UNLOCKING CARE:

CONTINUING MENTAL HEALTH CARE FOR PRISONERS AND THEIR FAMILIES

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The Australia Institute
Research that matters.

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TAI

Policy Brief

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Summary

People in prison have a higher incidence of mental illness than the general population. The prevalence of mental health issues is higher again for women prisoners. Although evidence suggests that some improvement can be achieved during imprisonment, new research reported in this paper finds that average mental health deteriorates in the year following release.

Table 1: Psychological distress levels at the start of, end and after imprisonment.

	Proportion with high or very high levels of psychological distress
Entering prison	31%
Prior to release	18%
Back in the community	44%

Source: AIHW (2013a), *The health of Australia's prisoners 2012*, Table 4.2; HILDA Survey 2011.

The imprisonment of a close family member also places strains on families, including increased mental distress. The effects on children can be long lasting. While the mental health needs of prisoners have been recognised by federal, state and territory governments, the needs of their families has received less attention.

Providing continued care from prison into the community is known as 'throughcare'. The continuation of health services helps overcome some of the barriers people face re-connecting with services in the community and may contribute to a reversal of the decline in mental health following release.

Accessing mental health services will often be one challenge among many, including the reestablishment of relationships with children and partners, finding secure housing, maintaining substance-use programs or counselling and finding a job. Coordinating social services for people returning to society will improve the overall success of transition.

Families can also play an important role in supporting this transition – therefore, investing more resources into understanding their needs will have a flow-on benefit for former prisoners and society more generally. The design and delivery of mental health services for adults and children needs greater research and coordinated policy development.

Federal leadership has led to the measuring and reporting of prisoner mental health. This program should be extended to include measurements following release and widened to include the families of prisoners.

Interest in throughcare a decade ago resulted in a move towards the integration of prison and community health services. A majority of jurisdictions – Victoria, Queensland and Western Australia being the exceptions – now have an integrated health service, providing the foundation for the development of throughcare services. Improved delivery of mental health services potentially reduces the risk of re-imprisonment; providing wider personal, familial and community benefits.

Introduction

There were 30,775 prisoners in Australia at the end of June 2013 – an increase of five per cent on the 2012 census conducted by the Australian Bureau of Statistics (ABS).[1] Almost six out of ten (58 per cent) prisoners had previously served a sentence as an adult. The cost of housing a prisoner in 2012-13 was $297 per day.[2] In comparison, annual expenditure on mental health-related services in 2011-12 was $322 per person – less than a dollar a day. State and territories provided 61 per cent of this funding.[3]

The prison population has higher rates of mental illness than the wider population. While treatment in prison can improve a person's mental health, it appears that, for some, mental health deteriorates after release. Mental health support is, therefore, an important service for people returning to the community.

If people are re-offending and returning to the prison system in part due to a failure to provide adequate mental health services following release, improvements make sense. The difference in cost for community mental health services and imprisonment provides a budget window for increased spending to improve mental health services. This paper outlines the case for a new model of continued mental health care from prison out into the community.

The mental health of prisoners

Among the general population one in ten Australians (11 per cent)[4] registers a high or very high level of psychological distress, suggesting they may have moderate or severe mental health issues. In comparison the Australian Institute of Health and Welfare (AIHW) has reported that almost a third (31 per cent) of prison entrants in 2012 had a high or very high level of psychological distress. Almost one in four (38 per cent) people entering prison in 2012 had previously been told they had a mental health disorder.[5] The rate of referrals to prison mental health services, however, was only 26 per cent in 2012.[6] This referral rate did not differ for men and women, despite women prisoners having a higher rate of mental illness.[7] At the point of leaving prison, twice as many women (31 per cent) as men (16 per cent) had a high or very high level of psychological distress. In 2012 the level of psychological distress among Indigenous prisoners was 22 per cent of prison entrants and 18 per cent prior to release. The data confirms previous research, both in Australia and internationally, that has shown the incidence of mental illness is higher among prisoner populations.

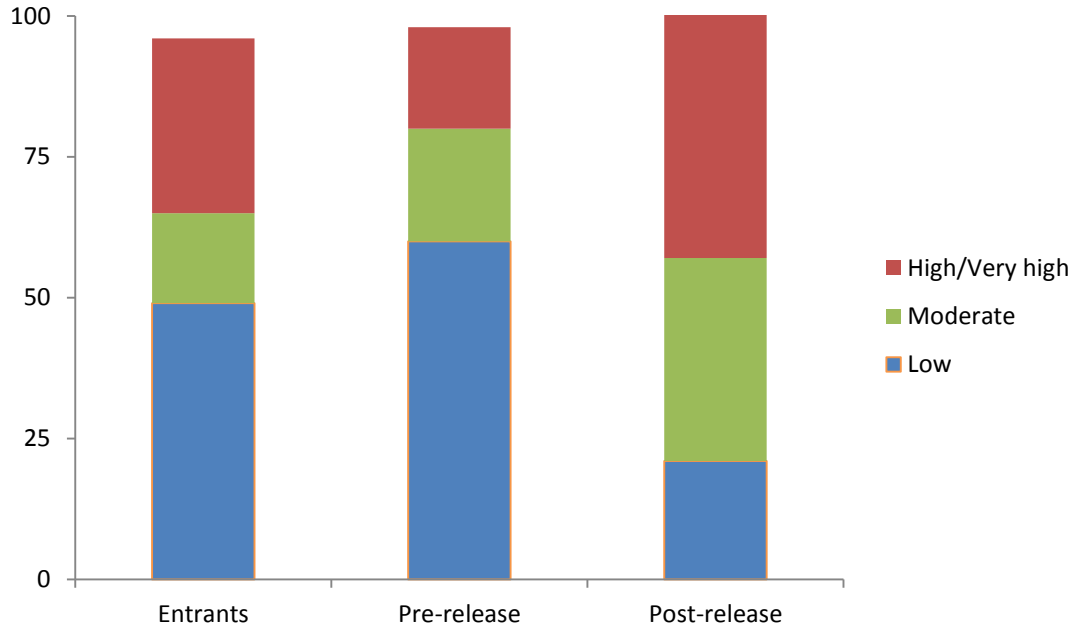
This paper reports that the average level of distress increases after release from prison, reversing evident improvements achieved during imprisonment. More than four in ten people who had been in prison within the previous year had high or very high levels of distress. This rate is higher than that reported by the AIHW for people entering prison and among those preparing to leave. For some people negative mental health outcomes present following release which were not evident in the lead-up to leaving prison.[8] For people suffering a

[1] ABS (2013), *Prisoners in Australia, 2013*.
[2] Productivity Commission (2014), *Report on Government Services 2014.*
[3] AIHW (2013b), *Health expenditure Australia 2011-12. Health and welfare expenditure series 50*.
[4] ABS (2012), *Australian Health Survey: Frist Results, 2011-12*.
[5] National Mental Health Commission (2013), *A Contributing Life: The 2013 National Report Card on Mental Health and Suicide Prevention*.
[6] AIHW (2013a), *The health of Australia's prisoners 2012*.
[7] de Motte, Bailey and Ward (2012), 'How does prison visiting affect female offenders' mental health? Implications for education and development'; Butler et al (2011), 'Co-occurring mental illness and substance use disorder among Australian prisoners'; Howells et al (2004), Correctional offender rehabilitation programs: The national picture in Australia.
[8] Lattimore et al (2012), *Prisoner Reentry Services: What Worked for SVORI Evaluation Participants?*

mental illness, the move back into the community can worsen psychiatric symptoms – contributing to greater difficulties adjusting to the change.[9]

The mental wellbeing of those leaving prison is better than that of people entering prison, reflecting the ability of prison health services to deliver targeted, appropriate mental health care. The AIHW data shows that prior to release fewer than two in ten (18 per cent) people are likely to continue to have a moderate or severe mental health issue. A majority (91 per cent) of people being discharged from prison in 2012 reported that their mental health and wellbeing had improved. This positive outcome does not appear to apply to women. A UK study found that while the mental health of men improved in the first three months of imprisonment, there was no real change among women.[10] Improvements achieved in prison, however, may not be maintained after release. Analysis of the Household, Income and Labour Dynamics in Australia (HILDA) Survey provides a third measurement of the psychological distress of people who had been in prison in the past year.

