriginal and Torres Strait Islander research officer facilitated discussion about basic demographic information and Social Emotional Wellbeing, and the mental health clinician completed sections relating to mental health and neuropsychological testing. Overall, interviews varied in length from 50-240 minutes, depending on the prisoner's willingness to disclose information. Participants were offered regular breaks and drinks throughout the interviews to assist in maintaining concentration.

All interviews were conducted in private rooms visible to custodial staff, and where possible, researchers were provided with personal duress alarms. To guarantee confidentiality, consent forms were stored separately from the completed questionnaires and unique identifiers were applied.

Data Analyses

All data were analysed using the Statistical Package for the Social Sciences (SPSS), version 20. Descriptive and frequency data were calculated for all of the variables. Univariate analyses were conducted to compare differences in item scores for people who had particular mental illnesses and those who did not. Pearson correlational correlations were calculated to determine the relationship between variables across the domains studied. Finally, linear regression analyses were conducted to determine which factors combine to help predict the outcome (i.e., presence of mental illness). Given the small sample size of female participants, only descriptive and frequency data were calculated.

It was hypothesised that factors associated with SEWB would correlate positively with high prevalence mental disorders (i.e., affective/mood disorders and anxiety disorders) but not low prevalence disorders (i.e., psychotic illnesses). It was further hypothesised that resilience would be inversely correlated with high prevalence disorders but not low prevalence ones. It was not anticipated that measures of cognitive impairment would correlate with mental illness.

After the descriptive and frequency data were obtained, a data workshop was held with VACCHO (Dr. Karen Adams and Mr. Chris Halacas) and the CFBS (Prof. James Ogloff, Dr. Jenny Patterson, Mr. Simon Larmour) to help plan the analyses to investigate the relationship between the factors (SEWB and unmet needs) and outcome (mental illness). Mr. Graham Gee and Associate Professor Stuart Thomas also contributed to this discussion although they were unable to attend the data workshop. Finally, advice was also sought from the Steering Committee and Project Advisory Committee regarding questions to be answered from the data.

Phase II: Stakeholder Interviews

Sampling

Members of the steering committee and/or the Director/Manager of the participating organisations were asked to identify relevant individuals to approach to participate in the survey. A range of organisations providing services to Aboriginal and Torres Strait Islander people involved with the justice system were asked to participate in the survey to gain a broad understanding of the current service delivery models. The following services were approached:

Department of Justice:

Justice Health
Koori Offender Support and Mentoring Program and Local Justice Workers
Koori Corrections Officers (as per Marie Murfet)
Aboriginal and Torres Strait Islander Community Corrections Officers
Prison Providers: representative AWOs/ALOs, Marngoneet Senior
Clinicians, Aboriginal and Torres Strait Islander specific program providers, Reintegration Programs Branch, ITP Program (Coleen Pearce/John Chesterman), Court Integrated Service Response (Kylie Kilgour)
RAJAC Chairs

Non-Governmental Service Providers:

Njernda Family Services, Echuca
Western Suburbs Indigenous Gathering Place
Konnect Program, Jesuit Social Services

Health Providers:

Forensicare
St. Vincent's Prisoner Health Services
Geo Health Services
Caraniche

Semi-Structured interview format

The interview was intended to be largely non-directive and allow participants an opportunity to raise the issues that concerned their given service; however, some questions were developed to guide the interview. The questions were as follows:

1. What are the main issues faced by Koori individuals when coming into prison?
2. What are the main issues that impact on mental illness, cognitive functioning and social and emotional wellbeing for Koori men and women in prison?
3. What are the main barriers to:
   Social Emotional Wellbeing and mental health service access for Koori men and women in prison, including transition services?
   Social Emotional Wellbeing and mental health service delivery for Koori men and women in prison, including transition services?
4. What works in the existing service delivery system?
5. What else could work and is needed, but is not part of the current service delivery model?
6. Any additional comments/issues of relevance?

Procedure

Organisations were provided with the explanatory statement and consent form. This was passed on to interested parties who then contacted the researchers to organise a time to conduct the interview. Interviews were conducted by telephone and generally lasted 30 minutes. Notes from the interview were used to qualitatively analyse the information provided.

Data Interpretation

A thematic analysis was undertaken to consider the responses of each of the organisations and individuals interviewed. All of the responses were considered in the themes presented. The preliminary results were shared with the Steering Committee and the Project Advisory Committee to validate them and consider the context in which the responses were provided.

RESULTS

Phase I: Koori prisoner interviews

Demographics

Sampling Information was collected across 10 correctional centres in Victoria and 122 offenders participated in this study (Figure 3).

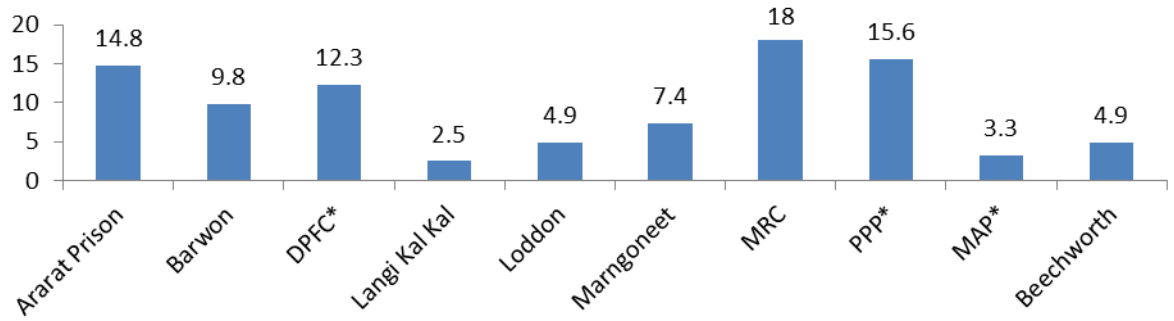


Figure 3. Distribution of participants by correctional centres (%)

Table 1 summarises the demographic characteristics of participants by gender and the total sample.

Table 1. Demographic characteristics from participants

	Males (n = 107)		Females (n = 15)		Total (N = 122)	
	N	%	n	%	n	%
Aboriginal	100	93.5	14	93.3	114	93.4
TSI	5	4.7	0	0	5	4.1
Both	0	0	1	6.7	1	.8
N/A	2	1.9	0	0	2	1.6
Relationship status						
Single	26	24.3	2	13.3	28	23.3
Spouse/Partner	59	55.1	10	66.7	69	57.5
Married/defacto	20	18.7	3	20	23	19.2
N/A	2	1.9	0	0	2	1.6
Age (mean & SD)	34.6 (10.4)	-	32.7 (9.3)	-	34.4 (10.3)	-

As can be seen in Table 1, the majority of participants identified themselves as Aboriginal. Five males identified themselves as Torres Strait Islander, and a single female identified herself as both Aboriginal and Torres Strait Islander. The majority of participants were in a relationship (male: 75.2% female: 86.7%) before custody. None were divorced or widowed.

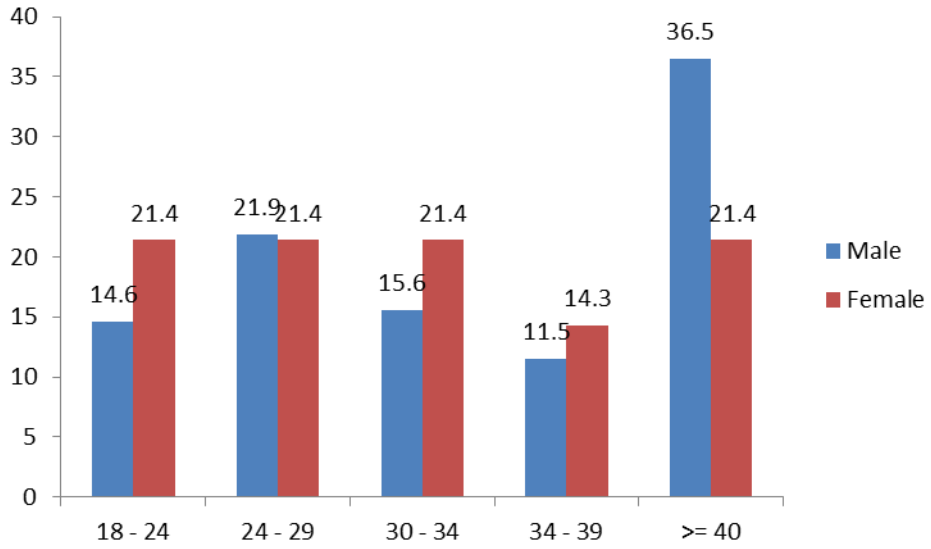


Figure 4. Age distribution for participants by gender

As can be seen in Figure 4, the mean age for both males and females was around early thirties to mid-thirties. Age distribution for males and females were similar, except for participants over forty years of age.

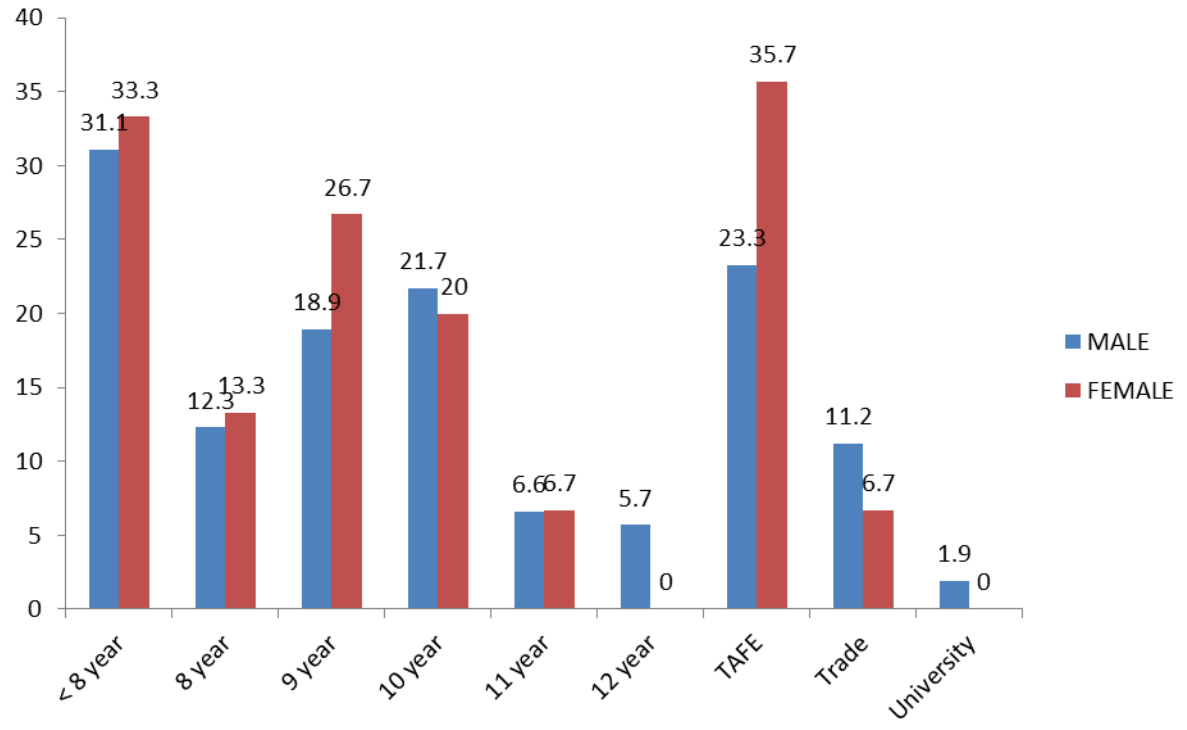


Figure 5. Level of education for participants by gender

Approximately one third of both males and females did not complete 8 year and relatively few participants had completed 12 year (male: 90.6%, female: 93.3%). One quarter of males and one third of females completed TAFE (Figure 5).

Table 2. Comparison of with those from the general offender population in Victoria

	Males (n= 106)	Male offenders in VIC (2010)	Females (n= 15)	Females offenders in VIC (2010)
	% (n)	%	*% (n)*	%
Age	34.9	37.2	32.7	37.7
Education				
Did not complete secondary	90.5 (96)	92.5	100 (15)	77.6
Completed secondary	4.7 (5)	3.7	0	3.9
Technical or trade school	.9 (1)	0.1	0	0.2
Tertiary education	1.8 (2)	1.6	0	2

Table 3 summarises the birth state for participants. The majority of participants were born in Victoria (61.1%), and around 20% of participants were born in NSW. Only two participants did not learn English as their first language and seven participants had learned a second language (e.g. Spanish, Mandarin, & Hindi). The majority of participants identified as Yorta Yorta or Gunai. The following language groups had fewer than five people: Torres Strait Islander and Wemba Wemba.

Table 3. Birth state for both males and females

	Male (n= 98) % (*n*)	Female (n= 15) % (*n*)	Total (N= 113) % (*n*)
State of birth			
Victoria	58.2 (57)	80 (12)	61.1 (69)
NSW	21.4 (21)	13.3 (2)	20.4 (23)
NT	1 (1)	0	0.9 (1)
QLD	10.2 (10)	6.7 (1)	9.7 (11)
WA	2 (2)	0	1.8 (2)
SA	3.1 (3)	0	3.5 (4)
TAS	4.1 (4)	0	3.5 (4)

Table 4 summarises the pre-custody living arrangements and geographical location by gender. Just over half of participants lived in a town before custody and around 45% of them lived in a city. One male lived in a remote community and a second lived Aboriginal and Torres Strait Islander community. Around 14% of participants lived alone (male: 15%, female: 6.7%). Approximately 50% of participants lived with a spouse and around a quarter lived with a family member. In terms of the type of accommodation, a quarter of participants also lived in community housing and 40% lived in a privately rented accommodation. As for income, the majority listed Centrelink as their main source of income and 15% indicated having full-time employment before custody.

Table 4. Pre-custody living arrangements by gender

	Male (n= 106) % (*n*)	Female (n= 15) % (*n*)	Total (N= 121) % (*n*)
Residence			
Living in city	44.3 (47)	53.3 (8)	46.3 (56)
Living in town	52.8 (56)	46.7 (7)	52.1 (63)
Remote community	0.9 (1)	0	0.8 (1)
Aboriginal or TSI community	0.9 (1)	0	0.8 (1)
Living arrangements			
Alone	15 (16)	6.7 (1)	14 (17)
With non-family members	7.5 (8)	13.3 (2)	8.2 (10)
with partner/spouse	27.1 (29)	26.7 (4)	27.3 (33)
with partner/spouse and dependent children	22.4 (24)	20 (3)	22.3 (27)
with immediate family members	19.6 (21)	33.3 (5)	21.5 (26)
with extended family members	5.6 (6)	0	4.9 (6)
N/A	2.8 (3)	0	1.6 (2)
Place of living			
hostel/motel/boarding house	2.8 (3)	0	2.5 (3)
supported accommodation	3.8 (4)	13.3 (2)	5 (6)
sleeping rough/homeless/no fixed address	3.8 (4)	0	3.3 (4)
couch surfing	4.7 (5)	0	4.1 (5)
own home	12.3 (13)	6.7 (1)	11.6 (15)
private rental accommodation	38.7 (41)	33.3 (5)	38 (46)
community housing	22.4 (24)	40 (6)	24.8 (30)
Other	11.3 (12)	6.7 (1)	10.7 (13)
Main source of income			
Centrelink	75.5 (80)	93.3 (14)	77.7 (94)
Full-time	17 (18)	0	14.9 (18)
Part-time	2.8 (3)	0	2.5 (3)
Criminal activity	1.9 (2)	6.7 (1)	2.5 (3)
Other	2.8 (3)	0	2.5 (3)
Income before custody (median)	14,150(AUS)	18,200(AUS)	15,600(AUS)

Note: Some categories may not be mutually exclusive.

Custody status

Table 5 indicates custody status and security status by gender. Participants were asked to self-report present custodial status. The majority of participants were fully sentenced at the time of the interview and fewer than 30% of participants were on remand. Most participants

were placed in mainstream security, but females were more significantly more likely to be in mainstream protection (X^2= 7.84, p< .01).

Table 5. Custodial and security status

	Male (n= 106) *% (n)*	Female (n= 15) *% (n)*	Total (N= 121) *% (n)*
Current status			
Remand	28.3 (30)	40 (6)	29.8 (36)
Fully sentenced	65.1 (69)	60 (9)	64.5 (78)
Remanded and sentenced	5.7 (6)	0	5 (6)
Unknown	0.9 (1)	0	0.8 (1)
Security status			
Mainstream	64.2 (68)	100 (15)	68.6 (83)
Protection	35.8 (38)	0	31.4 (38)
Protection status			
High	2.8 (3)	0	2.4 (3)
Low	6.6 (7)	0	4.9 (6)
N/A	91.4 (97)	100 (15)	92.6 (112)

Table 6 indicates past and index offences by gender. Violent offences were the most prominent in both past and index offences for males and were the most prominent in index offences in females. The majority of females committed a theft offence in the past (66.7%). Although males and females did not significantly differ on past or index offence, there was a general trend indicating higher rates of past drug offences for male (X^2= 5.4, p< .06).

Table 6. Past and index offences by gender

	Male (n= 106) *% (n)*	Female (n= 15) *% (n)*	Total (N= 121) *% (n)*
Nature of Index offence			
Homicide	3.8 (4)	0	3.3 (4)
Sexual Assault	16.8 (18)	0	14.9 (18)
Violence	33.6 (35)	40 (6)	34.7 (42)
Kidnap	3.8 (4)	0	3.3 (4)
Weapons offence	7.5 (8)	6.7 (1)	7.4 (9)
Threat of violence	3.8 (4)	0	3.3 (4)
Property damage	3.8 (4)	0	3.3 (4)
stalking	0	0	0
Drug Offences	9.3 (10)	13.3 (2)	9.9 (12)
Deception offences	0	0	0
Theft Offences	18.7 (20)	13.3 (2)	18.2 (22)
Breach of legal order	8.4 (9)	6.7 (1)	8.3 (10)
Bad public behaviour	3.8 (4)	0	2.5 (3)
Past offences			
Homicide	2.8 (3)	0	2.5 (3)
Sexual Assault	3.8 (4)	0	3.3 (4)
Violence	64.8 (68)	40 (6)	61.9 (75)
Kidnap	3.8 (4)	0	3.3 (4)
Weapons offence	37.1 (39)	13.3 (2)	34.2 (42)
Threat of violence	35.2 (36)	13.3 (2)	32.5 (39)
Property damage	34.3 (35)	20 (3)	32.5 (39)
stalking	.9 (1)	0	0.8 (1)
Drug Offences	44.8 (47)	13.3 (2)	40.4 (49)
Deception offences	13.3 (14)	6.7 (1)	12.5 (15)
Theft Offences	60 (64)	66.6 (10)	60.8 (61)
Breach of legal order	35.2 (37)	26.7 (4)	34.2 (42)
Bad public behaviour	29.5 (31)	33.3 (5)	30 (36)

Note: Some categories may not be mutually exclusive.

In addition to categories of offences, Table 7 presents current self-reported custody time, total time spent in adult custody, and total time spent in youth custody. Males had significantly longer current sentences ($t= 4.33$, $p< .001$) and total time in custody as an adult ($t= 4.19$, $p< .001$) than females. Although accumulated time in custody for adults may seem high, age should be taken into consideration, due to the large number of male participants over forty years.

Table 7. Time in custody by gender (months)

	Male (n= 103) *M*(*SD*)	Female (n= 15) *M*(*SD*)	Total (N= 118) *M*(*SD*)
Current custody time	33.6 (31.5)	13.1 (11.5)	30.8 (30.4)
Adult - Time in custody (months)	78.9 (81.6)	30 (30)	72.7 (78.8)
Youth - Time in custody (months)	16.3 (26.9)	4.7 (11.8)	15 (25.8)

Females were found to have shorter sentences than males, with 69.3% having a sentence less than twelve months, whereas, only 31% of males had a sentence shorter than twelve months (Figure 6).

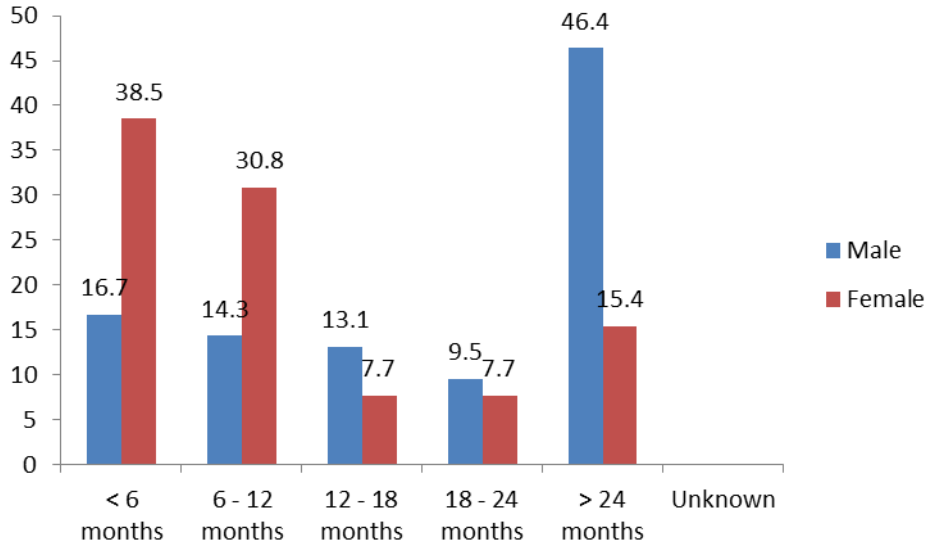


Figure 6. Length of current sentence by gender

Table 8. Comparing sentence lengths with those from general offender population in Victoria

	Aboriginal males (n= 106)	All male offenders in VIC (2010)	Aboriginal females (n= 15)	All female offenders in VIC (2010)
Length of sentence				
Under 1 month	0	0.7	0	0
1 and under 3 months	3.8	2.9	0	6.6
3 and under 6 months	6.4	9.2	30.8	11.5
6 and under 12 months	16.7	14.7	30.8	16.8
1 and under 2 years	23.1	18.2	23.1	23
2 and under 5 years	29.5	28.1	15.4	25.4
5 and under 10 years	15.4	15.1	0	9.8
10 years and over	5.1	10.5	0	7

Figure 7 indicates total custody time for both genders during youth (<18 years old). Most females (73.3%) and almost half of males (47.7) indicated spending less than one month in custody as a youth. Around 30% of males and 13% of females also claimed to have been in youth custody for over 24 months.

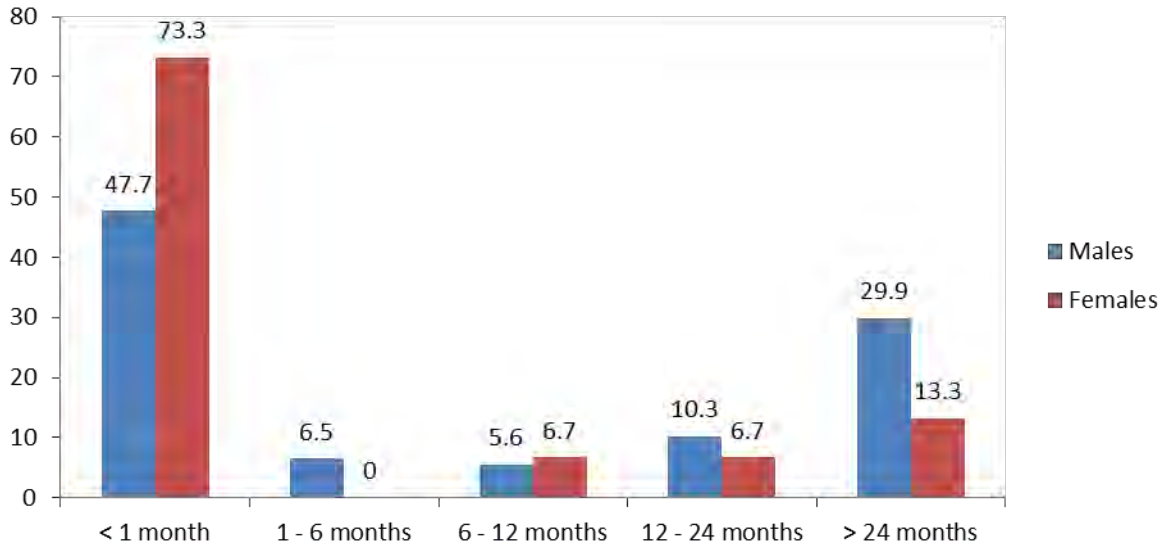


Figure 7. Time spent in youth custody by gender (< 18 years old)

Mental health

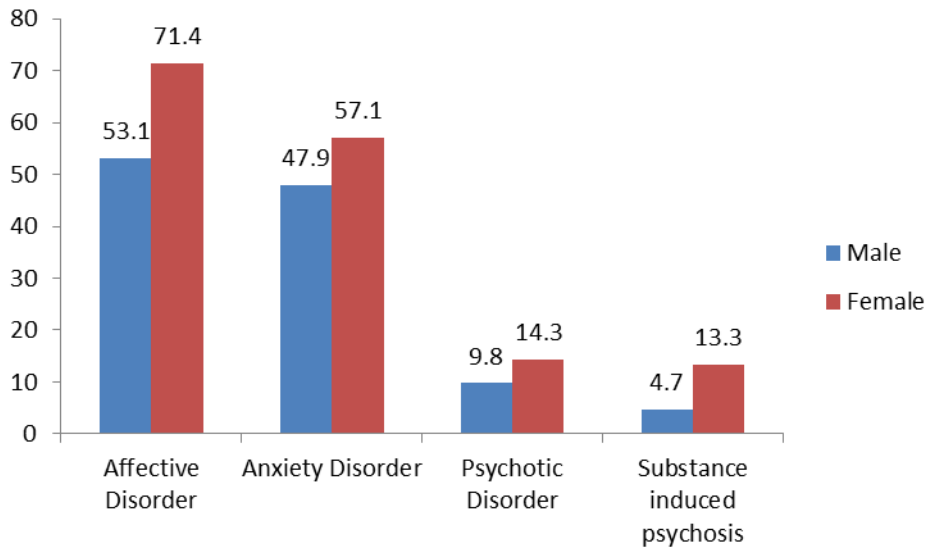


Figure 8. Lifetime prevalence of mental illnesses by gender

The majority of females (92.9%) and males (76.5%) were classified as having a current substance abuse problem (12 months). Rates of current anxiety disorders (1 month) were much higher than affective disorders.

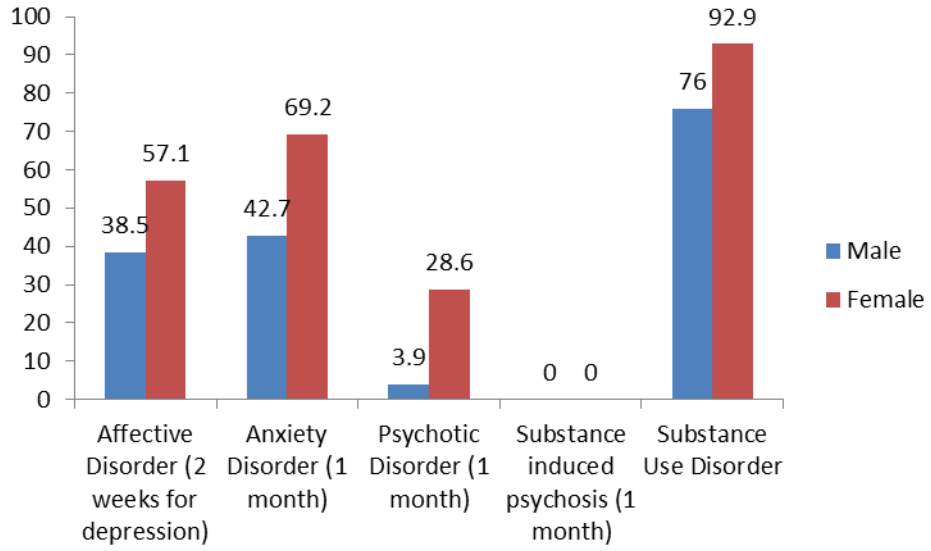


Figure 9. Rate of current mental illnesses by gender

Table 9 describes the breakdown of current and lifetime affective disorder for both males and females. Major depressive episodes was the most frequent current and lifetime affective disorder for males (10.8% & 32.7%, respectively) and the most frequent lifetime affective disorder for females (46.7%). Females had significantly higher rates of current hypomanic episodes (X^2= 7.35, p= .007) and current bipolar II disorder (X^2= 7.35, p= .007).

Table 9. Breakdown of affective disorders for males and females

	Current				Lifetime			
	Males		Female		Males		Female	
	n (107)	%	n (15)	%	n (107)	%	n (15)	%
Major depressive episode	11	10.8	1	6.7	35	32.7	7	46.7
Major depressive disorder	3	2.9	1	6.7	22	20.6	4	26.7
Manic/hypomanic episode	0	0	1	6.7	7	6.5	4	26.7
Bipolar I & II disorder	0	0	1	6.7	3	2.7	4	26.7

Note: Some categories may not be mutually exclusive

Table 10 indicates the breakdown of current and lifetime anxiety disorders for both males and females. Post-traumatic stress disorder was the most frequent current anxiety disorder for both males (14.7%) and females (46.2%). Females had significantly higher rates of postromantic stress disorder (X^2= 7.64, p= .006), non-generalised social phobia (X^2= 8.63, p= .013), and agoraphobia (X^2= 9.09, p= .011).

Table 10. Breakdown of anxiety disorders for males and females

	Current				Lifetime			
	Males n (107)	%	Female n (15)	%	Males n (107)	%	Female n (15)	%
Posttraumatic stress disorder	15	14.7	6	46.2	-	-	-	-
Generalized anxiety disorder	6	5.9	1	6.7	-	-	-	-
Social phobia (generalised & non generalized)	5	4.8	6	17.3	-	-	-	-
Panic disorder	4	3.9	1	6.7	16	15	5	33.3
Agoraphobia	10	9.8	5	35.7	-	-	-	-
Obsessive-compulsive disorder	5	4.9	1	6.7	-	-	-	-

Note: Some categories may not be mutually exclusive

Table 11 describes the breakdown of current and lifetime psychotic disorders for both males and females. Psychotic disorders/schizophrenia was the most frequent current and lifetime psychotic disorder for males (3.7% & 6.5%, respectively) and the most common lifetime psychotic disorder for females (13.3%). Schizoaffective/mood with psychosis was the most frequent current psychotic disorder for females (20%). Females had significantly higher rates of current mood disorder with psychotic features ($X2= 8.65$, $p= .003$) and current schizoaffective disorder ($X2= 7.35$, $p= .007$).

Table 11. Breakdown of psychotic disorders for males and females

	Current				Lifetime			
	Males n (107)	%	Female n (15)	%	Males n (107)	%	Female n (15)	%
Psychotic disorders / Schizophrenia	4	3.7	1	6.7	6	6.5	2	13.3
Schizoaffective / mood with psychosis	1	0.9	3	20	4	3.8	0	0
Brief psychotic disorder	0	0	0	0	1	0.9	0	0
Substance induced psychotic disorder	0	0	0	0	5	4.7	2	13.3

Note: Some categories may not be mutually exclusive

Table 12 presents the breakdown of current substance abuse for both males and females. For both males (50%) and females (66.7%), substance dependence was the most frequent disorder. The second most common disorder for males (41.2%) and females (33.3%) was alcohol dependence.

Table 12. Breakdown of substance abuse disorders for males and females

	Current			
	Males n (102)	%	Female n (15)	%
Alcohol dependence	42	41.2	5	33.3
Alcohol abuse	20	19.6	1	6.7
Substance dependence	51	50	10	66.7
Substance abuse	15	14.7	0	0

Note: Some categories may not be mutually exclusive

The majority of participants (67.2%) reported knowing someone who had committed suicide and half (51.4%) of these participants reported that they themselves had a history of suicide attempts. Suicide attempts were most often made whilst in the community (rather than whilst in custody). The majority of participants reported experiencing thoughts of suicide during their lifetime (64.2%), and over a quarter (26.6%) reported suicidal ideation in last 12 months.

Table 13. Experience with suicide

	Male (n= 101) *% (n)*	Female (n= 15) *% (n)*	Total (n= 116) *% (n)*
Experience with suicide			
Close friend or relative committed suicide	68.3 (69)	60 (9)	67.2 (78)
Thoughts about suicide	63.7 (65)	66.7 (10)	64.1 (75)
Thoughts about suicide in last 12 months	25 (24)	38.5 (5)	26.6 (29)
Where have the thoughts been worst			
In custody	17 (16)	15.4 (2)	16.8 (18)
In the community	39.4 (37)	38.5 (5)	39.3 (42)
Attempted suicide	51 (49)	53.3 (8)	51.4 (57)
In custody	4.5 (4)	7.7 (1)	4.9 (5)
In the community	43.2 (38)	53.8 (7)	44.6 (45)
Both	10.2 (9)	0 (0)	8.9 (9)

Note: Some categories may not be mutually exclusive

Table 14 shows the use of mental health, intellectual disability, and ABI services whilst in custody organised by gender and whether they have a mental illness or are registered with ID or ABI services.

Table 14. Registered with mental health services by gender

	Male (n= 101)		Female (n= 15)		Total (n= 116)	
	% (n)		*% (n)*		*% (n)*	
Psychiatric treatment during current custody						
	MI	No MI	MI	No MI	MI	No MI
Yes	28 (14)	32.1 (18)	50 (5)	25 (1)	31.7 (19)	31.7 (19)
No	36 (18)	46.4 (26)	10 (1)	50 (2)	31.7 (19)	46.7 (28)
Remand	20 (10)	21.4 (12)	40 (4)	25 (1)	23.3 (14)	21.7 (13)
Don't know	8 (4)	0	0	0	6.7 (4)	0
Psychiatric treatment during past custody						
Yes	36.7 (18)	40.4 (21)	45.5 (5)	75 (3)	38.3 (23)	42.9 (24)
No	42.9 (21)	57.7 (30)	45.5 (5)	25 (1)	43.3 (26)	55.4 (31)
Don't know	8.2 (4)	1.9 (1)	9.1 (1)	0	6.7 (4)	1.8 (1)
Registered with intellectual disability services						
	ID	No ID	ID	No ID	ID	No ID
Yes	0	7.9 (7)	0	8.3 (1)	0	7.9 (8)
No	100 (3)	89.9 (80)	100 (1)	91.7 (11)	100 (4)	90.1 (91)
Don't know	0	2.2 (2)	0	0	0	2 (2)
Registered with brain injury services						
	EFD	No EFD	EFD	No EFD	EFD	No EFD
Yes	85.7 (12)	8.4 (7)	0	8.3 (1)	13.3 (2)	8.4 (8)
No	14.3 (2)	86.7 (72)	100 (1)	91.7 (11)	86.7 (13)	87.4 (83)
N/A	0	4.8 (4)	0	0	0	4.2 (4)

Note: Some categories may not be mutually exclusive; MI = Mental Illness; ID = Intellectually Disabled; EFD = Executive Functioning Disabled.

As can be seen in Table 15, the most frequent factors restricting participants from seeking mental health services was the belief that services were unnecessary (12.6%) and issues in relation to transportation/distance (8.8%).

Table 15. Self-reported barriers to mental health services use in the community

	Male (n= 34) % (*n*)	Female (n= 3) % (*n*)	Total (n= 37) % (*n*)
Transport/distance	8.8 (3)	0	8.1 (3)
Cost	2.9 (1)	0	2.7 (1)
No service in area	2.9 (1)	33.3 (1)	5.4 (2)
Lack of service in area	2.9 (1)	0	2.7 (1)
Waiting time too long	0	33.3 (1)	2.7 (1)
not culturally appropriate	0	0	0
Did not trust services	5.9 (2)	0	5.4 (2)
Treated differently because of Aboriginal status	2.9 (1)	0	2.9 (1)
Did not think it was needed	11.7 (4)	33.3 (1)	13.5 (5)
Was not aware of services	5.9 (2)	0	5.4 (2)
N/A	61.8 (21)	66.6 (2)	62.2 (23)

Note: Some categories may not be mutually exclusive

Social and Emotional Wellbeing

Table 16 and Table 17 indicates item breakdown for each social and emotional wellbeing measure. Aboriginal and Torres Strait Islander specific social and emotional wellbeing measures are displayed in Table 16 and general social and emotional wellbeing measures are displayed in Table 17. These groupings were developed following the data workshop and were used for subsequent univariate and regression analyses.

Table 16. Breakdown of Aboriginal specific social and emotional wellbeing

Identification
Do you see yourself as being an Aboriginal and/or Torres Strait Islander person?
Are you Proud to be an Aboriginal and/or Torres Strait Islander person?
How often do you participate in Aboriginal and/or Torres Strait Islander activities or events (e.g. attend cultural events, going out bush)?
How often do you get a chance to hang out with Aboriginal and/or Torres Strait Islander people?
Do you Identify with a tribal group, language group or clan, or traditional owner group?
Connectivity
Do you feel connected to your homeland or traditional country?
Do you feel connected to you community?
Do you feel connected to your culture?
Knowledge
I have the knowledge to teach younger members of my family about Aboriginal and/or Torres Strait Islander culture
I have learned about my Aboriginal and/or Torres Strait Islander culture from my family/community
Positive Well-Being
How important is knowing about your people's history & culture for your wellbeing?
How important is knowing your own family history for your wellbeing
How important is knowing about & exercising your rights as an Aboriginal person for your wellbeing?
How important is spirituality for your wellbeing?
How often have you been able to practice or live your spirituality over the past 12 months
How important is being able to give to your family & friends for your wellbeing?
How often have you been able to give to your family & friends over the past 12 months
How important is being able to share with your family & friends for your wellbeing?
How often have you been able to share with your family & friends over the past 12 months?
How important is being with your family & extended family for your wellbeing?
How often have you been able to be with your family & extended family over the past 12 months?
How important is having a better level of education for your wellbeing?
How often have you been able to access education over the past 12 months?