Figure 1: Psychological distress levels among people entering prison, preparing to leave and after release (%)



Source: AIHW, The health of Australia's prisoners 2012, Table 4.2; HILDA Survey 2011.
Note: The post-release sample size (n=39) limits permissible analysis.

The transition from prison to the community can be a stressful and anxious period for many people. The AIHW has reported that impending release from prison was cited as a reason for psychological distress by almost half (45 per cent) the prisoners assessed as distressed prior to release. Australian research has found that for many people leaving prison there is a continuation of the problems, including mental health issues, faced prior to incarceration.[11] If mental health care provided in prison is not continued after a person's release, their mental

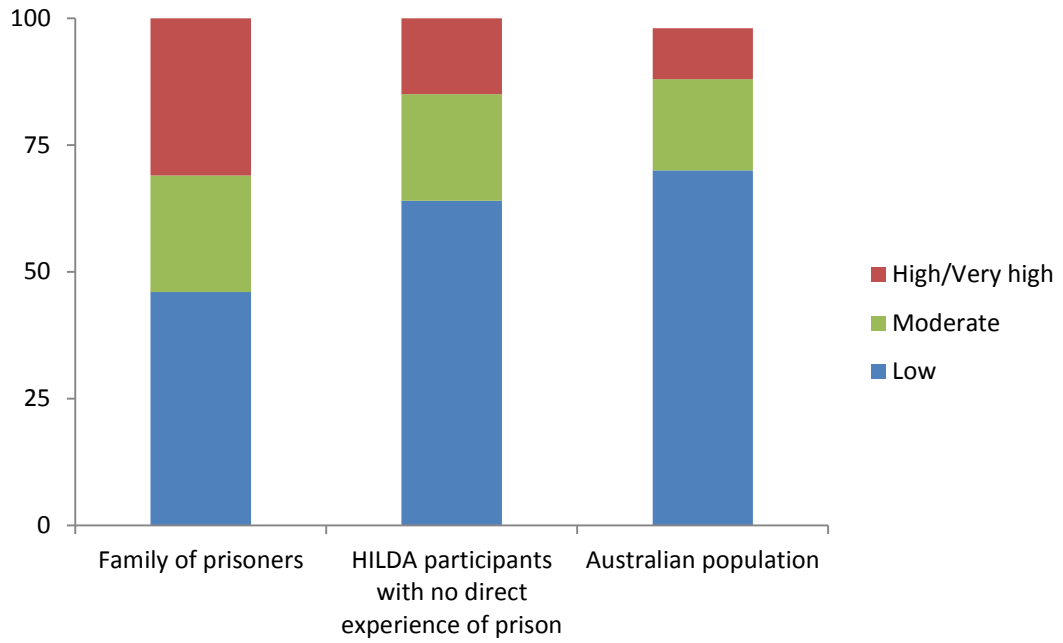
[9] Schnittker (2014), 'The Psychological Dimensions and the Social Consequences of Incarceration'; Binswanger et al (2011), '"From the prison door right to the sidewalk, everything went downhill," A qualitative study of the health experiences of recently released inmates'.
[10] Offender Health Research Network (2010), *The pathway of prisoners with mental health problems through prison health services and the effect of the prison environment on the mental health of prisoners*.
[11] Kinner, Burford, van Dooren and Gill (2013), *Service brokerage for improving health outcomes in exprisoners*.

health may worsen, undoing any health benefits that may have been achieved while in prison.

The effect on families

Alongside the high rates of mental illness among prisoners is the potential for incarceration to add to the psychological distress experienced by the families of prisoners. Addressing mental health issues among families is an important health issue for those affected but also for prisoners themselves. In many cases a prisoner's family is their primary source of support while in prison and following release. Familial support can be the difference between successfully returning to the community and returning to prison.

Figure 2: Psychological distress levels among families of prisoners and the wider population



Source: HILDA Survey 2011; ABS, Australian Health Survey 2011-12 (Table 4)
Note: Rounding errors in ABS data.

The psychological distress experienced by prisoners entering and exiting prison is measured by the AIHW. This information is useful in determining the need for mental health services and measuring the outcomes of this care. Changes in distress experienced by people adjusting back to life in the community are not reported by the AIHW, which limits our understanding of the services needed in the community. Neither is the psychological distress of family members – an area of public health policy that needs greater research. The absence of data limits the ability to measure the appropriateness of the health services available to families.

A person's mental health can affect their ability to resettle back into the community – this potential effect highlights the importance of continuing of mental health services after release. This paper considers changes to the delivery of health services to achieve a continuation of care and reasserts the need to improve our understanding of the particular needs of the families of prisoners, especially their children.

Connecting back into the community

Returning to life in the community requires a person to make numerous reconnections, including the re-establishment of relationships with children and partners, applying for a lease, maintaining substance-use programs or counselling, and finding a job. Despite the importance of these connections the AIHW has identified that:[12]

> *Connecting the provision of health care services in prison with those in the community often poses significant challenges.*

The presence of mental illness has been found to compound the stigma and disadvantage experienced by people returning to the community.[13] Any disruption in mental health treatment received in prison when a person transitions back to the community could exacerbate the other challenges faced as they return to society. A continuation of healthcare would remove one of the connections people may need to make.

Each reconnection a person makes is likely to increase the prospects that they will find their way back in society. Reducing the number of connections that need to be made and supporting the reconnections that remain will also improve a person's prospects. A trial in Queensland issued 'passports' to people, with connections tailored to their needs – for example, a GP who spoke the language of people for whom English was a second language. The trial resulted in an increase in the use of primary and mental health services in the first six months.[14] Each connection that can be easily facilitated reduces the barriers people face following release.

Barriers to connecting

Individuals will face different barriers when returning to the community. While barriers are going to be particular to a person's circumstances, some common themes are evident. People needing access to mental health care within the first two months of release have identified the following barriers:[15]

- a lack of knowledge about available services,
- difficulty making appointments,
- long waits, and
- a lack of access.

Many of these barriers point to the under-resourcing of services. Where services are available, the stigmatisation felt by people who have been to prison adds to the challenges they are confronted with. Australian and international evidence has shown that stigma makes accessing healthcare difficult.[16] The need to re-apply for a Medicare number, for example, highlights the disconnection a person has to overcome. In addition to this barrier, people leaving prison need to make other connections that may influence or interfere with healthcare connections. Two factors in particular are pivotal for people with a mental illness leaving prison – housing and substance use.

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[12] AIHW (2014), *Prisoner health services in Australia: 2012*.
[13] Borzycki (2005), *Interventions for prisoners returning to the community*.
[14] Kinner (2014), 'Evidence-based aftercare to reduce drug use, drug-related harm and recidivism in ex-prisoners'.
[15] Binswanger et al (2011).
[16] Turney, Lee and Comfort (2013), 'Discrimination and Psychological Distress Among Recently Released Male Prisoners'; van Dooren et al (2011), 'Beyond reintegration: a framework for understanding ex-prisoner health'.