Table 17. Breakdown of general social and emotional wellbeing

Resiliency
Overall, I feel like I have control over my life?
Working together with people close to me, I can overcome most of my problems?
I am able to handle painful feelings, like sadness, anger and fear?
When I am angry or sad I am able to talk to someone about it?
I am able to face problems without gambling, using drugs or alcohol, or harming others?
I feel safe in my community?
I feel safe in the broader society outside my community?
I have the skills to be confident in both indigenous and non-indigenous communities?
Stressors
Did you have a really bad illness or disability?
Where you in a really bad accident?
Did a family member or close friend pass away?
Did you discover/separate or get back together with a partner or get married?
Where there a lot of people living in the same house with you (overcrowding)?
Were you unable to get a job?
Did you lose your job, made redundant, sacked or retired?
Did you have any alcohol or drug related problems?
Did you have a gambling problem?
Did you witness violence?
Did you abuse anyone verbally or physically or commit violent crime?
Did you get in trouble with police/sent to/in jail for any other reasons (other than current custodial period offences)?
Did you have any family member's in prison or sent to prison?
Were you treated badly because of your indigenous heritage?
Distress
In the past 4 weeks, have you felt nervous?
In the past 4 weeks, have you felt without hope?
In the past 4 weeks, have you felt restless or jumpy?
In the past 4 weeks, have you felt like everything was an effort?

Most males (81.7%) and females (93.3%) identified with Aboriginal culture. Most males (65.4%) and females (66.7%) felt connected to their culture. Only a small portion of males (3.8%) felt no connection to culture.

Table 18. Social and Emotional wellbeing in relation to Aboriginal culture

	Male (n= 105) *% (n)*	Female (n= 15) *% (n)*	Total (n= 120) *% (n)*
Identification with culture			
Never to Rarely	0	0	0
Rarely to Sometimes	2.9 (3)	0	.8 (1)
Sometimes to Often	15.4 (16)	6.7 (1)	12.7 (15)
Often to Always	81.7 (86)	93.3 (14)	86.4 (104)
Connected to culture			
Never to Rarely	3.8 (4)	0	3.4 (4)
Rarely to Sometimes	7.7 (8)	0	6.7 (8)
Sometimes to Often	23.1 (24)	33.3 (5)	24.4 (30)
Often to Always	65.4 (69)	66.7 (10)	65.6 (79)

Table 19 indicates participant's perceived knowledge about Aboriginal culture and the source of their Aboriginal knowledge. The majority of participants (66.7%) were confident in their knowledge about Aboriginal culture. Fewer than 7% (6.7%) stated they had no knowledge about Aboriginal culture. The majority of participants (73.1%) also reported learning their Aboriginal culture from their family/community and relatively few (5.9%) reported not learning Aboriginal culture from their family/community.

Table 19. Description of knowledge about Aboriginal and Torres Strait Islander culture by gender

	Male (n= 105) *% (n)*	Female (n= 15) *% (n)*	Total (n= 120) *% (n)*
Knowledge about culture			
Strongly disagree	6.7 (7)	6.7 (1)	6.7 (8)
Disagree	16.2 (17)	26.7 (4)	17.5 (21)
Neither	10.5 (11)	0	9.2 (11)
Agree	30.5 (32)	40 (6)	31.7 (38)
Strongly Agree	36.2 (38)	26.7 (4)	35 (42)
I have learned Aboriginal or TSI culture from my family/community			
Strongly disagree	6.7 (7)	0	5.9 (7)
Disagree	7.7 (8)	20 (3)	9.2 (11)
Neither	13.5 (14)	33.3 (5)	11.8 (14)
Agree	32.7 (34)	0	32.8 (39)
Strongly Agree	39.4 (41)	46.7 (7)	40.3 (48)

Table 20 indicates the importance of positive social and emotional wellbeing for participants. No males or females reported that positive wellbeing was not important to them. A higher frequency of females (57.1%) than males (31.3%) indicated that positive wellbeing was very important to extremely important. The majority of males, 62.6% indicated that positive wellbeing was moderately to very important.

Table 20. Break down of positive wellbeing by gender

	Male (n= 99) *% (n)*	Female (n= 14) *% (n)*	Total (n= 113) *% (n)*
Importance of positive social and emotional wellbeing			
Not at all to a little bit important	0	0	0
Little bit important to moderately important	6.1 (6)	7.1 (1)	6.2 (7)
Moderately important to very important	62.6 (62)	35.7 (5)	59.3 (67)
Very important to extremely important	31.3 (31)	57.1 (8)	34.5 (39)

For both males and females, the most common reason behind stress was substance abuse problems (77.4% & 86.7%, respectively). For males, verbal and physical abuse (68.9%) was the second biggest stressor; whilst trouble with the police (73.3%) was the second biggest stressor was trouble with the police (73.3%).

Table 21. Stressors undermining social and emotional wellbeing by gender

	Male (n= 106) % (*n*)	Female (n= 15) % (*n*)	Total (n= 121) % (*n*)
Experience with Stressors (previous 12 months)			
Bad illness or disability	24.5 (26)	33.3 (5)	25.6 (31)
In a bad accident	12.3 (13)	0	10.7 (13)
Family member or close friend pass away	51.4 (54)	60 (9)	52 (63)
Did you divorce/separate or married	41.5 (44)	60 (9)	43.8 (43)
Overcrowded living arrangements	25.5 (27)	13.3 (2)	24 (29)
Unable to get job	45.7 (48)	60 (9)	47.5 (57)
lose job	17.1 (18)	7.1 (1)	16 (19)
SA related problems	77.4 (82)	86.7 (13)	78.5 (95)
gambling problem	6.6 (7)	20 (3)	8.3 (10)
Witness violence	65.1 (69)	53.3 (8)	63.7 (78)
abuse anyone verbally or physically or commit crime	68.9 (73)	46.7 (7)	66.1 (80)
In trouble with the police for any other reasons	48.1 (51)	73.3 (11)	51.2 (62)
Family member sent to prison	57.1 (61)	60 (9)	57 (70)
treated badly because of indigenous heritage	24.5 (26)	33.3 (5)	30.5 (31)

Note: Some categories may not be mutually exclusive

Relatively few participants (1.7%) reported having no resiliency, instead, the majority of males (80.6%) and females (66.7%) reported having resiliency most of the time.

Table 22. Psychological resilience by gender

	Male (n= 105) % (*n*)	Female (n= 15) % (*n*)	Total (n= 120) % (*n*)
Resilience			
Not at all to a little	1.9 (2)	0	1.7 (2)
A little to sometimes	17.5 (18)	33.3 (5)	20 (24)
Sometimes to often	47.6 (50)	20 (3)	44.1 (53)
Often to all of the time	33.3 (35)	46.7 (7)	35 (42)

In terms of distress, the majority of males (54%) and females (40%) reported little to no distress in their daily lives. Amongst those reporting distress, more females (40%) than males (20.6%) reported feelings of distress on a regular basis and 6.8% of the total sample reported feelings of distress more often than not.

Table 23. Psychological distress breakdown by gender

	Male (n= 102) % (*n*)	Female (n= 15) % (*n*)	Total (n= 117) % (*n*)
Distress			
None of the time to a little of the time	54.9 (56)	40 (6)	53 (62)
A little of the time to some of the time	24.5 (25)	20 (3)	23.9 (28)
Some of the time to most of the time	13.7 (14)	33.3 (5)	16.2 (19)
Most of the time to all of the time	6.9 (7)	6.7 (1)	6.8 (8)

Camberwell Assessment of Need

The Camberwell Assessment of Need was administered to participants as part of the interview. It is a standardised measure of a range of needs experienced by people with mental illnesses. The Forensic version was developed for offenders with mental illnesses. Analysis of the responses revealed that males and females in the sample reported relatively equivalent proportions of met and unmet needs during their incarceration. On average males and females reported 4 unmet needs out of a total of 25.

Table 24. Camberwell Assessment of Need – Forensic Short Version by gender

(SD)	Male (n= 103) *M*(*SD*)	Female (n= 15) *M*(*SD*)	Total (n= 118) *M*(*SD*)
CANFOR SV-S			
Met needs	6.76 (9.75)	5.87 (3.83)	6.65 (9.21)
Unmet needs	4.01 (3.27)	3.73 (2.55)	3.97 (3.18)
Total number of needs	9.78 (4.21)	9.60 (4.12)	9.75 (4.18)
Total needs for index offence	4.91 (3.18)	6.40 (3.23)	5.11 (3.21)

Cognitive Functioning

Three measures of cognitive function were administered: the Kimberly Indigenous Cognitive Assessment, the Trail-Making Test from the Delis-Kaplan Executive Function System, and the non-verbal scales of the Wechsler Abbreviated Scale of Intelligence.

The Kimberly Indigenous Cognitive Assessment (KICA), which is a measure of cognitive functioning that assesses gross cognitive impairment, such as dementia revealed that global cognitive functioning was broadly intact in the sample.

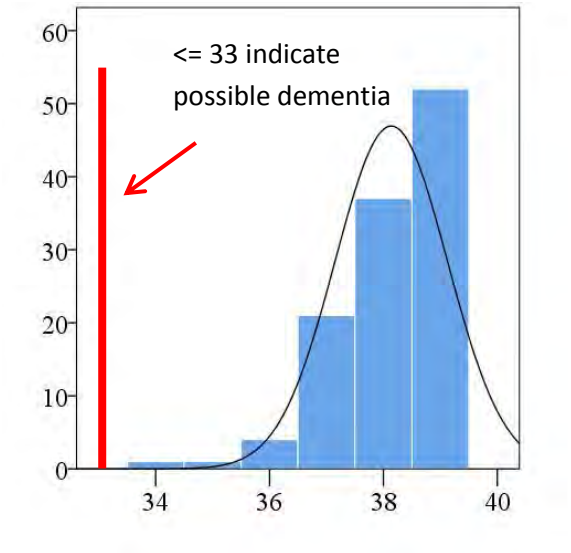


Figure 10. Kimberley Indigenous Cognitive Assessment

Amongst the sample, performance on tests of executive functioning was generally in the 'average' range for the majority of participants. The average scaled score was 8.57, which was lower than the community average (10). A total of 15 participants performed within the range that is indicative of an executive functioning deficit. Of those 15, 86.7% of had a diagnosed substance abuse disorder. T-test (participants: 8.57,SD=2.74) community (10,SD=3).

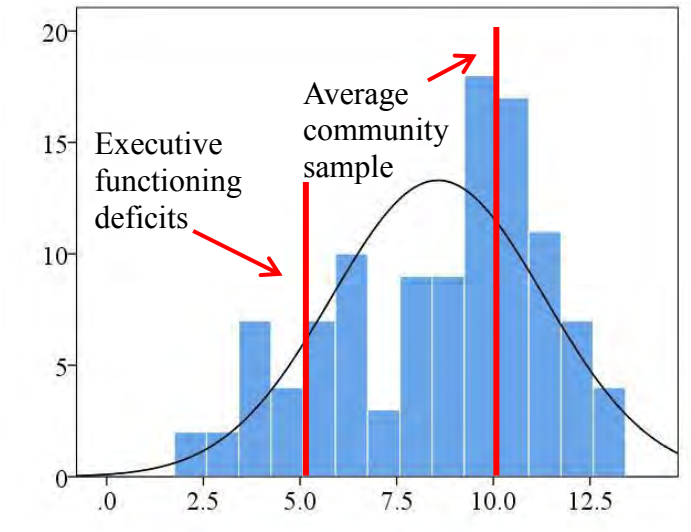


Figure 11. Mean DKEFS scores for males (n= 110)

The final measure of cognitive functioning employed was the performance (i.e., non-verbal) subscales of the Wechsler Abbreviated Scale of Intelligence (WASI). While mean participant scores on the WASI (92.22, SD = 14.39) fell significantly below the community average (100), the results do not appear to differ from that which would be expected of other prisoners (see Figure 12). Based on non-verbal intelligence, 4% of the sample had scores that fell greater than two standard deviations below the mean, which would be the cut-off for scores in the intellectual disability range.

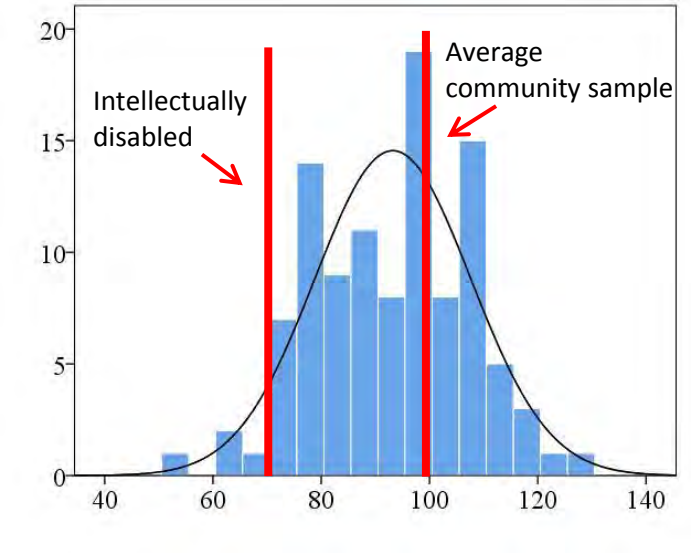


Figure 12. Performance IQ scores on the WASI

Pre-custody

For participants with a mental illness and no substance abuse, 30% attended a health care professional in the 12 months before custody. The most frequently used health care service was a general partitioner (20%). For participants with a substance abuse disorder and no mental illness, 34.9% had sought health care services. The most frequent health care service used was drug and alcohol services (20.9%), followed by counselling (18.6%). For participants who had both a substance abuse disorder and a mental illness, 45% had accessed health care services. The most attended service was drugs and alcohol services (17.5%), followed by COOPs (15.4%) and counselling (15.4%).

Table 25. Pre custody health care service usage in the 12 months before custody

	Current mental illness (exclusive) *% (n)*		Current substance abuse (exclusive) *% (n)*		Mental illness w/ substance abuse *% (n)*	
	Yes (n= 10)	No (n= 13)	Yes (n= 28)	No (n= 6)	Yes (n= 39)	No (n= 43)
Attended a health care professional	30 (3)	30.8 (4)	35.7 (10)	33.3 (2)	46.2 (18)	34.9 (15)
Psychiatrist	0	0	7 (2)	0	7.7 (3)	7 (3)
GP	20 (2)	7.7 (1)	7 (2)	16.6 (1)	12.8 (5)	7 (3)
Community MH services	0	0	7 (2)	0	2.6 (1)	7 (3)
Inpatient mental health services	0	0	3.6 (1)	0	2.6 (1)	2.3 (1)
Psychologist/Counsellor	0	7.7 (1)	17.9 (5)	16.6 (1)	15.4 (6)	18.6 (8)
Support group	0	0	3.6 (1)	0	5.1 (2)	2.3 (1)
COOP	0	0	10.7 (3)	16.1 (1)	15.4 (6)	9.3 (4)
Local community health centre/clinic	0	0	3.6 (1)	0	0	2.3 (1)
D&A services	10 (1)	30.8 (4)	21.4 (6)	33.3 (2)	17.9 (7)	20.9 (9)
Healing services	0	0	0	0	0	2.3 (1)
Men's group	10 (1)	15.4 (2)	7 (2)	16.6 (1)	5.1 (2)	9.3 (4)
Koori D&A services	0	0	7 (2)	0	5.1 (2)	4.6 (2)
Family violence worker	0	0	3.6 (1)	0	2.6 (1)	2.3 (1)

Note: Some categories may not be mutually exclusive

Post-release plans

Post-release plans for health care were recorded for participants who were anticipating release within twelve months. Out of the participants who exclusively have a mental illness, 75% of participants would seek health care services post custody release. Men's group (50%) was the most common health care service.

Of the participants who exclusively had a substance abuse disorder, 70.4% reported an intention to seek health care services post release. Men's group (29.4%) was still the most common health care service, followed by counselling (25.9%), and Koori connection (17.6%). Around one-fifth (22.2%) were undecided about seeking health services.

The majority of participants with a substance abuse disorder and a mental illness anticipated seeking health services post release. The most frequent health service was a general

practitioner (29.4%), followed by men's group (18.8%) and koori drug and alcohol services (18.8%). Around one-fourth (23.5%) were undecided about seeking mental health services.

Table 26. Post plan release for participants with mental illness and substance abuse for participants planning to be released within 12 months

	Current mental illness (exclusive) *% (n)*		Current substance abuse (exclusive) *% (n)*		Mental illness w/ substance abuse *% (n)*	
	Yes (n= 22)	No (n= 22)	Yes (n= 37)	No (n= 5)	Yes (n= 40)	No (n= 43)
Will seek health care services	91 (20)	86.3 (19)	94.6 (35)	60 (3)	60 (24)	69.7 (30)
Psychiatrist	13.6 (3)	13.6 (3)	8.1 (3)	0	12.5 (5)	11.6 (5)
GP	40 (9)	40 (9)	35.1 (13)	20 (1)	30 (12)	13.9 (6)
Community MH services	9 (2)	9 (2)	16.2 (6)	0	7.5 (3)	13.9 (6)
Inpatient mental health services	0	0	0	0	0	0
Counsellor	13.6 (3)	13.6 (3)	21.6 (8)	20 (1)	7.5 (3)	25.5 (11)
Support group	0	0	0	0	0	0
COOP	31.8 (7)	13.6 (3)	21.6 (8)	0	7.5 (3)	6.9 (3)
Local community health centre/clinic	0	0	5.4 (2)	0	7.5 (3)	6.9 (3)
D&A services	13.6 (3)	13.6 (3)	18.9 (7)	0	17.5 (7)	18.6 (8)
Healing services	0	0	2.7 (1)	0	0	6.9 (3)
Men's group	13.6 (3)	13.6 (3)	13.5 (5)	60 (3)	17.5 (7)	30.2 (13)
Koori D&A services	22.7 (5)	0	13.5 (5)	0	17.5 (7)	11.6 (5)
VARS	0	4.5 (1)	2.7 (1)	0	0	6.9 (3)
Koori connect	4.5 (1)	13.6 (3)	8.1 (3)	0	7.5 (3)	18.6 (8)
Undecided	13.6 (3)	9 (2)	13.5 (5)	20 (1)	25 (10)	23.2 (10)

Note: Some categories may not be mutually exclusive

Post plan living arrangements are displayed in Table 27. The majority of participants indicated that they would not be returning to their usual place of residence, with only one-fourth of participants reporting that they would return to their usual place of residence. One-fifth of participants also expressed worry about returning to where they usually resided.

Table 27. Post plan living location by gender

	Male (n= 98) % (*n*)	Female (n= 15) % (*n*)	Total (n= 113) % (*n*)
Plan to return where you usually live			
Yes	24.5 (24)	53.3 (8)	26.6 (4)
No	32.7 (32)	26.7 (4)	33.3 (5)
I don't know	5.1 (5)	13.3 (2)	6.6 (1)
N/A	37.8 (37)	13.3 (2)	33.3 (5)
Afraid of going back			
Yes	18.4 (18)	20 (3)	20 (3)
No	40.8 (40)	66.7 (10)	46.6 (7)
Don't know	2 (2)	0	6.6 (1)
N/A	38.8 (38)	13.3 (2)	33.3 (5)

Of the participants who answered, the majority plan to live at a relative's house post release (males: 19.6%, females: 13.3%), 14.4% of males and 33.3% of females plan on residing at their usual place of living. One third of participants (males: 34%, females: 33.3%) are planning to seek employment post release. The majority of females (46.7%) and 16.4% of males are not planning to seek employment post release. Half of participants plan on living of Centrelink/pensions (males: 40.2%, females: 80%) post release.

Table 28. Living and money arrangements post release

	Male (n= 97) % (*n*)	Female (n= 15) % (*n*)	Total (n= 112) % (*n*)
What type of accommodation			
Usual place	14.4 (14)	33.3 (5)	16.9 (19)
Home of relative	19.6 (19)	13.3 (2)	18.7 (21)
Home of Friend	6.2 (6)	0	5.4 (6)
Return to hostel	3.1 (3)	6.7 (1)	2.7 (3)
Nowhere to go	1 (1)	26.7 (4)	1.8 (2)
Unknown	3.1 (3)	6.7 (1)	3.6 (4)
Other	10.3 (10)	26.7 (4)	12.5 (14)
N/A	42.3 (42)	13.3 (2)	38.4 (43)
Seeking employment?			
Yes	34 (33)	33.3 (5)	54.5 (61)
No	16.4 (16)	46.7 (7)	20.5 (23)
Don't know	6.2 (6)	6.7 (1)	6.25 (7)
N/A	35.1 (34)	13.3 (2)	32.1 (36)
Main source of income			
Centrelink/Pension	40.2 (39)	80 (12)	45.5 (51)
Full-time work	16.4 (16)	0	12.5 (14)
Part-time work	1 (1)	6.7 (1)	1.8 (2)
Criminal activity	1 (1)	0	0.9 (1)
N/A	42.3 (41)	13.3 (2)	38.4 (43)

Note: Some categories may not be mutually exclusive.

In terms of substance use post-release, participants most often admitted to the intention to use alcohol (males: 23.7%, females: 21.4%), followed by cannabis (males: 16.5%, females: 13.3).Females indicated higher rates of anticipated speed use than males, although these differences were not statistically significant (Figure 13).

Table 29. Substance abuse post-release

	Male (n= 98) % (*n*)	Female (n= 15) % (*n*)	Total (n= 113) % (*n*)
Substance use post release			
Yes	47.9 (46)	13.3 (2)	53.1 (60)
No	47.9 (46)	86.6 (13)	41.6 (47)
Don't know	8.2 (8)	6.6 (1)	5.3 (6)

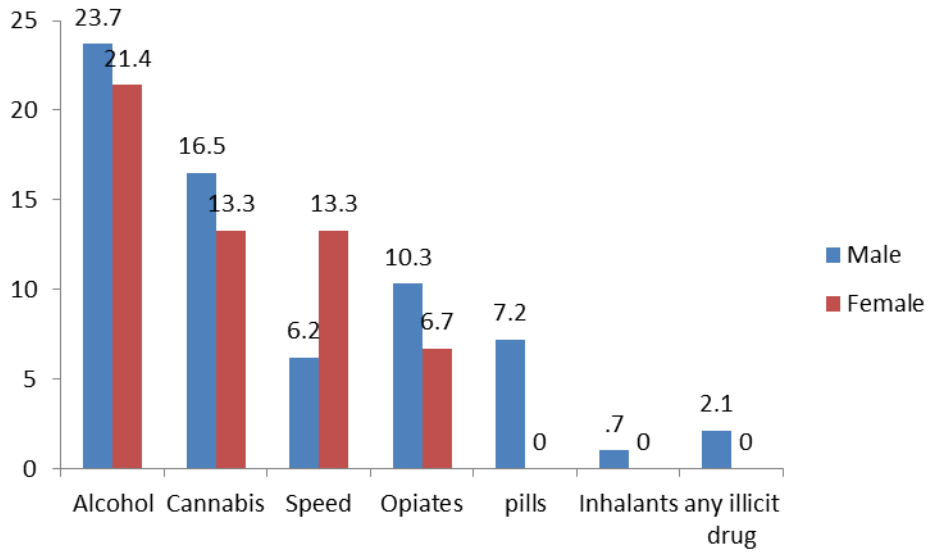


Figure 13. Substances that participants indicate they will use post-release

Relationship between mental illness, social and emotional wellbeing, and cognitive function

In the following section, the association between social and emotional wellbeing, mental illness, CANFor SV, and cognitive function was observed. Social and emotional wellbeing was divided into seven factors (Aboriginal identification, Aboriginal connectivity, Aboriginal knowledge, positive wellbeing, resilience, stressors, & distress). See Table 16 and Table 17 for a complete list of questions for each factor.

Mental illness was divided into seven factors (current affective disorders, lifetime affective disorders, current anxiety disorders, lifetime anxiety disorders, current psychotic disorders, lifetime psychotic disorders, & substance abuse disorders). Cognitive functioning was divided into three factors (executive functioning: DKEFS, non-verbal intellectual functioning and special reasoning: WASI, and culturally relevant general cognitive functioning: KICA). But, since the DKEFS was the only cognitive functioning factor which attained significance (current anxiety disorder: r= -.24, lifetime anxiety disorder: r= -.27, positive wellbeing: r= .29, resilience: r= .21, & stressors: r= -.28), the following section will focus on the relationship between social and emotional wellbeing, mental illness, and the CANFor SV.

Furthermore, since females only accounted for a small quantity (n= 15) of the total sample, The following section will focus solely on male participants (n= 107).

Zero-order correlations were conducted between mental illness and social and emotional wellbeing factors (table 30). Lower levels of resilience was associated with greater numbers of current affective disorders (r = -.33), current anxiety disorders (r = -.35), and lifetime anxiety disorders (r = -.37). Conversely, increases in the number of stressors were associated with significant increases in lifetime affective disorders (r = .35) and current psychotic disorders (r = .35). Likewise, increased Distress was significantly associated higher likelihood of current affective disorders (r = .41), lifetime affective disorders (r = .31), lifetime anxiety disorders (r = .29), and current psychotic disorders (r = .30).

Table 30. Zero-order correlations between mental illnesses and the Camberwell assessment of needs- forensic short version

	Identification	Connectivity	Knowledge	Positive	Resilience	Stressors	Distress
Affective							
Current	-.1	-.15	-.12	-.06	**-.33****	.19	**.41****
Lifetime	-.07	-.09	.07	-.02	-.19	**.35****	**.31***
Anxiety							
Current	.01	-.01	-.16	.04	**-.35****	.01	.26
Lifetime	-.18	-.10	-.02	-.24	-.19	.12	-.01
Psychotic							
Current	-.07	-.03	.07	.02	-.19	**.35***	**.30***
Lifetime	-.05	.00	.04	-.01	-.15	.17	.26
Substance abuse							
Current	-.05	-.04	-.09	-.18	-.05	.25	.06

Note: Anxiety lifetime was only measured for panic disorder. Bonf= .007.
*= p< .007
**= p< .001

Table 31 displays t-test results between participants with and without a mental illness on social and emotional wellbeing factors. There were significant differences in resilience scores and distress scores between participants with current affective disorders and participants without current affective disorders, between participants with current anxiety disorders and participants without anxiety disorders, and between participant with lifetime anxiety disorders and without lifetime anxiety disorders (Table 31).

A significant change in stressor scores between participants with lifetime psychotic disorders and participants without lifetime psychotic disorder and between participants with substance abuse disorders and participants without substance abuse disorders (table 31).

Table 31. t-test results between mental illness and social and emotional wellbeing factors.

T-test	Identification	Connectivity	Knowledge	Positive	Resilience	Stressors	Distress
	M(*SD*)	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)
Affective							
Current							
Yes (n=15)	18.2 (3.31)	7.74 (2.81)	6.93 (2.65)	33.27 (5.92)	**14.64 (5.05)****	7.00 (1.81)	**2.83 (1.15)****
No (n=84)	20.4 (3.69)	9.55 (2.80)	7.74 (2.13)	36.55 (5.97)	**21.57 (5.26)**	5.76 (2.21)	**1.95 (.89)**
Lifetime							
Yes (n=56)	19.66 (3.82)	8.93 (2.72)	7.88 (2.07)	36.00 (5.90)	19.51 (6.05)	6.27 (2.17)	2.24 (1.04)
No (n=47)	20.51 (2.89)	9.71 (3.02)	7.33 (2.36)	36.11 (6.31)	21.92 (5.10)	5.54 (2.17)	1.88 (.89)
Anxiety							
Current							
Yes (n=44)	19.81 (3.44)	4.54 (7.20)	7.09 (2.58)	35.75 (5.81)	**18.23 (6.04)****	6.30 (2.03)	**2.33 (1.11)***
No (n=59)	20.22 (3.46)	4.33 (6.42)	8.03 (1.81)	36.29 (6.29)	**22.42 (4.81)**	5.67 (2.29)	**1.87 (.82)**
Lifetime							
Yes (n=15)	20.50 (3.44)	9.33 (2.08)	8.14 (1.31)	37.55 (4.44)	19.76 (6.81)	6.65 (2.21)	2.50 (1.10)
No (n=84)	20.12 (3.44)	9.32 (3.03)	7.52 (2.27)	36.40 (6.15)	21.40 (5.51)	5.79 (2.21)	2.00 (.92)
Psychotic							
Current							
Yes (n=7)	17.00 (4.44)	8.33 (2.29)	6.00 (2.98)	30.63 (5.70)	15.88 (5.99)	7.33 (1.00)	2.83 (1.17)
No (n=96)	20.31 (324)	9.29 (2.99)	7.76 (2.11)	36.53 (5.88)	21.03 (5.56)	5.80 (2.23)	2.02 (.97)
Lifetime							
Yes (n= 18)	18.50 (4.38)	8.64 (2.34)	7.85 (2.67)	33.75 (7.93)	16.85 (5.49)	**7.14 (1.03)****	2.64 (1.27)
No (n= 85)	20.25 (3.27)	9.30 (3.03)	7.59 (2.16)	36.37 (5.73)	21.18 (5.59)	**5.75 (2.27)**	2.00 (.94)
Substance abuse							
Current							
Yes (n=80)	19.96 (3.52)	9.18 (2.82)	7.60 (2.27)	35.49 (6.07)	20.36 (5.70)	**6.43 (1.87)****	2.14 (.98)
No (n=23)	20.35 (3.21)	9.58 (3.06)	7.69 (2.03)	38.00 (5.70)	21.57 (5.88)	**4.10 (2.41)**	1.88 (.97)

Note: Anxiety lifetime was only measured for panic disorder. Bonf= .007.
*= p< .007
**= p< .001

Zero-order correlations were conducted between mental illness, social and emotional wellbeing factors and the Camberwell assessment of needs-forensic short version (table #). Greater number of unmet needs was significantly associated with current affective disorders (r = .31), lifetime anxiety disorders (r = .27), stressors (r = .26), distress (r = .41), and were

negatively associated with levels of resilience (r = -.61). Greater numbers of 'Total needs' was associated with increased Distress (r = .30), and less resilience (r = -.45). Greater numbers of number of needs relating to the index offence was significantly associated with greater current (r = .26) and lifetime (r = .35) affective disorders, stressors (r = .30), and lower resilience (r = -.30). Met need showed no significant relationships.

Table 32. Zero-order correlations between mental illnesses and the Camberwell Assessment of Needs- Forensic Short Version

CANFor SV	Met needs	Unmet needs	Total number of needs	Total needs in index offence
Mental illness				
Affective				
Current	.16	**.31***	.23	**.26***
Lifetime	.02	.16	.24	**.35****
Anxiety				
Current	-.05	.24	.15	.10
Lifetime	-.04	.07	.02	.05
Psychotic				
Current	-.02	.00	.00	.13
Lifetime	.00	.05	.05	.11
Substance abuse				
Current	-.08	-.06	.01	.06
SEWB				
Identification	-.02	-.23	-.21	-.02
Connectivity	.05	0	.05	.08
Knowledge	.06	-.04	.01	-.07
Positive	.09	-.02	.02	.15
Resilience	-.03	**-.61****	**-.45****	**-.30***
Stressors	-.05	**.26**	.15	**.30***
Distress	.09	**.41****	**.30***	.21

Note: Anxiety lifetime was only measured for panic disorder. Bonf= .012.
*= p< .012
**= p< .001

Table 33 displays t-test results examining participants with and without a mental illness on the Camberwell assessment of needs – forensic short version. There were significant differences in the number unmet needs and total number of needs between participants who

had a current affective disorder and participants who had no current affective disorder. Numbers of total needs in index offence were also significantly different between participants who had a current anxiety disorder and those who did not have a current anxiety disorder, as well as those who had a lifetime anxiety disorder, and those who did not have a lifetime anxiety disorder.

Table 33. t-test results between mental illness and Camberwell assessment of needs – forensic short version.

CANFor SV	Met needs *M*(*SD*)	Unmet needs *M*(*SD*)	Total number of needs *M*(*SD*)	Total needs in index offence *M*(*SD*)
Affective				
Current				
Yes (n=11)	5.64 (3.39)	**6.79 (4.14)****	**12.43 (4.01)***	6.50 (3.39)
No (n= 68)	5.90 (3.45)	**3.57 (2.91)**	**9.36 (4.11)**	4.65 (3.09)
Lifetime				
Yes (n= 42)	5.91 (3.41)	4.60 (3.62)	10.51 (4.34)	5.43 (3.18)
No (n= 37)	5.81 (3.49)	3.33 (2.70)	8.94 (3.94)	4.35 (3.11)
Anxiety				
Current				
Yes (n= 37)	6.09 (3.31)	4.91 (4.09)	10.77 (3.80)	**5.91 (3.39)***
No (n= 42)	5.69 (3.54)	3.34 (2.32)	9.03 (4.38)	**4.14 (2.81)**
Lifetime				
Yes (n= 12)	5.62 (3.58)	4.90 (4.23)	10.05 (4.13)	**6.94 (4.13)***
No (n= 65)	5.95 (3.49)	3.72 (2.91)	9.67 (4.24)	**4.74 (2.96)**

Note: Anxiety lifetime was only measured for panic disorder. Bonf= .012.
*= p< .012
**= p< .001

Regression Analyses

Seven linear regressions were conducted to investigate if significant social and emotional wellbeing would predict mental illness (current affective disorder, lifetime affective disorders, current anxiety disorders, lifetime anxiety disorders, current psychotic disorder, lifetime psychotic disorder, & substance abuse).

Current and lifetime affective disorder were positively associated with distress (β= .293, *p*= .009; β= .263, *p*= .025) respectively. Linear regressions revealed that current and lifetime affective disorder factors were not significantly associated with resilience and unmet needs.

Current anxiety disorders was positively association with age (β= .258, *p*= .007) and was negatively association with resilience (β= -.292, *p*= .009). Linear regression revealed that current anxiety disorder was not significantly associated with distress.

Current psychotic disorders was positively associated with distress (β= .217, *p*= .038), while linear regression showed no associations with stressors.

Although substance abuse was only negatively associated with age (β= -.224, *p*= .029), stressors came close to significance (β= .198, *p*= .053).

Older age was associated with less substance abuse (β= -.224, *p*= .029). Trends suggested that increased stress was associated with increased substance use (β= .198, *p*= .053); however, the difference did not reach statistical significance.

Regression Results

Affective current: *F*(3, 93)= 7.99, *p*< .001, R^2= .205, AdjR^2= .179
- Resilience: *t*= -.37, *p*= .712, β= -.046, *B*= -.004, *SE*= .010, sr^2= .001
- Distress: *t*= .2.66, *p*= .009, β= .293, *B*= .135, *SE*= .051, sr^2= .060
- Unmet needs: *t*= 1.74, *p*= .086, β= .204, *B*= .028, *SE*= .016, sr^2= .025

Affective lifetime: *F*(2, 94)= 4.87, *p*= .010, R^2= .094, AdjR^2= .075
- Resilience: *t*= -.61, *p*= .544, β= -.070, *B*= -.023, *SE*= .038, sr^2= .004
- Distress: *t*= 2.28, *p*= .025, β= .263, *B*= .482, *SE*= .211, sr^2= .050

Anxiety current: *F*(3, 93)= 7.92, *p*< .001, R^2= .203, AdjR^2= .178
- Resilience: *t*= -2.68, *p*= .009, β= -.292, *B*= -.074, *SE*= .028, sr^2= .062
- Distress: *t*= .95, *p*= .347, β= .104, *B*= .148, *SE*= .157, sr^2= .007
- Age: *t*= 2.76, *p*= .007, β= .258, *B*= .034, *SE*= .012, sr^2= .065

Psychotic current: *F*(2, 91)= 3.39, *p*= .038, R^2= .069, AdjR^2= .049
- Distress: *t*= 2.10, *p*= .038, β= .217, *B*= .060, *SE*= .028, sr^2= .045
- Stressors: *t*= 1.10 *p*= .275, β= .113, *B*= .014, *SE*= .012, sr^2= .012

Psychotic lifetime: *F*(1, 94)= 2.70, *p*= .104, R^2= .028, AdjR^2= .018
- Stressors: *t*= 1.64 *p*= .104, β= .167, *B*= .029, *SE*= .017, sr^2= .028

Substance Abuse: *F*(2, 93)= 5.86, *p*= .004, R^2= .112, AdjR^2= .093
- Stressors: *t*= 1.96 *p*= .053, β= .198, *B*= .121, *SE*= .062, sr^2= .037
- Age: *t*= -2.22, *p*= .029, β= -.224, *B*= -.029, *SE*= .013, sr^2= .047

Phase II: Stakeholder interviews

To provide in-depth information to supplement the empirical data, a series of stakeholder interviews were conducted with Aboriginal and Torres Strait Islander and other non-governmental organisations, governmental staff, and health and mental health service providers. The people who were interviewed were drawn from the following agencies:

- Njernda Family Services, Echuca
- Western Suburbs Indigenous Gathering Place
- Konnect Program, Jesuit Social Services
- GEO Care Australia (two interviews)
- St. Vincent's Prisoner Health Service (three interviews)
- Caraniche
- Independent Third Parties Program
- Forensicare (two interviews)

The interviews were semi-structured and enabled participants to speak openly about matters canvassed along the lines of the following seven questions:

1. Does your organisation have an Aboriginal and Torres Strait Islander Health Policy?
2. What are the main issues faced by Koori individuals when coming into prison?
3. What are the main issues that impact on mental illness, cognitive functioning and social and emotional wellbeing for Koori men and women in prison?
4. What are the main barriers to Social Emotional Wellbeing and mental health *service access* for Koori men and women in prison, including transition services?
5. What are the main barriers to Social Emotional Wellbeing and mental health *service delivery* for Koori men and women in prison, including transition services?
6. What works in the existing service delivery system?
7. What else could work and is needed, but is not part of the current service delivery model?

Thematic analysis

The following is a summary of the responses received for each of the questions covered in the stakeholder interviews.

1. **Does your organisation have an Aboriginal and Torres Strait Islander Policy?**

In general, interviewees indicated that their organisations had an Aboriginal and Torres Strait Islander policy that was made available to staff. One organisation indicated that a policy was not currently available, but rather the organisation was in the process of developing a policy.

2. **What are the main issues faced by Koori individuals when coming into prison?**

Service providers across the board reported mental health to be a major issue for Koori individuals entering prison. Specifically, displaced intergenerational trauma and grief expressed through substance abuse, poor perceptions of self-worth, loss of identity, high levels of untreated mental illness (Post-Traumatic Stress Disorder, anger, depression, and anxiety), interpersonal violence and self-harm were most often reported. The majority of Koori prisoners were noted to lack pro-social coping skills. As such, management of substance withdrawal needs was another need commonly reported by service providers.