Stable housing

For people leaving prison, stable housing provides a foundation from which to make further connections. The AIHW has reported that although housing 'is an important indicator of stability post-release',[17] nearly half (43 per cent) of the people leaving prison expected to spend their first night in short-term or emergency accommodation. Australian research has previously found that housing instability was high among people leaving prison[18] and that living with family halved the likelihood of returning to prison.[19] A study of services for women in Western Australia found a link between stable housing and improved mental health outcomes.[20] The importance of housing support is also illustrated by a US study that found increased risk of re-arrest and probation violation among people experiencing homelessness and serious mental illness.[21] Providing support to find stable housing alongside mental health services is likely to deliver greater benefits for people returning to society.

Substance use

The presence of a mental illness can manifest in attempts to self-medicate, especially where an illness goes undiagnosed or untreated. This pathway to substance use has been identified as likely to be typical for many people with substance use issues. Conversely, mental health issues can also arise from substance use. An Australian study of mental illness and substance use among prisoners found a co-occurrence in three out of ten (29 per cent) prisoners, with a higher prevalence among women (46 per cent) than men (25 per cent).[22] The combination of substance use and mental illness highlights the need for the delivery of linked or comprehensive health services. The Australian Medical Association (AMA) has recommended that, due to high incidence of combined mental illness and substance use issues, services need to be integrated in prison and community settings.[23] The risks are likely to be higher where adequate support is missing. The importance of addressing housing and substance use as part of a mental health treatment plan underlines the need to provide coordinated support.

Other barriers

Many other factors may contribute to the challenges people face re-connecting with society. The presence of mental illness can also exacerbate 'more systemic obstacles such as poor education, unemployment and debt',[24] making release even more difficult.

The breadth of these potential factors is illustrated in the following selected examples:

- The interruption of existing health treatment by short sentences or remand that does not permit sufficient time involvement in a prison treatment program.
- Past negative experiences of the criminal justice system that have been identified as a challenge in engaging prisoners and dischargees in a continuation of care.

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[17] AIHW (2014), p.26.
[18] Graffam and Shrinkfield (2012), The Life Conditions of Australian Ex-Prisoners: An Analysis of Intrapersonal, Subsistence, and Support Conditions'; Shinkfield and Graffam (2009), 'Community Reintegration of Ex-Prisoners: Type and Degree of Change in Variables Influencing Successful Reintegration'.
[19] Baldry et al (2006), 'Ex-prisoners, accommodation and the state: Post-release in Australia'.
[20] Lackner (2012), *Prisoner re-entry and reintegration: Perspectives of the women involved in Outcare's St John of God women's program*.
[21] Vanderloo and Butters (2012), *Treating Offenders with Mental Illness: A Review of the Literature*.
[22] Butler et al (2011).
[23] Australian Institute of Family Studies (2012), Position Statement on Health and the Criminal Justice System, p.7.
[24] Borzycki and Baldry (2003), 'Promoting Integration: The Provision of Prisoner Post-release Services', p.2.

- Further challenges faced by people with special needs including intellectual and cognitive disability.
- Participation in general counselling being more likely than mental health specific counselling or treatment.

Mental illness cannot be considered in isolation, without regard for the need for support and appropriate support delivery. One or more of the barrier factors are likely to complicate the making of connections for people leaving prison – therefore the greater the coordination of support, the better the outcome is likely to be. This paper focuses on the integration of healthcare services to enable continuous mental health treatment for people from prison into the community.

Integrating healthcare

The disconnection between 'inside' and 'outside' mental health services and the need for integration has been identified in Australia and internationally.[25] The integration of prison-based health services with public health should be pursued as a policy for a number of reasons. From a health-services perspective, integrated care can facilitate improvements through the delivery of an equivalent level of care in prison and in the community. The integration of health services also establishes a connected service network that allows the continuation of care from prison out into the community, known as throughcare. The benefits of integrating mental health services have previously been documented in the Australian context.[26]

Some people are released from prison with planned treatment, often with specialist forensic mental health services – although this differs around the country, as does the duration of care provided. Others must find support within the public health care system, possibly with a referral for which they must arrange an appointment. This division can present feelings of marginalisation, both for those channelled into specialist services,[27] and those who need to access public services.[28] In the UK, it has been noted that most mental health needs among prisoners are at a level that is best addressed through 'mainstream' services.[29] Comparisons of specialist and general psychiatric services for people returning to the community have found no evidence to support 'parallel' specialist services.[30] Benefits of treating former prisoners in a general setting would improve the understanding of their needs among professionals and might effect a reduction in stigmatisation. Less attention, however, has been paid to possible responses from the public to the integrated provision of services. Previous evaluation of Australian proposals raised the need to generate community support for integration.[31]

A Senate committee report tabled in 2006 (the same year prison care in the UK was integrated into the public health system) recommended "that state and territory governments transfer responsibility for mental health in general prisons to the department within each state

[25] Schnittker (2014); Hanley and Ross (2013), 'Forensic Mental Health in Australia: Charting the Gaps'; Vanderloo and Butters (2012); Fraser (2009), 'Mental health in prisons: A public health agenda'; Byrne and Hummer (2005) '"Thinking Globally, Acting Locally": Applying International Trends to Reentry Partnerships in the United States'.
[26] Hanley and Ross (2013); Graffam and Shinkfield (2012); and Levy (2005), 'Prisoner health care provision: Reflections from Australia'.
[27] Maguire and Raynor (1997) 'The Revival of Throughcare: Rhetoric and Reality in Automatic Conditional Release'.
[28] Brooker et al (2011), *An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population*.
[29] May and Meiklejohn (2010), 'Prison mental health: representation and reality'.
[30] Coid, Hickey and Yang (2007), 'Comparison of outcomes following after-care from forensic and general adult psychiatric services'.
[31] Borzycki and Baldry (2003), p.3.

or territory with portfolio responsibility for health".[32] The transition to integrated health services has been completed in a majority of states and territories with the exception of Victoria, Queensland and Western Australia. The transition in Victoria is complicated by the private management of some prisons.

Equivalent levels of care

Ensuring prisoners receive equivalent levels of mental health care is an important objective of integrating care. The AMA has stated that prisoners should have access to health services that "are equivalent in quality to that provided in the community, and commensurate with their heightened health needs".[33] In the UK a survey of community based staff working in the prison system following integration found that while funding and staffing were identified as issues, six out of ten respondents thought they could provide equivalent levels of care in the prison as they do in the general community.[34] Prisoner perceptions of equivalency, however, can differ from agency measurements of service delivery. For example, a review of prisoner assessments of clinic services in NSW prisons conducted in 2001 and again 2004 found services were perceived to be of the 'same standard' as community health services. Interestingly, the authors argued that this favourable assessment reflected the relevance of prison health services for people with complex health needs, which they claimed were 'poorly' served within the public health system.[35] The aim of providing equivalent care should be to take the best aspects of both health services into the integrated health service.

A new approach: throughcare

Throughcare is the delivery of 'continuous, coordinated and integrated treatment' for people moving from prison to the community.[36] In Australia interest in throughcare previously peaked in the early to mid-2000s. In 2005 a report for the Federal Attorney-General's Department identified inter-agency collaboration and resourcing of programs as challenges[37] for the implementation of throughcare in Australia.[38] Criticism of throughcare programs at the time argued they suffered from under-funding and a lack of evidence.[39] A central tenet of throughcare identified by service users was seeing the same practitioner or team. Other factors that have been identified as supporting reconnections with health services include: flexible opening times, non-stigmatising services and co-location with criminal justice services, which can also increase continuity of care.