Common themes relating to socio-economic disadvantages were frequently reported, including lower rates of formal education, chronic health issues, lower rates of employment and lack of housing. Some suggested that these disadvantages provided "recidivism incentives" to prisoners, in that, prison offered an escape from life and problems in the community. Others suggested that incarceration was normalised given that the majority of prisoner's families also had a history of incarceration.

The isolation/disconnection from country and mob were frequently raised concerns. However, the importance of individualised assessment and planning and cultural consultation was highlighted by some who suggested that the types of crimes committed by some Koori individuals would result in high levels of shame and rejection from the community. In these instances, it was inappropriate to place Koori individuals on units with other Koori prisoners.

Interviewees reported a general mistrust the system amongst Koori prisoners. Issues of racism from co-prisoners, staff and the broader correctional system were raised. For example, one interviewee pointed out that the units at Port Phillip Prison are named after the First Fleet that colonised Australia, suggesting an engrained lack of awareness and respect for Indigenous history. This racism, in combination with a mistrust of the system, lack of cultural awareness and integrated planning and communication between Koori-specific and mainstream services was reported to have significant implications for Koori prisoner's engagement with services – which has typically been found to be much lower compared to mainstream prisoners.

3. What are the main issues that impact on mental illness, cognitive functioning and social and emotional wellbeing for Koori men and women in prison?

The major theme arising from this question related to a lack of awareness and understanding of mental illness and health-related behaviours as they are conceptualised in the Westernised model of care currently in place in prisons in Victoria. Non-compliance with medical regimes stemming from lack of understanding of the need for treatment and suspicion about medication/vaccinations was reported. Stigma associated with mental illness, lower "emotional literacy", and reluctance to acknowledge problems were common issues reported to impact on mental health and wellbeing amongst Koori prisoners. Fear and avoidance of services was also reported due to concerns that the service response would not be helpful (e.g., "put in the slot" if suicidal ideation is expressed).

Guilt and shame associated with criminal conduct and incarceration was identified as a concern by some interviewees. Feelings of hopelessness about future opportunities (e.g., getting a job with a criminal record) and lack of life skills (e.g., parenting and communication skills) were highlighted as significant concerns expressed by Koori individuals. A final issue related to a concern about over-assessment and under-treatment of Koori prisoners which tended to result in prisoners further disengagement from services due to repeated traumatising resulting from re-telling their story to multiple professionals. This was further exacerbated by a reported lack of communication and continuity of mental health services within the prison and transitioning into the community.

4. What are the main barriers to Social Emotional Wellbeing and mental health *service access* for Koori men and women in prison, including transition services?

An inherent defensiveness arising from past negative experiences with non-Indigenous individuals was noted as a core problem in service access by Koori prisoners. Some suggested that the short time-frames for mental health services were insufficient to allow rapport to develop to enable this initial defensiveness to be overcome. The importance of building relationships over time and the inclusion of holistic, personal and intergenerational questions in treatment were common themes identified by interviewees. The lack of Koori mental health workers was reported to be a substantial barrier to engagement of Koori individuals in therapeutic processes. Nevertheless, others noted the importance of seeking the prisoner's perspective given that some Koori individuals may prefer mainstream services over Koori-specific services due to issues relating to shame about being seen by family attending certain services.

From a service perspective, lack of inter-agency communication, long waiting-lists for services and complicated referral processes were reported to be factors that discouraged Koori individuals from accessing services.

5. What are the main barriers to Social Emotional Wellbeing and mental health *service delivery* for Koori men and women in prison, including transition services?

Many of the same issues identified as impediments to service access were also reported as barriers in service delivery. That is, lack of understanding and training amongst professionals in Indigenous mental health, insufficient time to develop relationships/rapport to enable disclosure and treatment to occur and poor continuity of treatment from the community to prison and back, as evidenced by frequent contact with numerous professionals and changes to medication regimes. Moreover, specific to mental health, it was noted by several interviewees that the current model of care does not seem to be culturally meaningful to Koori people.

From a practical perspective, lack of resources and funding was reported as a barrier to care. For example, the pre- and post-release funding model was described as too rigid and

reported to produce inaccurate assessments of prisoner needs. Lack of follow-up in the community, inadequate housing and short timeframes for post-release planning were reported to significantly impact on post-release planning and outcomes.

6. What works in the existing service delivery system?

The inclusion of culturally consonant practices such as healing programs and smoking ceremonies (provided at DPFC) were reported to be infrequently available, but highly beneficial to Koori prisoners. Placing treatment and services into a culturally meaningful context for Koori people by highlighting the value of service in a way that is meaningful to Koori people was reported to increase acceptance of services. For example, one interviewee reported that acceptance of treatment of sexually transmitted diseases, such as Chlamydia, was more likely amongst males if they were made aware that untreated Chlamydia could result in infertility amongst females. Regular and frequent contact with family and social supports was also reported to improve outcomes for Koori prisoners.

In terms of engaging Koori prisoners with services, it was reported that better outcomes were achieved when workers had the opportunity to meet with prisoners on several occasions to establish a relationship *prior* to release. Informal systems of referral such as talking via prisoners who then encourage others to attend services and an "open-door" policy were also reported to be useful engagement strategies. Consistency of professionals to enable a trusting relationship to build and persistence in following-up prisoners over multiple occasions were also noted as important engagement factors. Amongst non-Indigenous professional interviewed, most reported that the availability of a well-respected, knowledgeable ALO was invaluable in engaging Koori prisoners in treatment and also planning for release. Finally, screening of mental illness upon reception into prison and Koori-specific prison programs were also noted to be beneficial in the current service delivery system.

7. What else could work and is needed, but is <u>not</u> part of the current service delivery model?

Several interviewees suggested that it may be worthwhile to examine models of care in other States. For example, ACCHS relationship with the prison in ACT could serve as a new model of care. Other more specific suggestions for improvements included:

- A regular screening process to detect mental illness that develops in prison after the initial screen.
- Provision for more sophisticated psychological work dealing with trauma, rather than just offence-specific psychological work.
- Holistic approach to mental health and wellbeing that incorporates a relational framework
- ALOs should be an identified position and there should be more ALOs
- Greater flexibility around meeting with prisoners – limit the use of referral process in favour of more informal opportunities to connect
- Co-ordinated release planning across agencies with more follow-up
- Greater focus on non-acute needs to address the needs of individuals who may otherwise "fly under the radar"
- Mentoring programs both in prison and upon release to connect prisoners with pro-social role models
- Increased focus on employment outcomes

DISCUSSION OF FINDINGS AND RECOMMENDATIONS

In this final section of the report, we provide a brief discussion of the findings of the studies and then present the recommendations. Given the very small percentage of female prisoners included in the study, caution must be taken considering their findings as they may not be generalizable to the broader sample of Koori female prisoners.

Discussion of Findings

Demographic and Background Information

Data from the prisoner interviews revealed that the proportion of survey participants was generally representative of the population distribution of Koori prisoners in Victoria. This suggests that the findings of the study would be applicable to the broader population of Koori prisoners. Most participants identified themselves as Aboriginal, with a small percentage of men (5%) identifying a Torres Strait Islander heritage, and a small percentage of women (6.7%) identifying a mixed Aboriginal and Torres Strait Islander background. In terms of demographic background information, the majority of participants were born in Victoria (58% of women and 80% of men). A relatively large percentage of men (21%) and women (13%) were born in New South Wales, and one out of ten (10%) men and 7% of women were born in Queensland

All but two participants learned English as their first language. Seven participants (6%) had learned a second language – that being Spanish, Mandarin, and Hindi). The majority of participants identified as Yorta Yorta or Gunai, which the following groups having fewer than five participants (Torres Strait Islander and Wemba Wemba). Educational attainment was generally low with the vast majority of men and all of the women reporting that they did not complete secondary education.

Prior to coming into custody, almost half of the men (44%) and just over half of the women (53%) were living in a city. Only one person had lived in an Aboriginal or TSI community. Most people lived with a partner or a partner and children. Very few people lived alone. Most people obtained their income from Centrelink.

Custodial Status and Offence History

A majority of both men and women were serving a sentence and were in the mainstream population. Twenty-eight per cent of men and 40% of women were on remand. With respect to current offending, a broad range of offences were realised, with very few people only having property offending (3%). Similarly, a broad range of prior offending was

reported, with offences involving violence being quite common (62%). Current and past offence histories did not differ significantly between males and females; however, no women had sexual offences while almost 20% of males did and men tended to have higher rates of past drug offences. Men reported significantly longer current sentences and total time in custody than women.

Mental Health

The vast majority of participants (71.7% of men and 92.3% of women) presented with some form of mental illness (excluding substance misuse disorders), with major depressive episodes and post-traumatic stress disorder (PTSD) the most prevalent for both males and females. Major depressive episodes were the most frequent current and lifetime disorder experienced by males. While major depressive episodes were also the most frequent lifetime mood disorder for women, they had significantly higher rates of current hypomanic episodes (i.e., with current being in the last month).

With respect to anxiety disorders, almost half of women (46%) and 15% of men were experiencing Post Traumatic Stress Disorder at the time of the assessments. Relatively few men experienced other anxiety disorders. High percentages of women met the diagnostic criteria for social phobias (17%) and agoraphobia (36%).

Psychotic disorders, which are generally perceived to be the most serious clinical disorders, were also over-represented in the sample. Consistent with research findings for other prisoners, 13% of women and 7% of men met the criteria for a diagnosis of a psychotic disorder (schizophrenia) over their lifetime. This compares with population-based research in Victoria that shows that 0.7% of people are diagnosed with schizophrenia over their lifetime (Short, Thomas, Luebbers, Ogloff, & Mullen, 2010). Focussing on current diagnoses, 4% of male Koori prisoners and 7% of female Koori prisoners met the diagnosis for a psychotic disorder (schizophrenia) at the time of the interview.

Mood disorders, which are among the most prevalent for people in the community, were also over-represented for Koori prisoners. Almost one-third of men (32.7%) and almost half of women (46.7%) were found to have experienced major depressive episodes – with one in five women meeting the criteria for a diagnosis of major depression. Relatively high rates of women also had bipolar disorder.

Taken together, all of the clinical disorders were over-represented when compared to community prevalence rates. Moreover, all of the mental illnesses were over-represented when compared to rates found in other prisoners. The sole exception was the psychotic

illnesses which, while still greatly over-represented compared to people in the community, is equivalent to other prisoners.

Substance Abuse and Dependence

Consistent with previous findings regarding high rates of substance misuse among prisoners, with most male and female prisoners met the criteria for a diagnosis of substance abuse or dependence. Substance abuse is a lesser serious form of a substance disorder than substance dependence. Half of males (50%) and two-thirds of women (66.7%) met the criteria for a diagnosis of substance dependence (other than alcohol). Thus, women were worse off. With respect to alcohol specifically, 41% of men were alcohol dependent and an additional 20% alcohol abusers. Relatively fewer women were alcohol dependent (33.3%) or abusers (6.7%). Where the abuse rates seem low, it is because participants met criteria for the more serious dependence forms of the disorders.

Experience with Suicide/Self-Harm

More than two-thirds of men (68%) and women (67%) reported having a close friend or relative who had committed suicide. Almost two-thirds of male and female Koori prisoners reported that had thought about suicide; with one quarter having occurred in the past month. Interestingly, both men and women reported that they were much more likely to consider suicide when they are in the community (39%) rather than when they are in custody (17%).

Half of men and women reported that they had attempted suicide, with most having attempted while they were in the community. Nonetheless, almost 15% of women and 8% of men reported having made a suicide attempt whilst in prison.

Mental Health Service Utilisation

Results show that more than one-third of men found in this study to meet the criteria for a current diagnosis of mental illness had NOT received mental health treatment during the current period of incarceration. This same was true for only one woman. When considering whether they had received psychiatric treatment in custody previously, the findings were similar for men, but more women reported that they had not received previous psychiatric care whilst incarcerated (45%) than the one woman found to be mentally ill in this study who was not currently receiving psychiatric care. Curiously, a number of both males and females reported that they received psychiatric care during incarceration, although they were not identified in this study as having a mental illness. Given the

limitations regarding the questions asked, this finding could not be examined further but is a matter worth exploring with health care providers.

Social and Emotional Wellbeing

As described in this study, participants were asked a number of questions regarding social and emotional wellbeing. Questions were divided into those pertaining to Koori or ATSI specific social and emotional wellbeing and general social and emotional wellbeing (stressors and resilience). The majority of men (82%) and the vast majority of women (93.3%) reported that they 'always' or 'often' identified with Aboriginal culture. Only a small portion of males (4%) felt NO connection to their Aboriginal culture – no women fell into this category. The majority of participants reported feeling knowledgeable about their culture. Most people reported learning their culture from their family or community.

Beyond simply identifying as part of their community, participants were asked how important cultural positive social and emotional well-being was to them – not one person reported that positive wellbeing was not important to them. Positive wellbeing was generally seen as more important by women than men.

With respect to stressors, both males and females reported the most common factor undermining their social and emotional wellbeing was substance abuse problems (79%). Witnessing violence, experiencing abuse,and having a family member being sent to prison, and being in trouble with the police themselves were identified as other significant factors. One-quarter of males (24.5%) and one-third of females reported that being treated badly due to their Aboriginal heritage undermined their wellbeing. Almost one-third of women but only 14% of men reported experiencing psychological distress "most of the time" or "all of the time." Most males (81%) and two-thirds of females (66.7%) were found to have at least some resilience.

Examination of responses relating to social and emotional well-being revealed that, unfortunately, many people felt that their opportunities to practice or live their spirituality were very limited in the prison context. Nevertheless, the majority of participants were found to have a positive level of resilience. This is an important finding because the d ata suggested that those with greater levels of resilience were less likely to experience mood disorders (e.g., depression, bipolar disorder) and anxiety disorders (e.g., PTSD, panic disorder).

Cognitive Functioning

Global cognitive functioning was found to be largely intact, with only 4% of prisoners falling in the borderline IQ range; however, almost 12% of participants were found to have

some significant executive functioning deficits (e.g., poor decision making, concrete thinking). These results suggest that, on the whole, Koori prisoners do not have greater difficulties with cognitive functioning as compared to other prisoners. The results reveal, however, that their levels of cognitive impairment far exceed what one would see in the community.

Relationship between Mental Illness, SEWB, and Cognitive Function

Given the interactive effects of mental illness, social and emotional well-being and cognitive function, the study attempted to further understand the association between these factors. The analyses here were only possible for men, given the small number of women in the study. As the relationship between cognitive functioning with mental illness and social and emotional wellbeing was found to be limited to current anxiety disorders, only the relationship between mental illness and the factors associated with social and emotional wellbeing were considered further. Taken together, the presence of stressors and distress were positively associated with mood disorders and anxiety disorders. A smaller effect was found for psychotic illnesses, which is to be expected given the more biological nature of psychotic disorders. Having resilience was associated with lower levels of mood and anxiety disorders but not psychotic illnesses. The presence of stressors was the only social and emotional well-being variable associated with substance abuse.

The extent to which individuals identified with, felt connected with, and were knowledgeable about their Aboriginal culture was not significantly related to any mental illness or substance misuse. This finding is likely due to the fact that levels of connectedness and related matters were quite high. Importantly, the lack of significant findings here does not mean that these matters are unimportant – rather that they are present in most participants and do not differentiate those with or without mental illnesses or substance misuse disorders.

Finally, analyses were undertaken to determine whether significant social and emotional wellbeing would predict presence of mental illness or substance abuse. The presence of stressors and distress predicted mood disorders, psychotic disorders, and substance abuse. Resilience, by contrast, only predicted lower levels of anxiety disorders. Interestingly, anxiety disorders could not be predicted by the presence of stressors or distress, but only by lower levels of resilience. Older prisoners were found to have high levels of anxiety but lower levels of substance abuse.

Stakeholder Interviews

Results of stakeholder interviews revealed that most organisations had a policy or were in the process of developing a relevant policy in this area. A number of issues were identified including displacement, intergenerational trauma and grief, substance misuse and withdrawal, isolation from their country and mob. It was noted that many Koori prisoners have a distrust of the "system" and those who work in it; as such, there is a perceived lower level of engagement among Koori prisoners than most other prisoners. Stakeholders noted the presence of racism in the prisons and a lack of cultural awareness or planning. Also noted was a lack of integrated planning and communication between Koori-specific and mainstream services.

It was believed that guilt and shame associated with crime and incarceration impacts prisoners' mental state and social and emotional well-being. Some Koori prisoners also demonstrate a lack of understanding of the importance of some health related behaviours. It was also noted that some Koori prisoners exhibit a degree of defensiveness that stems from negative experiences with non-Indigenous Australians. Factors such as frequent prisoner transfers and the over-assessment and relative under-treatment of Koori prisoners were reported to have detrimental effects. Moreover, Koori prisoners often have chaotic family lives, lack some skills, and experience feelings of hopeless about future opportunities.

A lack of trust among Koori prisoners, a lack of interagency communication, and the time limited nature of services were all noted to impede mental health service access. It was reported that movement of prisoners can make follow-up and continuity of care difficult or impossible. There are long waiting lists for services and too many steps in the referral process before people actually make contact with a service provider. There are limited Koori specific programs, they are not found in all prisons, and those that exist have limited places in them.

A lack of understanding and training amongst professionals in Aboriginal mental health was identified; this is compounded by a lack of Koori mental health workers. The current model of mental health care provided in prisons is not embedded within a culturally sensitive context and may not be meaningful to Koori people. There is poor continuity of treatment from community to prison and back (i.e., frequent changes to medication regime, lack of communication between services). Adding to feelings of mistrust previously identified, the insufficient time available to develop professional relationships and rapport are seen as challenging. The pre- and post-release funding model is seen as too rigid and often results in an inaccurate assessment of prisoners needs. Significant concerns were raised relating to the lack of follow-up services upon release, raising the need for more preparation around post-release planning which should commence much earlier.

A number of factors that may have success with Koori prisoners were identified. For example, healing programs were highlighted, but it was noted that too few are available. Other programs and services that place treatment in a context that is relevant to Koori people are helpful. Aboriginal Welfare Officers (AWOs) and Aboriginal Liaison Officers (ALOs) can be very effective. The mental health screening of prisoners coming into prison is seen as positive in identifying mental health needs in all prisoners, including Koori prisoners. Family contact may be helpful and there is a need for more opportunities to help prisoners re-connect to their families. It was noted that very high needs clients tend to receive better support and post-release planning because they tend to attract considerable attention. The informal system of referrals which involves talking to other prisoners and AWOs helps to encourage people to attend services. A consistency in professionals is helpful; it was noted that all too often there are changes in staffing.

The interviews suggested that a need exists for systematically detecting mental illness after prisoners are incarcerated. There is a need for more sophisticated psychological treatment to deal with trauma. The approach to mental health services needs to be holistic – not just about illness, but about resilience and other aspects of well-being. Coordinated release planning across agencies – including Koori services – is required. It was noted that services are required for non-acute needs.