The demarcation of both health and justice as state or territory responsibilities means individual jurisdictions have been in a position to develop and implement throughcare models. The following examples demonstrate how some jurisdictions and NGOs have worked to implement throughcare principles.

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[32] Select Committee on Mental Health (2006), *A national approach to mental health – from crisis to community*.
[33] AMA (2012), p.8.
[34] Caufield and Twort (2012), 'Implementing change: staff experiences of changes to prison mental healthcare in England and Wales'.
[35] Barling, Halpin and Levy (2009), 'Capturing perceptions: Prisoners assess their health services – Australia, 2001 and 2004'.
[36] AMA (2012), p5.
[37] Two more challenges were also identified; working with a prison population and available research and data.
[38] Borzycki (2005).
[39] Kinner (2006), *The Post-Release Experience of Prisoners in Queensland*.

Examples of throughcare programs in Australia

A number of trials and programs by government, non-government organisations and the private sector in Australia are moving to, or have adopted, a form of throughcare. In the ACT a dedicated Alcohol and Drug Services counsellor began working at the adult prison to "provide continuity of counselling care when they are discharged". A senior nurse is also employed to work with prisoners close to release who are receiving opioid maintenance treatment. While this example does not include mental health services it is a good example of the throughcare model and could be readily extended to the integration of mental health services.

A throughcare program for Indigenous prisoners is provided by the Aboriginal and Torres Strait Islander Legal Service (Qld) Ltd (ATSILS) in Queensland. Prisoner Throughcare Officers, working for ATSILS, are case managers who work with prisoners through transition from prison to the community. Officers also work collaboratively with a client's family and community members where it is possible and appropriate.

In NSW the Throughcare Jigsaw Group was formed in 2008 by a group of non-government organisations that provided services to prisoners while they were inside and following release and also to their families. Group members provide a variety of services, including mental health counselling and support, and collaborate to match these services into a throughcare model.

In Victoria a degree of integration of prison and community mental health care has been inadvertently achieved as a result of the outsourcing of management of some prisons. At the privately operated Port Phillip Prison, in-prison and outpatient mental health services are sub-contracted to St Vincent's Correctional Health Services (also delivered at St Vincent's Hospital), while secondary residential mental health services are outsourced to St Paul's Psycho-Social Unit.

There has been renewed interest in throughcare in Australia over the last two years, with service providers, peak bodies and academics supporting a move towards an integrated, continual approach to mental health care for people moving from prison into the community.

Jesuit Social Services, a statewide provider of services to people exiting prison in Victoria, recently recommended that the Victorian government should "put in place processes to enable a seamless transition between health, disability, and alcohol and drug services in and out of custody".[40] In Victoria the mixed public/private operation of prisons presents additional barriers to the integration of healthcare – specifically the development of continued mental health care. Commenting on his report *Mental Health Strategies for the Justice System*, the Victorian Auditor-General said that, despite developments that have occurred in the area of prisoner mental health:[41]

> *… there are gaps with planning, collaboration and coordination. There is no overarching leadership or strategy for mental health in the criminal justice system that could provide the basis for focusing and coordinating agencies' responses.*

The National Mental Health Commission has also reported a lack of throughcare type services in Australia and sought greater collaboration between prison services and local

[40] Jesuit Social Services (2014), *Strengthening prisoner transition to create a safer Victoria*, p.7.
[41] Victorian Auditor-General (2014), *Mental Health Strategies for the Justice System*.

mental health teams.[42] A review of gaps in specialist mental health services in Australia highlighted the inadequacy of connections with community health agencies.[43] The review authors were critical of stated federal government commitments to mental health that ignored the needs of people in prison. The AMA has also argued for the establishment of throughcare.[44] Ten years after a peak in interest in throughcare prompted the move to integrated health services there is renewed interest in the prospects for improvements that throughcare may provide. This interest provides an opportunity for a new wave of reform that could establish throughcare services.

Understanding the role of families and their needs

A prisoner's family can provide important support for people while in prison and upon their release. A less-recognised issue is the support families need – in particular, the needs of children.

Providing support

There is evidence to support the realistic expectation that imprisonment of a family member will have a 'considerable' emotional impact on family members.[45] There are, however, limitations in the available research.[46] The effects and experiences of having a family member imprisoned are not the same for every family. Expectations of the impact imprisonment will have on relationships has been found to be strongly influenced by the pre-existing relationship.[47] This finding indicates that the support required by families will differ, and reinforces the need to engage families in determining the most appropriate support.

Strong familial ties during imprisonment and following release underpin the transition back into the community. An earlier study of imprisonment and wellbeing using HILDA data found that, while there were negative mental health outcomes among people who had spent time in prison, they reported increased satisfaction with family relationships.[48] The maintenance and potential improvement of family relationships during a prison sentence underpins the support role that family can provide. For example, an Australian literature review found evidence that prisoners who receive visits are less likely to reoffend (52 per cent compared with 70 per cent).[49] The maintenance of relationships provides a foundation on which a person can rebuild their life back in the community.

Support is critical in the first month following release, with family relationships providing a vital resource. In particular, families can provide emotional support and assistance with housing.[50] In the month after leaving prison a majority of people found support from immediate and extended family.[51] In Australia the evidence shows that living with family following release from prison halved the likelihood of returning to prison.[52] Providing support to families during the imprisonment of a family member is likely to increase the level of support they are in turn able to provide a family member after release.

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[42] National Mental Health Commission (2013).
[43] Hanley and Ross (2013).
[44] AMA (2012).
[45] Sainsbury Centre for Mental Health (2008).
[46] Woodward (2003)), *Families of prisoners: Literature review on issues and difficulties*.
[47] Christain and Kennedy (2011), 'Secondary narratives in the aftermath of crime: Defining family members'.
[48] Velamuri and Stillman (2007)), *Longitudinal Evidence on the Impact of Incarceration on Labour Market Outcomes and General Well-Being*.
[49] Bartels and Gaffney (2011).
[50] Vishner and Travis (2003), 'Transitions from Prison to Community: Understanding Individual Pathways'.
[51] Graffam and Shinkfield (2012).
[52] Baldry et al (2006).

The impact on children

There is little available research into the experience and particular needs of children who have had a parent imprisoned.[53] Almost three out of ten (28 per cent) prison entrants reported that they had at least one child who depended on them for their basic needs.[54] The imprisonment of a family member, in particular a parent, can affect a child's mental health[55] and their social and education participation, which will likely impact their development.[56]

An international review of existing studies into the effect of parental imprisonment on a child's mental health found that children of prisoners have twice the risk of poor mental health outcomes – though it is recognised that other aspects of social disadvantage may also contribute.[57] Factors affecting the mental health of children include the stress of visits, disengagement of fathers, keeping it a secret, denial and depression.[58] The risk of stigma, discrimination and bullying leads many carers to instruct children not to tell people about their situation.[59] Stigma is also associated with accessing support services. Children report that the availability of services at prisons where they visit a parent is helpful because of the 'non-stigmatised environment'. Supporting children to contact the justice system can also overcome the dual barriers of a lack of knowledge and difficulty accessing services.[60]

Maintaining relationships between children and their parents

A qualitative study of children in the Australian Capital Territory found parental imprisonment was akin to the 'loss of a parent' and that most children do not want to lose contact.[61] A review of best practices in women's prisons by the Australian Institute of Criminology has identified a number of features that can facilitate strong relationships between mothers and their children, including having pre-school children live with their mothers or have extended visits.[62] The child-friendliness of visiting facilities was also considered in the review. Ideally separate visiting areas for children and mothers should be provided, with quality playground equipment and childcare staff to engage children in play and learning activities identified as good examples. The need for greater evidence of the impact of prison programs designed to support the mother-child relationship has also been highlighted recently,[63] underlining the need for research into families' experiences.