Taken together, the findings from the stakeholder interviews were consistent with the Phase I findings in relation to the importance of prioritising assessment and treatment of mental illness amongst Koori prisoners. Such treatment should be conducted within a holistic and culturally meaningful context. Time for rapport building should be prioritised to facilitate the engagement of Koori prisoners and greater interagency communication is needed to ensure treatment gains are not lost in after care.

Recommendations

Drawing on the findings from the study, the following recommendations were developed focussing on systems recommendations and recommendations pertaining to practice. Two figures follow the recommendations – the first depicts some of the problems associated with the system and the second shows the flow of services incorporating the recommendations made.

Systems Recommendations

1. The Department of Justice should identify the mental health and well-being of Koori prisoners as an immediate priority for service development.

2. The findings from the Koori Prisoner Mental Health and Cognitive Function Study should inform an up-to-date action plan to underpin mental health service development and delivery for Koori prisoners. Once established, the action plan should be measured within AJA3's Monitoring and Evaluation Framework and monitored by the Aboriginal Justice Forum for five years to ensure it is implemented appropriately. The action plan should be linked to existing accountability processes for the Victorian Aboriginal Justice Action Plan, including Justice Health's Koori Inclusion Action Plan and Justice Health's Aboriginal Justice Action Plan.
3. The philosophy underpinning the development and delivery of a model of mental health care for Koori prisoners should be based on the Social and Emotional Well-Being (SEWB) model of mental health. A variety of specific delivery models should be considered for use, including enhanced culturally sensitive practice, the training and recruitment of Aboriginal mental health professionals and mobile Koori mental health care teams.
4. Mechanisms, such as scholarships and internships, should be investigated to increase the availability of Aboriginal mental health professionals in prisoner health and mental health services.
5. Justice Health and contracted health service providers require an overarching policy for mental health assessments and the delivery of mental health services to Koori prisoners. While establishing standards, the policies need to be flexible and responsive to local needs.
6. Increased availability of cultural and spiritual practices and supports are required to assist Koori people to participate in activities to enable them to connect with their culture and practice their cultural activities while incarcerated.
7. Any service delivery model or practices implemented for Koori prisoners must be evaluated to help determine their utility in addressing the needs of this population. An evaluation framework should be embedded in the service development and delivery model that ensures that Koori people are involved in data collection, analysis, and interpretation.

8. Objective, measureable, key performance indicators should be set for health providers to ensure that the health, mental health and social and emotional well-being of prisoners are being met.
9. The development of mental health and SEWB services should ensure continuity of care across the period of incarceration. To the extent possible, the service model should allow prisoners to have ongoing access to mental health professionals with whom they can build a trusting therapeutic relationship over time.
10. Culturally competent efforts to enhance mental health services for Koori prisoner must be linked to aftercare in the community, with emphasis on Aboriginal Community Controlled Organisations. There is a fundamental need for the continuity of care in mental health services provided to Koori women and men as they exit prison. The means to help Koori prisoners connect to health, mental health and social services in the community should be explored since different approaches, such as in-reach models, the use of AWOs who work outside of the prison to provide support and assistance, might be appropriate.

Practice Recommendations

11. The Aboriginal concept of health is holistic and encompasses all aspects of health: physical, mental, cultural and spiritual. The assessment and treatment of mental health, therefore, should be conducted in the context of a broad Social and Emotional Well-Being framework that includes the following elements:
    a. Mental health assessments and the delivery of mental health services to Koori prisoners must be done in a culturally informed and culturally safe manner.
    b. Health and mental health staff should receive training to assist them to develop cultural competence in working with Koori people. Health and mental health practitioners and those responsible for the delivery of services should take into account the historical, cultural, and environmental experiences and contemporary circumstances of Koori people.
    c. Services should be provided to address elements of social and emotional well-being that impinge on mental health including the importance of connection to culture, ancestry, spirituality, land, family and community.

d. Services should also help individuals build resilience (e.g., coping strategies, strengths), as the study revealed that men and women with higher degrees of resilience experience lower levels of most mental illnesses.

12. The study identified particularly high rates of anxiety (PTSD) and mood disorders among Koori prisoners, and revealed a relationship between these disorders and elements of social and emotional well-being including distress, stressors, and lack of resilience. As such, in addition to managing symptoms, services are required that address the underlying distress experienced by Koori men and women in custody. Given the high rate of mental disorder and social and emotional damage among female Koori prisoners, all Koori women should undergo a culturally appropriate mental health assessment upon incarceration. The assessment should be used to develop care plans for female prisoners that can help address their mental health and social and emotional well-being needs during their period of incarceration and into the community.

13. Although the rates of mental disorder and social and emotional damage are somewhat lower for male Koori prisoners, they are still significantly higher than what is found for other prisoners. As such, health and mental health professionals should be acutely aware of the heightened level of need for services that many male Koori prisoners may have to ensure that men in need of services are appropriately referred and treated.

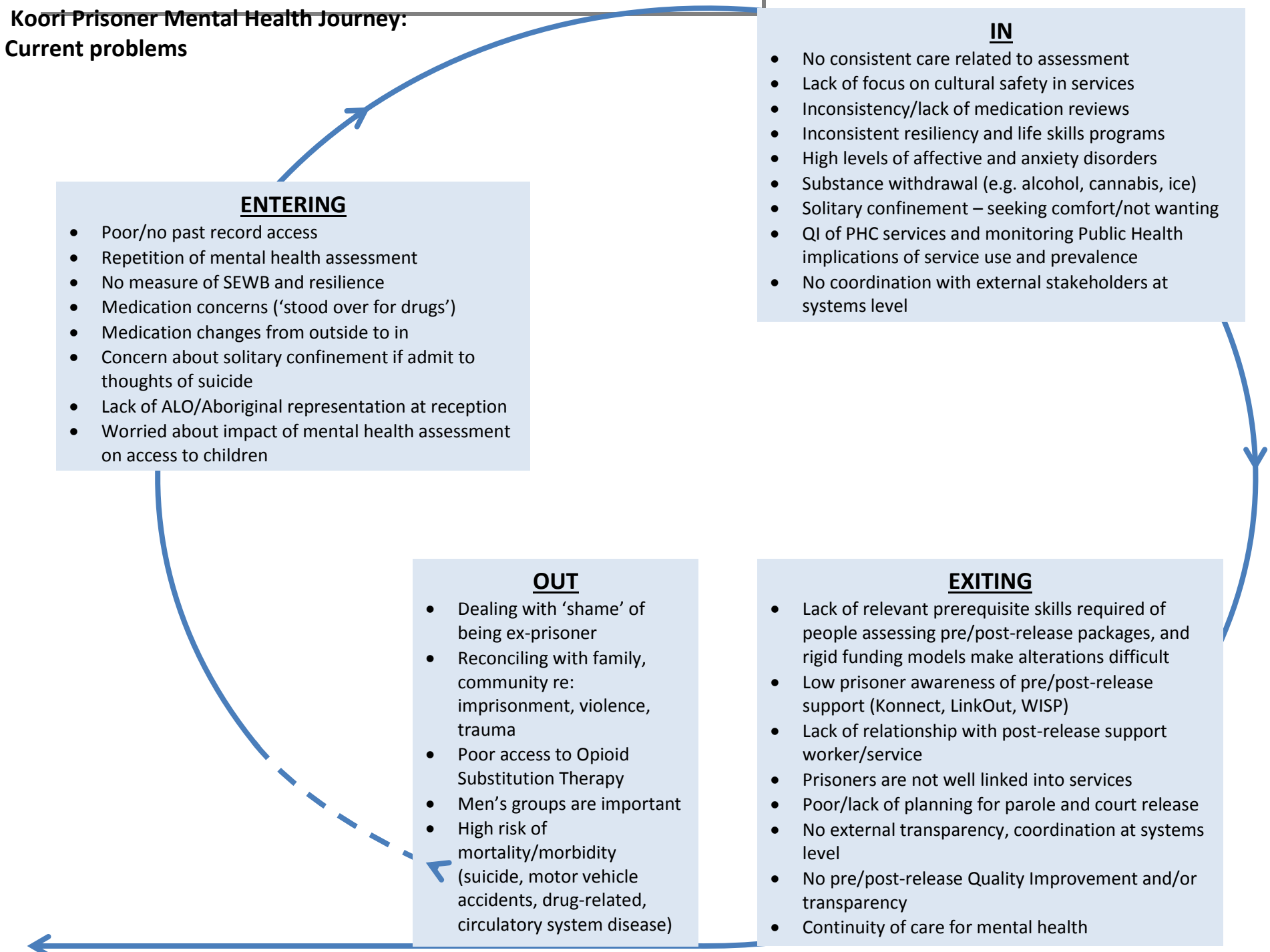
14. Rates of substance misuse are high among both female and male Koori prisoners; therefore, culturally relevant intervention programs for substance use disorders, and co-occurring mental illnesses and substance use disorders are required. Interventions should include life building skills and the development of resilience to help address some of the underlying factors that may relate to elevated levels of substance misuse (e.g., grief, loss, trans-generational trauma, and psychological distress).

15. Although the estimated rates of cognitive impairment deficits among Koori prisoners do not appear to differ from rates for other prisoners, a small but significant proportion of Koori prisoners have intellectual disability and cognitive impairments that can impact negatively on their well-being. Appropriate evaluation and intervention are required where needed that take into account the cognitive deficits of prisoners.

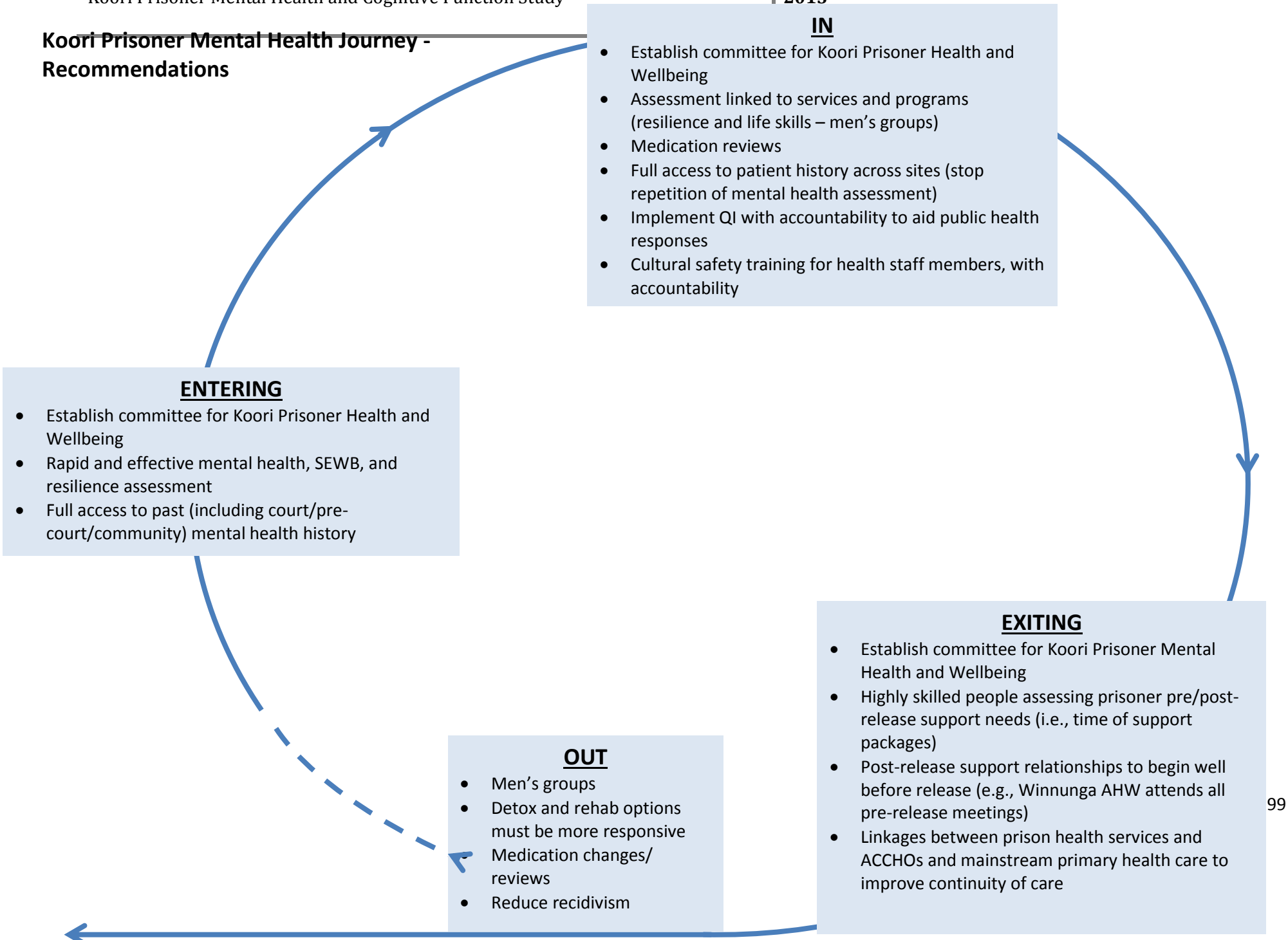
16. Families may provide a support of ongoing support for Koori prisoners with mental health and social and emotional well-being needs; therefore, where appropriate, the role of the family in providing information and support should be considered in the mental health care of prisoners.

17. Given the diversity across Koori prisoners from different regions and mobs, attempts should be made to reconnect people to their mobs and enlist support of the mobs in providing prisoner care.
18. Aboriginal and Torres Strait Island prisoners sometimes come from other states and jurisdictions and staff should, therefore, consider their unique cultural issues and needs.

Koori Prisoner Mental Health Journey: Current problems



Koori Prisoner Mental Health Journey - Recommendations



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Glossary

Mental Illness: Characterised by alterations in thinking, mood or behaviour associated with significant distress and impaired functioning.

Affective Disorder: Characterised by a consistent, pervasive alteration in mood and thoughts.

Anxiety Disorder: Characterised by excessive worry, fear, and uneasiness.

Psychotic Disorder: Umbrella term covering several disorders (e.g. Schizophrenia) - Characterised by abnormal thinking and perception. Many people lose touch with reality and experience delusions or hallucinations.

Substance Abuse Disorder: Includes substance use (overindulgence) and dependence.

KOORI PRISONER MENTAL HEALTH AND COGNITIVE FUNCTION STUDY

RESEARCH NUMBER: _ _ _ _ _ _ _ _

INTERVIEW DATE: _ _ / _ _ / _ _ _ _

NAME OF INTERVIEWER/S: _

SITE: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section 1: Informed Consent

Explain the nature of the project and expected time involve.

EXAMPLE: We know very little about how many Aboriginal and Torres Strait Islander People in custody experience significant mental health and social and emotional wellbeing problems, as well as other difficulties with thinking or cognitive functioning.

Experience suggests that more needs to be done to help Indigenous People in custodial settings, and this project will help us to understand how we can provide better support for those who need it.

The reason we are doing this project is because we know that we could be doing more to support Indigenous people in custody in terms of their mental health, social & emotional wellbeing, and cognitive functioning. But first we need to identify what type of difficulties people are experiencing, and then we can think about what to do about it.

This interview should take about two-three hours and may need to be spread over two or three sessions. Please feel free to ask for a break any time.

I will be asking some questions and getting you to do some puzzles. I will be recording your answers.

This project has an Indigenous advisory committee that has made sure this study is culturally appropriate.

If the participant indicates that they are interested in knowing more about the study, explain the study by taking them through the Information Sheet, which is for the participant to keep.

You will need to read the information sheet to the participant; although if they indicate that they can read and understand the content, the participant may wish to read the document themselves.

Explain any concepts the participant may have difficulty understanding and answer any questions they may have.

FOR EXAMPLE: If you agree we will be going through some questions with you. Some of the questions may seem kind of personal, and you don't have to answer anything you don't want to. In fact, you can stop the interview at any time.

By confidential I mean that the information that you give today will not be discussed with anyone else. No one will ever be able to trace your answers from here, and the only means of identifying you today will be via this consent form, which will be placed in a sealed envelope in front of you.

Unfortunately, I cannot give any advice on legal matters or agree to help you in a personal way, but I am able to refer you to the support services available in the centre (e.g., PSH).

I am also obliged to inform my supervisors if you tell me that you are thinking about hurting yourself or someone else. If this is the case, we have to inform relevant services to ensure your safety.

Mental health is a state of *wellbeing* in which the individual can cope with the normal stresses of life and achieve their potential.

The concept of mental health comes more from an illness model and its focus is more on the individual and their level of functioning in their environment. The Social Emotional Wellbeing (SEWB) concept is broader and considers the importance of connection to land, culture, spirituality, ancestry, family and community, and *how these affect the individual*.

If you are keen to go on, these are the forms I need you to sign.

One copy is for you to keep.

The other is for me to put into this sealed envelope.

If the participant indicates they are interested in participating in the study, take them through the consent form.

Ask them to explain in their own words what is involved in participating in this study, and what it means to give consent.

If you believe that the Participant does not understand the information presented to them, do not proceed and please inform the Project Manager.

If you are satisfied that they are able to give consent, and they have agreed to participate in the study, have the Participant sign one copy of the consent form for them to keep.

The other copy of the consent form is for the researcher to keep and is also to be signed by the participant. Place the signed form in an envelope and seal it in front of the participant.

NB: Have the participant tick all or some of the 'yes' boxes if they agree to have their details passed onto other agencies to collect further information, or 'no' if they do not. They can still participate in the study if they do not consent to having their collateral information collected.

Section 2: PARTICIPANT DETAILS

2.1 This section looks at the Demographic details of the Participants, including identification with the Aboriginal and Torres Strait culture, and offending history.

To start off, I would like to ask you some questions about yourself, including your Indigenous status, level of education, and how long you have been in custody for.