Maintaining relationships between parents in prison and their children, where this is beneficial, will likely have positive mental health outcomes for children and parents. The continued relationship may also assist in the return of a mother or father to their parenting role on release.[64] The potential benefits can be affected by a child's parent or carer. Australian research has identified the importance of carers in maintaining and building a

[53] Dennison, Stewart and Freiberg (2013), 'A prevalence study of children with imprisoned fathers: annual and lifetime estimates'; AIHW (2012).
[54] AIHW (2013a).
[55] Tasca, Turanovic, White and Ridriguez (2012), 'Prisoners' assessments of mental health problems among their children'.
[56] Bartels and Gaffney (2011).
[57] Murray, et al (2009), 'Effects of parental imprisonment on child antisocial behaviour and mental health: a systematic review'.
[58] Pope (1987), '"We all went to prison": The distress of prisoner's children'.
[59] Saunders and McArthur (2013), *Children of Prisoners: Exploring the needs of children and young people who have a parent incarcerated in the ACT;* Dawson, Jackson and Nyamathi (2012), 'Children of incarcerated parents: Insights to addressing a growing public health concern in Australia'.
[60] Saunders and McArthur (2013).
[61] Saunders and McArthur (2013).
[62] Bartels and Gaffney (2011).
[63] Burgess and Flynn (2013), 'Supporting imprisoned mothers and their children: A call for evidence'.
[64] Dennison, Stewart and Freiberg (2013); Newman, Fowler and Cashin (2011), 'The development of a parenting program for incarcerated mothers in Australia: A review of prison-based parenting programs'.

relationship with an imprisoned parent.[65] There is also the potential for negative effects; a study of 20 Victorian children found that young people with unsupportive fathers did not visit their mothers regularly.[66] A program in regional Western Australia has had success using free online video-conferencing for e-visits. The response from prisoners has been positive, with the format preferred over phone calls.[67]

The imprisonment of a parent has been linked to the heightened possibility the child may also be imprisoned in the future. One estimate suggests that four per cent of children will see their father imprisoned during their lifetime. The figure was four times higher for Indigenous children.[68] The National Mental Health Commission has reported that one-in-five prisoners (21 per cent) had had a parent in prison when they were a child.[69] An earlier Australian review of the literature found the likelihood of imprisonment was six times higher if they had had a parent spend time in jail when they were a child.[70]

Policy development in this area is inhibited by the comparative lack of available research. More attention is needed to understand the mental health needs of the families of prisoners. In a modest contribution to this project, this paper examines the psychological distress reported by the families of prisoners.

Distress among families of prisoners

While the need for mental health services for people in prison and after release has been recognised, less attention has been paid to the impact of imprisonment on the families of inmates and their psychological distress. The average distress reported by families is presented in Table 2.

Table 2: Average distress levels of persons after prison, families and general population

	Number	Mean	Category
Respondent was in jail in the past year	39	22.5	High
Close family member was in jail in the past year	212	18.9	Moderate
No direct experience of imprisonment	14,898	15.7	Moderate

Source: HILDA Survey 2011.
Note: High (score 22-29); Moderate (score 16-21).

Table 2 shows that close family members of prisoners have a heightened level of psychological distress. Although a moderate level of distress was also found among general population, the average score for the two population groups are towards opposite ends of this category (16-21).

This finding illustrates the need for further examination of the mental health needs of families and the use of this research to inform a review of existing mental health services provided to families during and following the imprisonment of a family member.

[65] Dawson, Jackson and Nyamathi (2012).
[66] Flynn (2012), 'Caring for the Children of Imprisoned Mothers: Exploring the Role of Fathers'.
[67] Spencer (2011), 'Using collaboration and technology to support the children of incarcerated parents: A Case Study'.
[68] Dennison, Stewart and Freiberg (2013).
[69] National Mental Health Commission (2013).
[70] Woodward (2003).

Policy directions

New findings presented in this paper indicate the average person's psychological distress worsens in the year after release from prison. Four in ten (44 per cent) people who reported having been in prison in the year prior to the 2011 HILDA survey had a high or very high distress level and the average distress level was high. The increased level of distress following release is concerning and raises policy issues for the delivery of mental health services for people returning to the community.

The AIHW's reporting on mental health among prisoners would be strengthened by the inclusion of mental health data after release. Ideally this data would be reported for the short-, mid- and longer-term. Increased reporting would inform the design of policies to improve mental health outcomes among former prisoners.

Families of prisoners also have a need for greater access to mental health services. The proportion of respondents in the HILDA survey who said a close family member had been in prison in the past year and had a high or very high level of psychological distress was 31 per cent. This is the same proportion reported by the AIHW for prison entrants and is approximately double the balance of the HILDA sample and three times the proportion of the general population in the Australian Health Survey.

The evidence presented in this paper highlights the need for improved mental health services for former prisoners and their families. There is a strong economic argument for developing the policy case for improved mental health care for people leaving prison – better mental health care provided in prison will also contribute to a person's preparedness for the task of reconnecting with society.

Continuing care after leaving prison

Throughcare health service models continue the delivery of mental health care from prison into the community. Continuation of healthcare reduces the risk that people will miss out on or fail to pursue care after release. Integrating community healthcare into the prison system supports the implementation of throughcare. The benefits of integrated healthcare include reduced stigmatisation, increased awareness and the provision of equivalent care.

Following initial interest in the early 2000s, various throughcare models have been trialled by governments and non-government organisations around Australia. While early trials drew some criticism they now provide policy experience from which larger throughcare programs can be developed. Evidence from the UK suggests 'very low levels' of access and continuity of mental health services despite the integration of healthcare.[71] Difficulties have been documented in involving families in the implementation of throughcare programs.[72] More research is needed in this area around the support families need and the support they can provide to family members leaving prison.

The idea of throughcare on its own will not deliver improvements. A review of existing and previous programs that examines what has been learnt would contribute to the development of a nationally coordinated throughcare program. National direction would help ensure adequate resourcing and a consistent approach across the country. The Council of Australian Governments (COAG) has previously led the establishment of a national database and reporting of prisoner health. COAG is an appropriate forum for implementing a national throughcare program.

[71] Byng, et al (2012), *COCOA: Care for Offenders, Continuity of Access*.
[72] Warr and Hoyle (2007), 'Women's mental health in prison: developing an integrated care pathway'.

Care for the families of prisoners

While the need and preconditions for throughcare are increasingly understood, the mental health needs of families with a close family member serving a prison sentence are less well understood, especially the needs of children.

The mental health needs of families have not received the same level of research attention as have prison populations. The AIHW is well placed to coordinate the collection of data on the mental health of a prisoner's family. This data would extend and complement existing data reporting on prisoner mental health. This data should include but not be limited to the following:

- mental health levels,
- awareness and take-up of available services,
- the prevalence and impact of stigma, and
- the impacts on children.

It is important that data collection methods are developed that support families and do not risk adding further stress. Special consideration needs to be given to the collection of data regarding children. The AIHW would be a suitable agency for undertaking this research considering its existing role in the collection of data about prisoner health, however, a collaboration with the Australian Institute of Family Studies (AIFS) would be beneficial in light of its existing work in this field.

Where possible contact with families should facilitate increased awareness of existing services and identify any gaps in existing mental health services. The possibility of including services for families within a throughcare model could also be explored. Greater integration of services will likely increase the proportion of families and people exiting prison who receive care.