		COMMENTS/NOTES
2.1a GENDER	☐ 1. Male ☐ 2. Female	
2.1b DOB	_ _ / _ _ / _ _ _ _	
2.1c INDIGENOUS STATUS **Where are you from/who is your mob?** **What State were you**	☐ 1. Aboriginal ☐ 2. Torres Strait Islander □ Victoria □ NSW □ NT □ ACT □ QLD	

born in?	□ WA □ SA □ Tasmania	
2.1d FIRST LANGUAGE **What is your first language?**	☐ 1. English ☐ 2. Aboriginal English ☐ 3. Torres Strait Islander ☐ 4. OTHER	
2.1e OTHER LANGUAGES **Do you speak any other languages?**	List any other languages spoken.	
2.1f EDUCATION LEVEL **How far did you get in school?**	☐ 1. Did not complete Year 8 ☐ 2. Completed Year 8 ☐ 3. Completed Year 9 ☐ 4. Completed Year 10 ☐ 5. Completed Year 11 ☐ 6. Completed Year 12 ☐ 7. Completed University degree ☐ 8. Completed TAFE (e.g., vocational training not including completing VCE) ☐ 9. Completed technical trade skills training (e.g., apprenticeship)	

	☐ 10. Not stated/unknown ☐ 11. OTHER	
2.1g CUSTODY STATUS **Are you currently…?**	☐ 1. On Remand ☐ 2. Fully Sentenced ☐ 3. Remanded and Sentenced ☐ 4. Not stated/unknown	
2.1h CORRECTIONAL CENTRE SECURITY STATUS **Where are you currently placed in the prison?**	☐ 1. Mainstream ☐ 2. Protection ☐ 2a. High ☐ 2b. Low ☐ 3. Not stated/unknown ☐ 4. OTHER	
2.1i NATURE OF INDEX OFFENCE **What offence led to your current sentence?** **(Tick all applicable)** **DO NOT ASK PARTICIPANTS ON REMAND!** **Prior to asking this question remind participants you do not**	☐ 1. Homicide ☐ 2. Sexual assault ☐ 3. Violence ☐ 4. Kidnap ☐ 5. Weapons offence ☐ 6. Threats of violence ☐ 7. Property damage ☐ 8. Stalking ☐ 9. Drug Offences ☐ 10. Deception offences ☐ 11. Theft offences ☐ 12. Breach of legal order	

want specific details. **Interrupt participants who provide you with details of their offence.**	☐ 13. Bad public behaviour (Note: Refer to offence list for correct classification).	
2.1j NATURE OF PAST OFFENCES **What offences have you been <u>charged</u> with in the past?** **(Tick all applicable)** **Prior to asking this question remind participants you do not want specific details.** **Interrupt participants who provide you with details of their offence.**	☐ 1. Homicide ☐ 2. Sexual assault ☐ 3. Violence ☐ 4. Kidnap ☐ 5. Weapons offence ☐ 6. Threats of violence ☐ 7. Property damage ☐ 8. Stalking ☐ 9. Drug Offences ☐ 10. Deception offences ☐ 11. Theft offences ☐ 12. Breach of legal order ☐ 13. Bad public behaviour	
2.1k **How long have you been in custody on this occasion?**	..... months/years	
2.1l **How many times have you been in adult prison?**	..... number of times	

2.1m **In total how much time have you spent in custody as an adult (>18 years old)?**	…… months/years	
2.1n **How much time did you spend in custody as a youth (<18 years old)?**	…… months/years	
2.1o **Have you received psychiatric treatment during your current custody period?** **Do not ask if remand.**	☐ 1. Yes ☐ 2. No ☐ 3. Don't Know	
2.1p **Have you received psychiatric treatment during any periods of custody?**	☐ 1. Yes ☐ 2. No ☐ 3. Don't Know	
2.1q **Have you been diagnosed with any of the mental illnesses?** **(Tick all applicable)**	☐ 1. Psychotic/Schizophrenias ☐ 2. Mood Disorder ☐ 3. Anxiety Disorder ☐ 4. Substance Abuse ☐ 5. Personality Disorder ☐ 6. OTHER…… ☐ 7. Don't Know	*(Check appropriate category and record any relevant details about diagnoses)*

2.1r **Are you registered with intellectual disability services?**	☐ 1. Yes ☐ 2. No ☐ 3. Don't know	
2.1s **Are you registered for acquired brain injury services?**	☐ 1. Yes ☐ 2. No ☐ 3. Don't know	

2.2 This section looks at the social circumstances of the Participant before coming into custody on this occasion.

I would now like to ask you some questions about your social circumstances. Please think about the following questions which best describes you and your circumstances in the **two months before** you were arrested.

(The arrest that relates to your current custodial sentence).

2.2a RELATIONSHIP STATUS **Before coming in to prison were you in a relationship? If yes, what type?** **(Tick most applicable)**	☐ 1. Single ☐ 2. Spouse/Partner ☐ 3. Married/defacto ☐ 4. Divorced/separated ☐ 5. Widowed ☐ 6. OTHER	
2.2b **Where were you living before you came into custody on this occasion?**	☐ 1.City ☐ 2. Town ☐ 3. Remote Community ☐ 4. Aboriginal or Torres Strait Islander Community (e.g., Lake	*(Name of Town, Community, Suburb and/or City)*

	Tyres, Ebenzer, Corranderrk, Framlingham) ☐ 5. Not stated	
2.2c LIVING SITUATION **Were you living with anyone before coming to prison?** **(Tick all applicable)**	☐ 1. Alone ☐ 2. With non-family members ☐ 3. With partner/spouse ☐ 4. With partner/spouse AND dependent children ☐ 5. With immediate family members ☐ 6. With extended family members ☐ 7. OTHER	
2.2d TYPE OF ACCOMMODATION **What sort of a place were you living in?** **(Tick all applicable)**	☐ 1. Hostel/motel/ boarding house ☐ 2. Supported accommodation ☐ 3. Sleeping rough/homeless/no fixed permanent address ☐ 4. Moving from family/friend member to family/friend member's place (couch surfing) ☐ 5. Own home ☐ 6. Private rental accommodation ☐ 7. Community housing ☐ 8. OTHER	
2.2e MAIN INCOME SOURCE **Were you working before you came to prison?** **If no, where did you get money?**	☐ 1. Centrelink/pension ☐ 2. Full time work ☐ 3. Part time work ☐ 4. From friends and family ☐ 5. Criminal activity ☐ 6. OTHER	*(Detail nature of main employment)*

2.2f **Approximately how much money did you earn in the year before you came into custody?**		

Section 3: SOCIAL AND EMOTIONAL WELLBEING

3.0 This section looks at some different aspects of social and emotional wellbeing, with particular reference to the Participants identification and understanding of their Aboriginal and/or Torres Strait Islander culture.

Now I would like to ask you some questions about yourself and your culture, as an Aboriginal and/or Torres Strait Islander Person.

(Provide visual scale for NEVER to ALWAYS)

3.1a **Do you see yourself as being an Aboriginal and/or Torres Strait Islander person?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	
3.1b **Are you proud to be an Aboriginal and/or Torres Strait Islander person?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	
3.1c **How often do you participate in Aboriginal and/or Torres Strait Islander activities or events (e.g., attend cultural events, going**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often	

out bush)?	☐ 4. Always	
3.1d **How often do you get a chance to hang out with Aboriginal and/or Torres Strait Islander people?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	
3.1e **Do you identify with a tribal group, language group or clan, or traditional owner group?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	
3.1f **Do you feel connected to your homeland or traditional country?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	
3.1g **Do you feel connected to your community?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	
3.1h **Do you feel connected to your culture?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	

3.1i **Do you feel uncomfortable around non Aboriginal/Torres Strait Islander people?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	
3.1j **Do you feel you have ever been treated badly because of your Indigenous background (e.g., experienced racism)?**	☐ 0. Never ☐ 1. Rarely ☐ 2. Sometimes ☐ 3. Often ☐ 4. Always	

3.2 This section looks again at social and emotional wellbeing and asks different questions about the Participants understanding of their culture and themselves.

Now I would like to ask you some different questions about yourself and your culture, as an Aboriginal and/or Torres Strait Islander person.

Provide visual scale for STRONGLY DISAGREE (meaning no experience/knowledge at all) to STRONGLY AGREE (meaning a lot of experience/knowledge).

3.2a **I have the knowledge to teach younger members of my family about Aboriginal and/or Torres Strait Islander culture.**	☐ 1. Strongly disagree ☐ 2. Disagree ☐ 3. Neither ☐ 4. Agree ☐ 5. Strongly Agree	
3.2b **I have learned about my Aboriginal and/or Torres Strait Islander culture from my**	☐ 1. Strongly disagree ☐ 2. Disagree ☐ 3. Neither	

family/community.	☐ 4. Agree ☐ 5. Strongly Agree	

3.3 This section looks at the participants' positive wellbeing within the SEWB framework.

I am now going to ask you some questions about what things are important to your wellbeing and how much you have been able to do these things.

(Provide visual scale of NOT AT ALL IMPORTANT to EXTREMELY IMPORTANT)

3.3a **How important is knowing about your people's history & culture for your wellbeing?**	☐ 0. Not at all ☐ 1. A little bit important ☐ 2. Moderately important ☐ 3. Very important ☐ 4. Extremely important	
3.3b **How important is knowing your own family history for your wellbeing?**	☐ 0. Not at all ☐ 1. A little bit important ☐ 2. Moderately important ☐ 3. Very important ☐ 4. Extremely important	
3.3c **How important is knowing about & exercising your rights as an Aboriginal**	☐ 0. Not at all ☐ 1. A little bit important ☐ 2. Moderately important	

person for your wellbeing?	☐ 3. Very important ☐ 4. Extremely important	
3.3d **How important is spirituality for your wellbeing?**	☐ 0. Not at all – *go to q 3.3f* ☐ 1. A little bit important ☐ 2. Moderately important ☐ 3. Very important ☐ 4. Extremely important	
3.3e **How often have you been able to practice or live your spirituality over the past <u>12 months</u>?**	☐ 0. Not at all ☐ 1. A little bit ☐ 2. Sometimes ☐ 3. Most of the time ☐ 4. All of the time	
3.3f **How important is being able to give to your family & friends for your wellbeing?**	☐ 0. Not at all - *go to q 3.3h* ☐ 1. A little bit important ☐ 2. Moderately important ☐ 3. Very important ☐ 4. Extremely important	
3.3g **How often have you been able to give to your family & friends over the past <u>12 months</u>?**	☐ 0. Not at all ☐ 1. A little bit ☐ 2. Sometimes ☐ 3. Most of the time ☐ 4. All of the time	
3.3h **How important is being able to share with your family & friends for your wellbeing?**	☐ 0. Not at all - *go to q 3.3j* ☐ 1. A little bit important ☐ 2. Moderately important ☐ 3. Very important ☐ 4. Extremely important	

3.3i **How often have you been able to share with your family & friends over the past <u>12 months</u>?**	☐ 0. Not at all ☐ 1. A little bit ☐ 2. Sometimes ☐ 3. Most of the time ☐ 4. All of the time	
3.3j **How important is being with your family & extended family for your wellbeing?**	☐ 0. Not at all - *go to q 3.3l* ☐ 1. A little bit important ☐ 2. Moderately important ☐ 3. Very important ☐ 4. Extremely important	
3.3k **How often have you been able to be with your family & extended family over the past <u>12 months</u>?**	☐ 0. Not at all ☐ 1. A little bit ☐ 2. Some times ☐ 3. Most of the time ☐ 4. All of the time	
3.3l **How important is having a better level of education for your wellbeing?**	☐ 0. Not at all - *go to q 3.3n* ☐ 1. A little bit important ☐ 2. Moderately important ☐ 3. Very important ☐ 4. Extremely important	
3.3m **How often have you been able to access education over the past <u>12 months</u>?**	☐ 0. Not at all ☐ 1. A little bit ☐ 2. Sometimes ☐ 3. Most of the time ☐ 4. All of the time	
3.3n **How has being in custody affected your wellbeing?**	*Record details of response in prose.*	

3.4 This section also is about social and emotional wellbeing and looks at Participants' life experiences and stressors over the 12 month period prior to custody.

I would now like to ask you some questions about your experiences, or some of the good and not so good things, that may have happened to **you**.

Thinking about the **12 months before** you came into custody (current sentence) please answer yes or no to the following:

EVENT	EXPERIENCED?	
3.4a **Did you have a really bad illness or disability?**	☐ 1. Yes ☐ 2. No	
3.4b **Were you in a really bad accident?**	☐ 1. Yes ☐ 2. No	

3.4c **Did a family member or close friend pass away?**	☐ 1. Yes ☐ 2. No	
3.4d **Did you divorce/separate OR get back together with a partner OR get married?**	☐ 1. Yes ☐ 2. No	
3.4e **Were there a lot of people living in the same house with you (overcrowding)?**	☐ 1. Yes ☐ 2. No	
3.4f **Were you unable to get a job?**	☐ 1. Yes ☐ 2. No	
3.4g **Did you lose your job, made redundant, sacked or retired?**	☐ 1. Yes ☐ 2. No	
3.4h **Did you have any alcohol or drug related problems?**	☐ 1. Yes ☐ 2. No	
3.4i **Did you have a gambling problem?**	☐ 1. Yes ☐ 2. No	
3.4j **Did you witness violence?**	☐ 1. Yes ☐ 2. No	
3.4k **Did you abuse anyone verbally or physically or commit violent crime?**	☐ 1. Yes ☐ 2. No	
3.4l **Did you get in trouble with police/**	☐ 1. Yes	

sent to/in jail for any other reasons (other than current custodial period for offences)?	☐ 2. No	
3.4m **Did you have any family member's in prison or sent to prison?**	☐ 1. Yes ☐ 2. No	
3.4n **Were you treated badly because of your Indigenous heritage?**	☐ 1. Yes ☐ 2. No	
3.4o **Did any really good event(s) happen in your life in the <u>12 months</u> before you came into prison?**	☐ 1. Yes ☐ 2. No	*If YES: "what were they?"*

3.5 This section looks at resiliency factors in terms of sense of self-efficacy and control, emotional regulation, safety and bicultural skills.

Thinking about yourself <u>both in custody and in the community</u>, please consider the following:
(Provide visual scale for NOT AT ALL to ALL OR MOST OF THE TIME)

3.5a **Overall, I feel like I have control over my life?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	
3.5b **Working together with people close to me, I can overcome most of my problems?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	
3.5c **I am able to handle painful feelings, like sadness, anger and fear?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	
3.5d **When I am angry or sad I am able to talk to someone about it?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	
3.5e **I am able to face problems without gambling, using drugs or alcohol, or harming others?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	

3.5f **I feel safe in my community?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	
3.5g **I feel safe in the broader society outside my community?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	
3.5h **I have the skills to be confident in both Indigenous and non-Indigenous communities?**	☐ 0. Not at all ☐ 1. A little ☐ 2. Sometimes ☐ 3. Often ☐ 4. All or almost all the time	

Section 4: SERVICE USAGE

4.1 This section looks at the Participants health care in the 12 MONTHS prior to coming into custody.

I would now like to ask you some questions about your health care.

Thinking about obtaining health care for yourself in the **12 months before** coming into custody

4.1a **Did you attend a professional for mental health or social & emotional wellbeing needs in the 12 months prior to custody?** **(Tick all applicable)**	☐ 1. Psychiatrist ☐ *2. GP/Local Doctor ☐ 3. Community Mental Health Services ☐ 4. Inpatient Mental Health Services ☐ 5. Counsellor ☐ 6. Support group ☐ *7. Traditional Healer/Medicine ☐ *8. Local Aboriginal Controlled Organisation - COOP ☐ 9. OTHER ..... ☐ 10. Never accessed mental health care	*(* Record details about frequency of visits, medication prescribed, and contact details, if consent given to contact).*
4.1b **Did you attend health professional/s for any health needs in the 12 months prior to custody?**	☐ 1. GP/Local Doctor ☐ 2. Local Community Health Centre/Clinic ☐ *3. Drug And Alcohol Services ☐ 4. Traditional Healer/Medicine	*(* Record details about frequency of visits, medication prescribed, and contact details, if consent given to contact).*

(Tick all applicable)	☐ *5. Local Aboriginal Controlled Organisation - COOP ☐ 6. OTHER ..... ☐ 7. Never accessed mental health care	
4.1c **In the <u>12 months prior</u> to custody, did you access any of these services for other reasons**	☐ 1. Co-Op ☐ 2. Healing Service ☐ 3. Men's Group (e.g., time out) ☐ 4. Centre's Against Sexual Assault (CASA) ☐ 5. Koori Drug & Alcohol Service ☐ 6. Family Violence Worker ☐ 7. Court Integrated Services Program (CISP) ☐ 8. Victim Assistance And Relief Service (VARS) ☐ 9. OTHER.....	*(Record details about the purpose or nature of visit)*
4.1d **Did you know how to access health care before coming to custody?**	☐ 1. Yes ☐ 2. No ☐ 3. Sometimes ☐ 4. Not stated/unknown	
4.1e **If response 10 (4.1a) or response 7 (4.1b) is chosen, ask:** **Why didn't you access**	☐ 1. Transport/distance ☐ 2. Cost of service ☐ 3. No service in area ☐ 4. Not enough services in area	

health services in the <u>12 months prior</u> to custody?	☐ 5. Waiting time too long or not available at time required ☐ 6. Service not culturally appropriate ☐ 7. Didn't trust service ☐ 8. Treated badly because of Aboriginal/Torres Strait Islander status ☐ 9. OTHER.....	
4.1f **How do you feel you were treated when you sought health care in the <u>12 months prior</u> to custody compared with non-Indigenous people?**	☐ 1. Worse ☐ 2. Same ☐ 3. Better ☐ 4. Not stated/unknown	
4.1g **Were you confident or did you feel safe in identifying your indigenous status to services?**	☐ 1. Yes ☐ 2. No ☐ 3. Sometimes ☐ 4. Not stated/unknown	

4.2 This section involves completing relevant parts of the Camberwell Assessment of Need – Forensic Short Version (CANFor SV) which identifies areas of problematic needs that may or may not be addressed as <u>perceived by the Participant</u>. Complete the areas of need as identified by the participant: 1) at the time of the index offence (last column); and, 2) currently, that is, <u>over the past month</u> (first column 'user').

I would now like to ask you some questions about a number of areas of need, like accommodation, your relationships and treatments experienced **at the time of your offence**, and currently over the **past month**.

Questioning process for the CANFOR

To assist you in coding participant's responses, inquire about each of the categories of need listed on the CANFOR record, using the following seven questions:

1. Have you ever had any difficulties in this area?

2. Have you had any difficulties in this area in the last month?

3. Do you need any help in this area?

4. Are you receiving any help for these difficulties at the moment?

5. Do you think that any help you are receiving (from services) is actually helping? How much?

6. Overall, how satisfied are you with the help you are currently receiving for difficulties in this area?

7. Did difficulties in this area contribute to the reasons for the index offence?

Camberwell Assessment of Need – Forensic Short Version

User name
Date of assessment __/__/__ Initials of assessor _____

0 = No problem 1 = Met need 2 = Unmet need
8 = Not applicable ** 9 =

Assessment number	1	2	3	Index Offence
Circle who is interviewed (U = User, S = Staff, C = Carer)	User	Staff	Carer	Y / N / dk
1. Accommodation ** *Do you have a place to live when you leave hospital?*				
2. Food *Are you able to prepare your own meals and do your own shopping for food?*				
3. Looking after the living environment *Are you able to look after your room? Does anyone help you?*				
4. Self-care *Do you have any problems keeping yourself clean and tidy?*				
5. Daytime activities *How do you spend your day? Do you have enough to do?*				
6. Physical health *How well do you feel physically? What about side-effects from medication?*				
7. Psychotic symptoms *Do you hear voices or have problems with your thoughts?*				
8. Information about condition and treatment *Have you been given clear information about your current medication, treatment and rights?*				
9. Psychological distress *Have you recently felt sad or low? Have you recently felt anxious or frightened?*				
10. Safety to self *Do you have thoughts of harming yourself? Do you put yourself in danger in any way?*				
11. Safety to others (excluding sexual offences and arson) *Have you threatened other people or been violent? For example, have you lost your temper?*				
12. Alcohol *Do you have a problem with alcohol?*				
13. Drugs (including solvents) *Do you have a problem with drugs?*				
14. Company *Are you happy with your social life? Do you wish you had more contact with others?*				
15. Intimate relationships *Do you have a partner? Do you have problems with your close relationships?*				
16. Sexual expression *How is your sex life? Are you experiencing any difficulties with sexual matters?*				
17. Child care ** *Do you have any children under 18? Do you care for them? Do you have access?*				
18. Basic education *Do you have any difficulty in reading, writing or understanding English?*				
19. Telephone *Do you know how to use a telephone? Is it easy to find one that you can use?*				
20. Transport ** *Do you have any problems using the bus, train or tube? Do you get a free bus pass?*				
21. Money *Do you have problems budgeting your money? Do you manage to pay your bills?*				
22. Benefits *Are you sure that you are getting all the benefits you are entitled to?*				
23. Treatment *Do you agree with the treatment (medical and/or psychological) prescribed?*				
24. Sexual offences (where indicated) ** *Do you think that you might be at risk of committing a sexual offence?*				
25. Arson (where indicated) ** *Do you think you might be at risk of setting fires?*				
A – Met needs (count the number of 1s in the column)				Total Yes Scores _____
B – Unmet needs (count the number of 2s in the column)				
C – Total number of needs (add together A and B)				

For those who anticipate release from custody in the next 6-12 months

4.3 This section looks at the social circumstances, including services, people anticipate they might experience when they are released from custody.