Cost savings

While this paper has not fully explored the economics of imprisonment and mental health services, the headline data reported in the introduction points to the potential for large savings. If the provision of continued care contributes to a reduction in re-offending rates state and territory budgets will also benefit, along with the community and former prisoners themselves. Further benefits may be realised if identified savings are reinvested in mental health services, where appropriate, for people regarded as at risk of offending – for example, those with substance use issues or who experience homelessness. The concept of 'justice reinvestment' was investigated by the Senate Legal and Constitutional References Committee in 2013. The committee concluded that:[73]

> *… justice reinvestment provides economic benefits in the long term through shifting resources away from incarceration towards prevention, early intervention and rehabilitation.*

The committee went on to recognise that, beyond economic benefits, there would be greater benefits for the community and individuals. Justice reinvestment could assist in addressing social determinants of crime – including health – alongside unemployment, homelessness and education issues.

[73] Legal and Constitutional References Committee (2013), *Value of a justice reinvestment approach to criminal justice in Australia*.

Tackling the problem from all sides

This paper has focused on the utilisation of throughcare in improving the delivery of mental health services to prisoners and their families. Optimising the potential outcomes of mental health services will in most cases require delivering healthcare as part of a suite of support services. This paper has briefly referred to the importance of housing and substance use as factors that can influence the effect of mental illness on a person's return to society, along with the contribution familial support can provide. Employment is another factor which has not been addressed. Each individual's successful release is going to be determined by a range of factors. While the coordination of support services is beyond the scope of this paper it would improve the potential outcomes of continued mental health services for people released from prison.

Conclusion

The incidence of mental illness is higher among prisoners than the rest of the population. Data show that the severity of psychological distress among prisoners falls during imprisonment, due in some part to the ability to diagnose and provide mental health care. This paper reports, however, that levels of distress increase in the year following release. The reversal of improved mental health points to the need to improve the delivery of mental health care in the transition from prison back into the community.

Above average distress has also been found among the families of people who have experienced imprisonment. A comparative lack of research into the needs of families, in particular children, also highlights the need for greater review of their support needs around mental health and wellbeing. The importance of families as support for people in prison and following release underlines the need to address this issue.

There is renewed momentum presently for throughcare as a model for providing continued healthcare for prisoners transitioning back into the community. Throughcare has been trialled in various forms around Australia and internationally, providing evidence for the development of a national program. The integration of prison health services into public health departments in many states will facilitate a national program, although further work is required to complete this integration in Victoria, Queensland and Western Australia.

COAG has previously shown leadership on the issue of prisoner mental health and is well positioned to lead the development and implementation of a national throughcare program. Existing work by AIHW and AIFS could be extended to support this work. This support will require extended research and comprehensive reporting of the mental health needs of people after they leave prison and their families.

Appendix

Measuring mental health

There are a range of assessment tools used to measure mental health. To measure prisoner mental health the AIHW uses the Kessler Psychological Distress Scale (K10). The K10 scale has been included in the Household, Income and Labour Dynamics in Australia (HILDA) Survey in alternate years since 2007. The HILDA data allows the AIHW data to be complemented with an analysis of the mental health of people after they have left prison.

The AIHW notes that data for entrants and dischargees cannot be directly compared as they are for different groups of prisoners. This limitation is also applicable to the post-release distress data collected from the HILDA dataset.

Household, Income and Labour Dynamics in Australia (HILDA) Survey

The HILDA survey is an annual, longitudinal household panel survey, which asks a range of questions about economic and subjective wellbeing, labour market participation and family. The panel survey started in 2001 with 7,682 households and 19,914 individuals and was topped up with an additional 2,153 households and 5,477 individuals in 2011.[74]

The K10 questions were last included in the 2011 survey, the data analysed in this paper. Analysis was restricted to respondents aged 18 years and over who answered the K10 questions and two questions about whether they or a close family member had been in prison or correctional facility in the 12 months prior to being surveyed. The demographic make-up of this subset of the HILDA survey is shown in Table A 1.

Table A 1: Demographics of study sample

	Men			Women			Total
	Number	(%)	Average age	Number	(%)	Average age	
Been in prison in past year	28	72%	37.9	11	28%	40.0	39
Close family member has been in prison in past year	93	44%	38.3	119	56%	39.7	212
No experience of imprisonment	7,011	47%	44.6	7,887	53%	44.9	14,898
Total	**7,132**			**8,017**			**15,149**

Source: HILDA Survey 2011.

This paper provides additional data complementing the AIHW's published data on prisoner mental health. The new data examines the self-reported mental health of former prisoners in the year after release. The paper also extends the study to the families with a member currently in prison or released in the past year.

Kessler Psychological Distress Scale

The K10 is a self-complete questionnaire used to assess a person's mental health. The K10 asks ten questions about such feelings such as tiredness, nervousness, restlessness and

[74] Melbourne Institute of Applied Economic and Social Research (2012), *Household, Income and Labour Dynamics in Australia (HILDA) Survey: Annual Report 2012*, p.5.

depression in the preceding four weeks. Responses are measured on a five-point scale ranging from none of the time (1) to all of the time (5). The K10 score range is ten to 50 and these scores are categorised from low to very high. Table A 2 lists the diagnostic definitions for each category used by General Practitioners administering the K10.

Table A 2: Kessler Psychological Distress Scale (K10) categories

Category	Score	Level of psychological distress
Low	10-15	are likely to be well
Moderate	16-21	are likely to have a mild mental disorder
High	22-29	are likely to have a moderate mental disorder
Very high	30-50	are likely to have a severe mental disorder

Source: ABS (2012), *Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2007-08*.

The AIHW has used the K10 in the study of the mental health of the prison population. The Australian Bureau of Statistics (ABS) has also used the K10 in its Australian Health Survey. This paper compares findings from the AIHW and HILDA data to examine the effect of incarceration on prisoners once they leave prison and the additional reference to ABS data to examine distress among the family members of prisoners.

SF-36 Health Survey

The HILDA survey has also included questions used in the SF-36 test annually since the survey began in 2001. The SF-36 Health Survey consists of 36 questions about eight aspects of an individual's health. Responses to the SF-36 are used to quantify a relative profile of a person's physical and mental health. The SF-36 results verified the validity of the K10 data.

Comparing levels of distress

The average K10 scores for three population groups within the HILDA sample (see Table 2) show that psychological distress is higher for those people who have had an experience (directly or indirectly) of prison.

The relative level of average psychological distress found through the K10 is confirmed in mental health results from the SF-36 survey of the three population groups. Table A 3 shows the relative degree of the mental health of the three population samples examined in this paper. Readers need to note that a higher score in the K10 represents psychological distress whereas a higher score in the SF-36 represents better health.

Table A 3: Post-release, families and general population, mental health profile (SF-36)

	Number	Mean
Respondent was in jail in the past year	39	59.2
Close family member was in jail in the past year	212	68.8
No direct experience of imprisonment	14,864	74.5

Source: HILDA Survey 2011.

Scores for the SF-36 survey in the HILDA sample show that people with no reported experience of prison have the best mental health. In comparison, relative mental health is lower among family members of prisoners and lower again among those people who reported spending time in prison in the past year. The link between lower mental health profiles in SF-36 results and contact with prison is similar to the higher levels of psychological distress found in the K10 results.

Statistical output

Table A 4: Comparison of results from mental health questionnaires

	Group	Sample size (n)	Mean safety score	Standard error	95% Confidence Interval	
					Lower	Upper
K10	Been in jail past year	39	22.54	1.368	19.77	25.31
	Close family member been in jail past year	212	18.86	.552	17.78	19.95
	Everyone else	14898	15.65	.051	15.55	15.75
SF-36	Been in jail past year	39	59.18	3.190	52.72	65.64
	Close family member been in jail past year	212	68.81	1.324	66.20	71.42
	Everyone else	14864	74.53	.140	74.25	74.80

Source: HILDA Survey 2011, age 18 and over; $p<.05$.

References

Abracen, J, Langton, C, M, Looman, J, Gallo, A, Ferguson, M, Axford, M and Dickey, R (2014), 'Mental Health Diagnoses and Recidivism in Paroled Offenders', *International Journal of Offender Therapy and Comparative Criminology*, 58(7), pp.765-779.

Australian Bureau of Statistics (2013), *Prisoners in Australia, 2013*, Cat. No. 4517.0, Canberra.

Australian Bureau of Statistics (2012), *Australian Health Survey: Frist Results, 2011-12*, Cat. No. 4364.0.55.001, Canberra.

Australian Bureau of Statistics (2012), *Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2007-08*, Cat. No. 4817.0.55.001, Canberra. Accessed online 18 September 2014 <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4817.0.55.001Chapter92007-08>

Australia Institute of Health and Welfare (2014), *Prisoner health services in Australia: 2012*. AIHW bulletin no. 123. Cat. No. AUS 183. Canberra.

Australian Institute of Health and Welfare (2013a), *The health of Australia's prisoners 2012,* Cat. No. PHE 170. Canberra.

Australia Institute of Health and Welfare (2013b), *Health expenditure Australia 2011-12. Health and welfare expenditure series 50*. Cat. No. HWE 59. Canberra.

Australian Medical Association (2012), *Position Statement on Health and the Criminal Justice System.*

Baldry, E. Dowse, L. and Clarence, M. (2012) *People with intellectual and other cognitive disability in the criminal justice system*, Sydney, University of New South Wales.

Baldry, E., McDonnell, D., Maplestone, P., & Peeters, M. (2006), 'Ex-prisoners, accommodation and the state: Post-release in Australia', *Australian and New Zealand Journal of Criminology*, 39(1), 20-33.

Barling, J, Halpin, R and Levy, M (2009), 'Capturing perceptions: Prisoners assess their health services – Australia, 2001 and 2004', *International Journal of Prisoner Health*, 1(2-4), pp. 183-198.

Bartels, L and Gaffney, A (2011), *Good practice in women's prisons: A literature review*, Technical and Background Paper, No.41, Australian Institute of Criminology, Canberra.

Binswanger, I A, Nowles, C, Corsi, K F, Long, J, Booth, R E, Kutner, J and Steiner, J F (2011), '"From the prison door right to the sidewalk, everything went downhill," A qualitative study of the health experiences of recently released inmates', *International Journal of Law and Psychiatry*, 34(4), pp.249-255.

Borzycki, M and Baldry, E (2003), 'Promoting Integration: The Provision of Prisoner Post-release Services', *Trends and issues in crime and criminal justice*, No.262, Australian Institute of Criminology, Canberra.

Borzycki, M (2005), *Interventions for prisoners returning to the community*, report for the Attorney-General's Department, Commonwealth of Australia, Canberra.

Brooker, C, Sirdifield, C, Blizard, R, Maxwell-Harrison, D, Tetley, D, Moran, P, Pluck, G, Chafer, A, Denney, D and Turner, M (2011), *An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population*, report for National Institute for Health Research (NIHR), University of Lincoln.

Brooks, R T, Beard, J and Steel, Z (2006), 'Factor Structure and Interpretation of the K10', *Psychological Assessment*, 18(1), pp.62-70.

Burgess, A and Flynn, C (2013), 'Supporting imprisoned mothers and their children: A call for evidence', *Probation Journal*, 60(1), pp.73-81.

Butler, T, Indig, D, Allnutt, S and Mamoon, H (2011), 'Co-occurring mental illness and substance use disorder among Australian prisoners', *Drug and Alcohol Review*, 30(2), pp.188-194.

Byng, R, Quinn, C, Sheaff, R, Samele, C, Duggan, S, Harrison, D, Owens, C, Smithson, P, Wright, C, Annison, J, Brown, C, Taylor, R, Henley, W, Qureshi, A, Shenton, D, Perter, I, Warrington, C and Campbell, J (2012), *COCOA: Care for Offenders, Continuity of Access*, Final report, National Institute for Health Research: Service Delivery and Organisation programme.

Byrne, J M and Hummer, D (2005) '"Thinking Globally, Acting Locally": Applying International Trends to Reentry Partnerships in the United States', *International Journal of Comparative and Applied Criminal Justice*, 29(1), pp.79-96.

Caufield, L S and Twort, H (2012), 'Implementing change: staff experiences of changes to prison mental healthcare in England and Wales', *International Journal of Prisoner Health*, 8(1), pp. 7-15.

Christian, J and Kennedy, L W (2011), 'Secondary narratives in the aftermath of crime: Defining family members' relationships with prisoners', *Punishment & Society*, 13(4), pp.379-402.

Coid J W, Hickey, N and Yang, M (2007), 'Comparison of outcomes following after-care from forensic and general adult psychiatric services', *The British Journal of Psychiatry*, 190(6), pp. 509-514.

Dawson, A, Jackson, D and Nyamathi, A (2012), 'Children of incarcerated parents: Insights to addressing a growing public health concern in Australia', *Children and Youth Services Review*, 34(12), pp.2433-2441.

de Motte, C Bailey, D and Ward, J (2012), 'How does prison visiting affect female offenders' mental health? Implications for education and development', *The Journal of Mental Health Training, Education and Practice*, 7(4), pp. 170-179.

Dennison, S, Stewart, A and Freiberg, K (2013), 'A prevalence study of children with imprisoned fathers: annual and lifetime estimates', *Australian Journal of Social Issues*, 48(3), pp.339-362.

Fitzpatrick, R, Chambers, J, Burns, T, Doll, H, Fazel, S, Jenkinson, C, Kaur, A, Knapp, M, Sutton, L and Yiend, J (2010), 'A systematic review of outcome measures used in forensic mental health research with consensus panel opinion', *Health Technology Assessment*, 14(18).

Flynn, C (2012), 'Caring for the Children of Imprisoned Mothers: Exploring the Role of Fathers', *Child Abuse Review*, 21(4), pp.285-298.

Forsythe, L (2013), *Measuring mental health in criminology research: Lessons from the Drug Use Monitoring in Australia program*, Technical and Background Paper, No. 54, Australian Institute of Criminology, Canberra.

Fraser, A (2009), 'Mental health in prisons: A public health agenda', *International Journal of Prisoner Health*, 5(3), pp.132-140.

Fleming, J, Gately, N and Kraemer, S (2012), 'Creating HoPE: Mental Health in Western Australian Maximum Security Prisons', *Psychiatry, Psychology and Law*, 19(1), pp.60-74.

Graffam, J and Shinkfield, A J (2012), 'The Life Conditions of Australian Ex-Prisoners: An Analysis of Intrapersonal, Subsistence, and Support Conditions', *International Journal of Offender Therapy and Comparative Criminology*, 56(6), pp. 897-916.

Hanley, N and Ross, S (2013), 'Forensic Mental Health in Australia: Charting the Gaps', *Current Issues in Criminal Justice*, 24(3), pp.341-356.

Howells, K, Heseltine, K, Sarre, R, Davy, R and Day, A (2004), Correctional offender rehabilitation programs: The national picture in Australia, Report for Criminology Research Council, Forensic Psychology Research Group, Centre for Applied Psychological Research, University of South Australia.

Jesuit Social Services (2014), *Strengthening prisoner transition to create a safer Victoria*, p.7.