I would now like you to think about yourself in the **two months after** your release from this centre.

4.3a **When do you expect to get released?**	..... months/years **If response is more than 12 months ..... GO TO SECTION 4.7**	
4.3b **Do you plan to return to where you usually live?**	☐ 1. Yes ☐ 2. No ☐ 3. Don't know	
4.3c **Are you worried about returning to where you usually live?**	☐ 1. Yes ☐ 2. No..... GO TO 4.3e ☐ 3. Don't know	
4.3d **If yes, what are your worries about returning there?**	*(Record details in prose)*	

4.3e **What type of accommodation will you live in?**	☐ 1. Will return home to usual place of residence ☐ 2. Will return home to a relative ☐ 3. Will return to the home of a friend ☐ 4. Will return to Hostel/Motel ☐ 5. Have nowhere to go ☐ 6. OTHER ..... ☐ 7. Unknown/ don't know	

4.4 This section looks at what the Participant will do for income post release.

Thinking about what you might do for income in the **first two months after** you leave this centre.

4.4a **Do you plan to seek employment?**	☐ 1. Yes ☐ 2. No ☐ 3. Don't know	
4.4b **What will you do for money?** **(Tick all applicable)**	☐ 1. Centrelink/Pension ☐ 2. Full time work ☐ 3. Part time work ☐ 4. Friends or family ☐ 5. Criminal activity ☐ 6. Don't know ☐ 7. OTHER	

4.5 This section looks at the Participants ideas about substance use post release.

Again, thinking about the **first two months after** you are released from this centre do you think you….?

4.5a **Might you be using substances?**	☐ 1. Yes ☐ 2. No.....GO TO Q 4.6 ☐ 3. Don't know	
4.5b **Are you likely to use any of the following after release?** **(Tick all applicable)**	☐ 1. Alcohol ☐ 2. Cannabis ☐ 3. Speed ☐ 4. Opiates ☐ 5. Pills (e.g., 'Benzos') ☐ 6. Inhalants (e.g., petrol, paint) ☐ 7. Any illicit drug use ☐ 8. OTHER	

4.6 This section looks at the Participants health care plans post release.

Thinking about what you might do to look after your health in the **first two months** after you leave this centre:

4.6a **Do you plan to access mental health/social & emotional wellbeing services?** **(Tick all applicable)**	☐ 1. Psychiatrist ☐ 2. GP ☐ 3. Community Mental Health Services ☐ 4. Inpatient Mental Health Services ☐ 5. Counsellor ☐ 6. Support Group ☐ 7. Cultural Healer ☐ 8. Local Aboriginal Controlled Organisation - COOP ☐ 9. OTHER ..... ☐ 10. Unknown	

4.6b **Do you plan to access any health services?** **(Tick all applicable)**	☐ 1. GP/Local Doctor ☐ 2. Local Community Health Centre ☐ 3. Local Community Clinic ☐ 4. Drug And Alcohol Services ☐ 5. Cultural Healer ☐ 6. Local Aboriginal Controlled Organisation - COOP ☐ 7. OTHER ..... ☐ 8. Unknown	
4.6c **Do you plan to access any other service providers?**	☐ 1. CO-OP ☐ 2. Healing Service ☐ 3. Men's Group (e.g., time out) ☐ 4. Centre's Against Sexual Assault (CASA) ☐ 5. Koori Drug & Alcohol Service ☐ 6. Family Violence Worker ☐ 7. Community Integrated Services Program (CISP) ☐ 8. Victim Assistance And Relief Service (VARS) ☐ 9. Koori Connect ☐ 10. OTHER.....	

4.7 This section allows the Participant to speak freely about themselves and their needs in the community and the Prison Mental Health Service. As the aim of the project is to identify barriers to services within prison and the community for Aboriginal and Torres Strait Islander people in custody, valuable input can be gained by giving the Participants an opportunity to discuss their own thoughts.

Thinking about yourself and other Aboriginal and Torres Strait Islander People in custody and keeping in mind that this project is looking at improving services regarding Mental Health, Social and Emotional Wellbeing and cognitive difficulties;

What services or supports do you think have been most helpful and could help you or other Indigenous people while in prison to help reduce offending or mental health or social and emotional wellbeing difficulties?

....And what about services and supports in the community?

Prison:

Most helpful - _____

_____

_____

Could help - _____

_____

_____

Community:

Most helpful- _____

_____

_____

Could help- _____

_____

_____

Section 5: MENTAL HEALTH

_____

5.1 This section involves the administration of the Kessler-5 (K5) measure of psychological distress, a subset of five questions from the Kessler Psychological Distress Scale-10 (K10). This provides a non-specific measure of negative emotion, and has been used to broadly measure emotional wellbeing.

I am now going to ask you some questions about the way you may have been feeling in the **past four weeks**.

Provide visual scale from NONE OF THE TIME to ALL OF THE TIME.

5.1a **In the past 4 weeks, have you felt nervous?**	☐ 0. None of the time ☐ 1. A little of the time ☐ 2. Some of the time ☐ 3. Most of the time ☐ 4. All of the time	
5.1b **In the past 4 weeks, have you felt without hope?**	☐ 0. None of the time ☐ 1. A little of the time ☐ 2. Some of the time ☐ 3. Most of the time ☐ 4. All of the time	
5.1c **In the past 4 weeks, have you felt restless or jumpy?**	☐ 0. None of the time ☐ 1. A little of the time ☐ 2. Some of the time ☐ 3. Most of the time ☐ 4. All of the time	
5.1d **In the past 4 weeks, have you felt like everything was an effort?**	☐ 0. None of the time ☐ 1. A little of the time ☐ 2. Some of the time ☐ 3. Most of the time	

	☐ 4. All of the time	
5.1e **In the past 4 weeks, have you felt so sad that nothing could cheer you up?**	☐ 0. None of the time ☐ 1. A little of the time ☐ 2. Some of the time ☐ 3. Most of the time ☐ 4. All of the time	

5.2 This section looks at the Participants experience of suicide and thoughts of suicide they may have experienced themselves.

I am now going to ask you some questions that can be hard to talk about. The questions are about suicide and upsetting things that may have happened in the past. Please tell me if you do not wish to talk about these things or if you feel like a break at any stage after we begin.

Sometimes people feel so down or stressed that they think about suicide;

5.2a **Have you ever had a friend or close relative commit suicide?**	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
5.2b **Have you ever had thoughts about suicide or ending your own life?**	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
5.2c **Where have the thoughts about suicide been the worst?**	☐ 1. In Custody ☐ 2. In the community ☐ 3. No answer	

5.2d **Have you had thoughts about suicide in the <u>last 12 months</u>?**	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
5.2e **Have you ever attempted suicide?**	☐ 1. Yes ☐ 2. No .....GO TO Q 5.2g ☐ 3. No answer	
5.2f **Where did you attempt suicide?**	☐ 1. In Custody ☐ 2. Out of custody ☐ 3. No answer	

5.2g **Do you have any current serious thoughts about suicide or ending your life?**	☐ 1. Yes ☐ 2. No ☐ 3. No answer	
5.2h **Do you want to, or need to talk to anybody further about these thoughts of suicide?**	☐ 1. Yes ☐ 2. No ☐ 3. No answer	

If the Participant reports yes or does not answer the last two questions (5.1g and 5.1h,) please make a crisis call to the health service to follow-up the participant within 2 hours for an at risk assessment. Also inform the custodial officer of this action and that the participant requires monitoring until the 'at risk' assessment is conducted. Formalise the process by writing and submitting a referral form to the prison health service. Inform the Project Manager of these actions.

5.3 This section involves administration of the MINI (Mini International Neuropsychiatric Interview), a structured interview to determine the presence of mental disorders currently (past month) and in their life time. Participants will be administered the interviews pertaining to the following class of disorders if applicable screen questions are answered in the affirmative (EXCEPT for Psychosis for which ALL questions will be asked regardless of whether the participant meets the screening criteria).

1. ANXIETY DISORDER (in PTSD section, a question will be asked about lifetime removal from natural family by a mission, the government or welfare)

2. MOOD DISORDERS

3. SUBSTANCE USE DISORDERS

4. PSYCHOTIC DISORDERS

I am now going to ask you some questions about the way you have been feeling, thoughts and behaviours. Again, some of these questions might not be relevant, while others may; just answer the questions as accurately as possible.

Proceed with administering the MINI.

Section 6: COGNITIVE ASSESSMENT

6.1 This section involves the administration of a battery of neuropsychological assessments to estimate the level of cognitive functioning of Participants. The following tests will be administered:

1. Kimberly Indigenous Cognitive Assessment – (KICA-Cog).

2. General Intellectual functioning–Matrix Reasoning subtest from the Wechsler Abbreviated Scale of Intelligence.

3. Digit span forward and reverse, from the Wechsler Assessment of Intelligence Scale IV.

4. Block design subtest from the Wechsler Abbreviated Scale of Intelligence.

5. Trail Making Test from the DKEFS.

In this last section, I will ask you some more questions and to do some puzzles. Some of these questions you may find easy, and others you may find difficult. Not everyone can answer all the questions; just give it your best shot.

6.1a **Have you ever been hit on the head (e.g., fight, accident, sports injury or fall)?**	☐ 1. Yes ☐ 2. No ☐ 3. Unsure	
6.1b **Have you ever been in a serious vehicle accident?**	☐ 1. Yes ☐ 2. No	
6.1c **Have you ever lost consciousness or had a black out?**	☐ 1. Yes ☐ 2. No ☐ 3. Unsure	
6.1d **Have you ever had a stroke?**	☐ 1. Yes ☐ 2. No ☐ 3. Unsure	

Proceed with administering the cognitive testing battery.

Section 7: CLOSURE

This is the conclusion of the interview.

Thank the Participant for their time and contribution to the Project.

The Participant should be given an opportunity to ask any questions they may have. If you are unable to answer any of the questions the Participants may bring up, please call the Project Research Manager.

Inform all participants that as a matter of protocol a mental health clinician from the prison will provide follow-up within the next 24 hours to determine their mental state and if interventions are required. Write and submit the appropriate referral form.

EXAMPLE: Is there any questions you would like to ask me about the project?

Is there anything else you would like to discuss about the topics we have discussed today?

As a matter of protocol, you, just like all participants, will have a mental health clinician from the prison check in on you within the next day to see if you are still okay.

It is important that the participant is told of our gratitude for their participation.

EXAMPLE: Once again, thank you very much for your contribution to this project. Your input has been very valuable. If you would like any further information regarding this project you can contact your Koori liaison or wellbeing officer.

Consent Form

Centre for Forensic Behavioural Science

Monash University

505 Hoddle Street

Clifton Hill Victoria 3068

Australia

Koori Prisoner Mental Health

and Cognitive Functioning Study

The original form will be kept by the researcher and a copy of this form is for the participant to keep.

I _____ agree to participate in a research project entitled: "The Koori Prisoner Mental Health and Cognitive Functioning Study", conducted by Monash University. The researcher _____ has discussed this research with me. I have had the opportunity to ask questions about this research and I have received answers that are satisfactory to me. I have read and kept a copy of the Information Sheet and understand the general purposes, risks and methods of this research.

I agree to take part because:

1. I know what I am expected to do and what this involves
2. The risks, inconvenience and discomfort of participating in the study have been explained to me
3. All my questions have been answered to my satisfaction
4. I understand that the project may not be of direct benefit to me
5. I can withdraw from the study at any time without being disadvantaged in any way
6. I am satisfied with the explanation given in relation to the project as it affects me and my consent is freely given
7. I can obtain a summary of the overall results when the study is completed
8. I understand that my personal information will be kept private, and that only my name, date of birth and gender will be disclosed to the organisations I consent to release information from. My personal information will not be disclosed to any other organisation or individual

9. I understand that data collected for this research will be kept in secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period.
10. I agree to the publications of results from this study provided details that might identify me are removed

and

I agree to the researcher receiving a health summary from Justice Health □ **Yes** □ **No**

I agree to the researcher disclosing my name, date of birth, and gender to Victoria Police, and collecting data from Victoria Police. The data collected from Victoria Police will include: details of my offending history including the number and type of charges and convictions against me and the judicial outcomes. □ **Yes** □ **No**

I agree to the researcher disclosing my name, date of birth, and gender to the Department of Health, and collecting data about my mental health history from the Department of Health. □ **Yes** □ **No**

I agree to the researcher disclosing my name, date of birth, and gender to my General Practitioner_____, and collecting data about the frequency of my visits, whether the purpose of visits were for mental health reasons and my prescribed medication. □ **Yes** □ **No**

I agree to the researcher disclosing my name, date of birth, and gender to

the service (e.g. drug and alcohol) _____, and collecting □ **Yes** □ **No**

data about the nature and frequency of my involvement with that service.

I agree to the researcher disclosing my name, date of birth, and gender to

the service(s)_____, and collecting □ **Yes** □ **No**

data about the nature and frequency of my involvement with that service.

Signed by the participant:_____
Date:_____

Signed by the researcher:_____
Date:_____

Research Number: _ _ _ _ _ _ _ _

Date: _ _/_ _/_ _ _ _

Data Collection Initials: _ _ _

Centre for Forensic Behavioural Science

Information Sheet

Monash University

505 Hoddle Street

Clifton Hill Victoria 3068

Australia

Project Title: **KOORI PRISONER MENTAL HEALTH and COGNITIVE FUNCTION STUDY**

This information sheet is for you to keep

WHAT IS THE STUDY ABOUT?

The Centre for Forensic Behavioural Science, Monash University and VACCHO are inviting you to participate in our study because you have identified yourself as an Aboriginal or Torres Strait Islander, who is currently in prison. We have been asked by the Victorian Department of Justice to undertake a research project investigating the social, cultural, mental health and cognitive (e.g. language abilities, memory, problem solving) needs of Koori[2] prisoners. We believe this information will help us to better understand your needs to improve services within prisons and the community. This project is coordinated by Indigenous and non-Indigenous people.

WHAT DO I HAVE TO DO?

If you agree to participate, you will be asked to sit a one-on-one interview that will last approximately two hours and may be spread over a few sessions. The interview will involve answering questions and performing some puzzles that will look at the following:

- Demographics (e.g. gender, date of birth, cultural identity, prior living and employment status, offence type – e.g. 'theft')
- Positive and negative life experiences and stressors
- Mental health problems, such as anxiety, depression, psychosis and substance use

[2] All Aboriginal and/or Torres Strait Islander people are welcome to participate in this survey. The use of the term "Koori" in this survey has been used to describe Indigenous inhabitants of Victoria and has been approved by Koori Caucus members of the Aboriginal Justice Forum for AJA initiatives.

- Cognitive functioning, such as memory, attention, problem solving, language
- Services used (e.g. traditional healers, general practitioner) and areas of unmet needs

We will also ask for your permission to contact the following agencies to support the information you have given:

- Ask Victoria Police to give us a copy of your offending history (including the number and type of charges and convictions, as well as number of sentences served in a Victorian prison)
- Ask the Department of Heath to give us information about whether you have had contact with Victorian public mental health services and past diagnoses
- Ask for the details of your General Practitioner, if you have one, to find out what medications you have been prescribed and if you have seen them for mental health issues
- Ask for the details of any drug and alcohol service you have accessed, to find out your involvement with any programs
- Ask for the details of any Koori specific services you have accessed, to find out your involvement with them.
- Ask Justice Health for a summary on your health and the health services you have used in prison.

When we ask Victoria Police, Department of Health and other relevant services for your information, we will only tell them you are participating in a study at Monash University and provide them with your name, date of birth and gender so they can look you up on their database or files. We will not inform them of the nature of this project, or that you are currently serving a prison sentence. Information will be communicated in a password protected secure electronic file. To protect your privacy, all personally identifying information (e.g. your name) will be deleted once all the data about you is linked together in a single database.

If you agree to participate, you will be asked to sign a consent form before beginning the interview.

WHAT'S IN IT FOR ME?

You will be participating in a project that aims to benefit mental health care for all Indigenous people in custody. The findings can also inform new policies to address unmet service needs for Indigenous people in the community, which may lead to a reduction in crime. For some people, they may find some of the questions asked in this study to be stressful or uncomfortable. If at any time during the interview you feel upset or sad, or have problems answering, you can discuss your concerns with the researcher and you may choose to skip the question. As a matter of

protocol, all participants will be followed up after the interview by a mental health clinician to check that you are okay.

YOUR RIGHTS

- You do not have to participate in any of this research. If you choose not to participate, it will have no effect on your parole or court hearing, or how you are treated by custodial staff, or access to services. If you do choose to participate, you have the right to not answer questions, or you can withdraw from the study.
- If you choose to participate, the information you provide us will be confidential. Information is not provided to corrective services or other agencies. However, you should not talk about illegal matters that you have not been charged with or have not been dealt with in court. If a participant reveals they intend to harm themselves or someone else, appropriate services within the prison may be informed of relevant information only.
- We will store a copy of the information, identified by a number only and not your name, in a locked filing cabinet or password protected computer file in the secure research building of the Centre for Forensic Behavioural Science. Only the researchers of this study have access to this information. Your information will be securely kept for five years.
- We won't publish your name or anything else that could identify you when we write up the results of the research.
- A summary of the study will be available to all prison Koori wellbeing or liaison officers for you to access after the study has been completed (expected June 2012).
- If you have a complaint about the way this research project (CF/11/7201) is being conducted, please contact the project manager, the Human Research Ethics Committee of Monash University or Human Research Ethics Committee of the Department of Justice. You can make your complaint about this project through your Koori liaison officer, or to the Independent Prison Visitor.

Executive Officer, Human Research Ethics Monash University Human Research Ethics Committee Research Office: Building 3E, Room 111 Monash University VIC 3800 Tel: 03 9905 2052 Fax: 03 9905 3831 Email: muhrec@adm.monash.edu.au	Secretary, Human Research Ethics Committee Department of Justice Postal address: Level 21, 121 Exhibition St Melbourne, VIC 3000 Tel: 03 8684 1514 Email: ethics@justice.vic.gov.au

Principal Researcher: Prof. James Ogloff, Centre for Forensic Behavioural Science, Monash University

Project Manager: Assoc. Prof. Stuart Thomas, Centre for Forensic Behavioural Science, Monash University

Tel: 03 9947 2600

Fax: 03 9947 2650

Thank you for your time and consideration.