Kessler, R C, Andrews, G, Colpe, L J, Hiripi, E, Mroczek, D K, Normand, S-L T, Walters, E E and Zaslavsky, A M (2002), 'Short screening scales to monitor population prevalences and trends in non-specific psychological distress', *Psychological Medicine*, 32(6), pp.959-976.

Kinner, S (2014), 'Evidence-based aftercare to reduce drug use, drug-related harm and recidivism in ex-prisoners', *Reintegration Puzzle Conference*, Conference proceedings, Singapore, 30 July-1 August.

Kinner, S A, Burford, B J, van Dooren, K and Gill, C (2013), *Service brokerage for improving health outcomes in exprisoners*, The Campbell Collabaration.

Kinner, S A (2006), *The Post-Release Experience of Prisoners in Queensland*, University of Queensland, March.

Lackner, M (2012), *Prisoner re-entry and reintegration: Perspectives of the women involved in Outcare's St John of God women's program*, Thesis, Master of Criminal Justice, Edith Cowan University.

Lattimore, P K, Barrick, K, Cowell, A, Dawes, D, Steffey, D, Tueller, S and Visher, C A (2012), *Prisoner Reentry Services: What Worked for SVORI Evaluation Participants?*, Final Report, National Institute of Justice, Washington.

Legal and Constitutional References Committee (2013), *Value of a justice reinvestment approach to criminal justice in Australia*, June, Commonwealth of Australia, Canberra.

Levy, M (2005), 'Prisoner health care provision: Reflections from Australia', *International Journal of Prisoner Health*, 1(1). pp.65-73.

Maguire, M and Raynor, P (1997), 'The Revival of Throughcare: Rhetoric and Reality in Automatic Conditional Release', *The British Journal of Criminology*, 37(1), pp.1-14.

May, P and Meiklejohn, C (2010), 'Prison mental health: representation and reality', *Prison mental health: vision and reality*, Royal College of Nursing, London, September, pp.10-15.

Melbourne Institute of Applied Economic and Social Research (2012), *Household, Income and Labour Dynamics in Australia (HILDA) Survey: Annual Report 2012*, University of Melbourne, Mebourne.

Ministry of Justice (2013), 'Transforming Rehabilitation: A summary of evidence on reducing reoffending', *Ministry of Justice Analytical Series*, United Kingdom.

Murray, J, Farrington, D P, Sekol, I and Olsen, R F (2009), 'Effects of parental imprisonment on child antisocial behaviour and mental health: a systematic review', *Campbell Systematic Reviews*, September.

National Mental Health Commission (2013), *A Contributing Life: The 2013 National Report Card on Mental Health and Suicide Prevention*, Australian Government, Sydney.

Newman, C, Fowler, C and Cashin, A (2011), 'The development of a parenting program for incarcerated mothers in Australia: A review of prison-based parenting programs', *Contemporary Nurse*, 39(1), pp.2-11.

Offender Health Research Network (2010), *The pathway of prisoners with mental health problems through prison health services and the effect of the prison environment on the mental health of prisoners*, Report to the National Institute of Health Research, April.

Polin, C, Lemoine, O, Poirier, L-R and Lambert, J (2005), 'Validation study of a nonspecific psychological distress scale', *Social Psychiatry and Psychiatric Epidemiology*, 40(12), pp.1019-1024.

Pope, V (1987), '"We all went to Prison": The Distress of Prisoners' Children', *Probation Journal*, 34(3), pp.92-96.

Productivity Commission (2014), *Report on Government Services 2014*, Canberra.

Renzaho, A M N, Houng, B, Oldroyd, J, Nicholson, J M, D'Esosito, F and Oldeburg, B (2013), 'Stressful life events and the onset of chronic diseases among Australian adults: findings from a longitudinal survey', *The European Journal of Public Health*, 24(1), pp.57-62.

Sainsbury Centre for Mental Health (2008), *On the Outside: Continuity of care for people leaving prison*, London.

Sanson-Fisher, R W and Perkins J J (1998), 'Adaptation and Validation of the SF-36 Health Survey for Use in Australia', *Journal of Clinical Epidemiology*, 51(11), pp.961-967.

Saunders, V and McArthur, M (2013), *Children of Prisoners: Exploring the needs of children and young people who have a parent incarcerated in the ACT*, SHINE for Kids, Canberra.

Schnittker, J (2014), 'The Psychological Dimensions and the Social Consequences of Incarceration', *The ANNALS of the American Academy of Political and Social Science*, 651, pp.122-138.

Select Committee on Mental Health (2006), *A national approach to mental health – from crisis to community, Final Report*, April, Commonwealth of Australia, Canberra.

Shinkfield, A J and Graffam, J (2009), 'Community Reintegration of Ex-Prisoners: Type and Degree of Change in Variables Influencing Successful Reintegration', *International Journal of Offender Therapy and Comparative Criminology*, 53(1), pp.29-42.

Spencer, M (2011), 'Using collaboration and technology to support the children of incarcerated parents: A Case Study', *Developing Practice*, 29, Spring, pp.86-91.

Sunderland, M, Mahoney, A and Andrews, G (2012), 'Investigating the Factor Structure of the Kessler Psychological Distress Scale in Community and Clinical Samples of the Australian Population', *Journal of Psychopathology and Behavioral Assessment*, 34(2), pp.253-259.

Sunderland, M, Slade, T, Stewart, G and Andrews, G (2011), 'Estimating the prevalence of DSM-IV mental illness in the Australian general population using the Kessler Psychological Distress Scale', *Australian and New Zealand Journal of Psychiatry*, 45(10), pp.880-889.

Tasca, M, Turanovic J J, White, C and Ridriguez, N (2012), 'Prisoners' Assessments of Mental Health Problems Among Their Children', *International Journal of Offender Therapy and Comparative Criminology*, 58(2), pp.154-173.

Turney, K, Lee, H and Comfort, M (2013), 'Discrimination and Psychological Distress Among Recently Released Male Prisoners', *American Journal of Men's Health*, 7(6), pp482-493.

VARCO and State of Victoria (2010), *Health Fact Sheet*, Department of Justice, Melbourne. Accessed online 18 September 2014 <http://assets.justice.vic.gov.au/corrections/resources/6305a7ab-f1a0-442b-8883-0dfaa0b7d30e/health_factsheet5.pdf>

Vanderloo M J and Butters R P (2012), *Treating Offenders with Mental Illness: A Review of the Literature*, Utah Criminal Justice Centre, The University of Utah.

van Dooren, K, Claudio, F, Kinner, S A and Williams, M (2011), 'Beyond reintegration: a framework for understanding ex-prisoner health', *International Journal of Prisoner Health*, 7(4), pp. 26-36.

Velamuri, M and Stillman, S (2007), *Longitudinal Evidence on the Impact of Incarceration on Labour Market Outcomes and General Well-Being*, HILDA Survey Research Conference 2007, 19-20 July, Melburne.

Victorian Ombudsman (2014), *Investigation into deaths and harm in custody*, March.

Victorian Auditor-General (2014), *Mental Health Strategies for the Justice System*, October.

Vishner, C A and Travis, J (2003), 'Transitions from Prison to Community: Understanding Individual Pathways', *Annual Review of Sociology*, 29, pp.83-113.

Warr, J and Hoyle, C (2007), 'Women's mental health in prison: developing an integrated care pathway', Mental Health Practice, 11(2), pp.24-27.

Woodward, R (2003), *Families of prisoners: Literature review on issues and difficulties*, Occasional Paper No. 10, September, Department of Family and Community Services, Australian Government, Canberra.

World Health Organization (2007), *Trenčín statement on prisons and mental health,* Copenhagen, Denmark: WHO Regional Office for Europe.