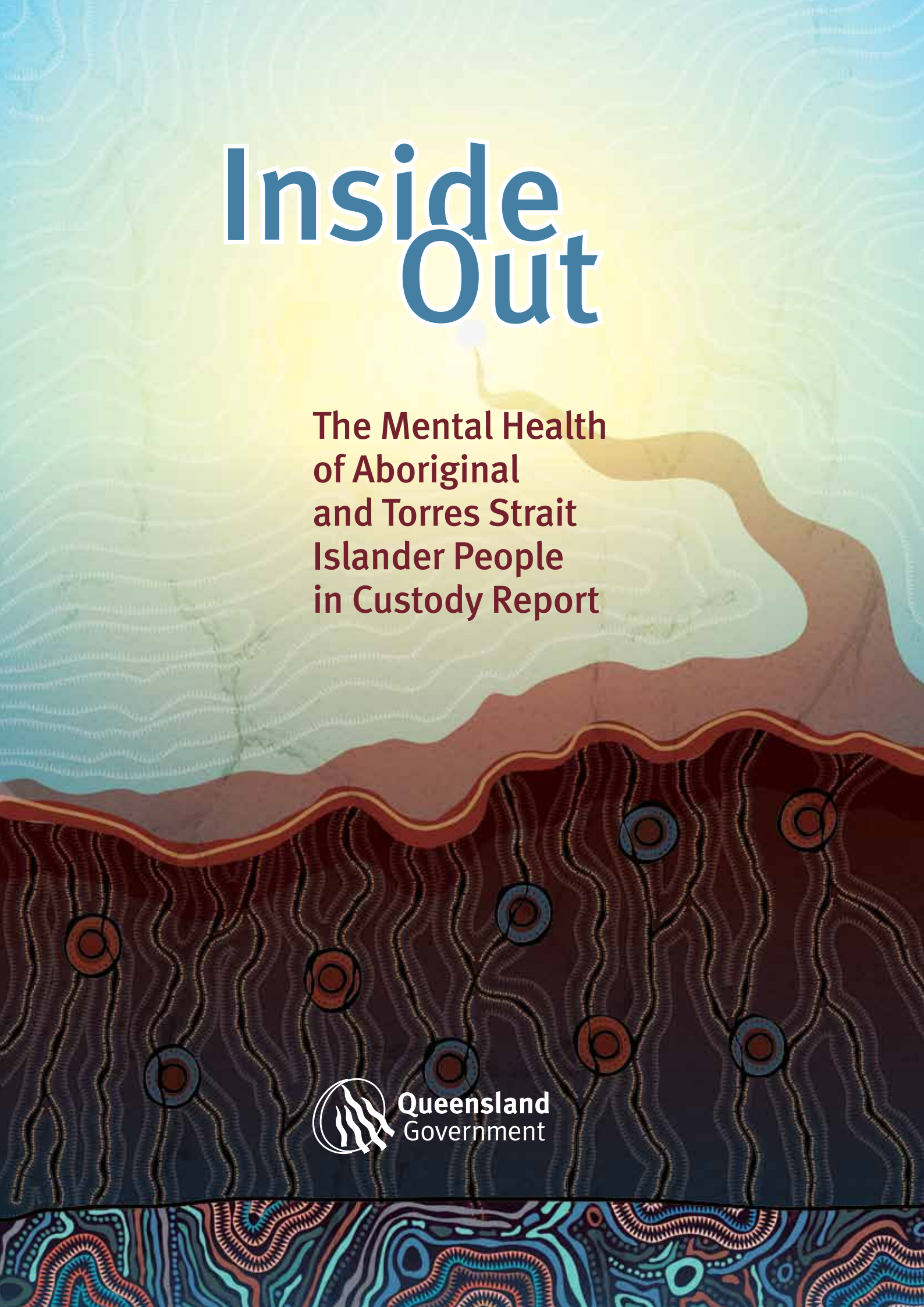
Inside Out

The Mental Health of Aboriginal and Torres Strait Islander People in Custody Report



Queensland Government

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Inside Out —The Mental Health of Aboriginal and Torres Strait Islander People in Custody Report

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Foreword

The health challenges for Aboriginal and Torres Strait Islander people are significant and for those in custody, these problems are magnified. *The Inside Out—The Mental Health of Aboriginal and Torres Strait Islander People in Custody Report* makes a significant contribution to the understanding of the mental health problems faced by Aboriginal and Torres Strait Islander people in custody. Mental health clinicians and researchers have worked directly in partnership with Indigenous people and communities to understand the mental health and wellbeing needs of Aboriginal and Torres Strait Islander people in the prison system.

Indigenous partnerships have been a hallmark of this project since its conception in 2007. Collaboration with mental health practitioners, Queensland Health, Queensland Corrective Services, Aboriginal and Torres Strait Islander people and communities, and a host of other stakeholders has been critical to ensure the goals of this project have been achieved. Maintenance of the cultural integrity of the project from beginning to end has been imperative to the success of this research.

The development of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004–2009*, solidified the efforts of a number of critical reports over the last decade. This included the *National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health, Ways Forward (1995)*, which identified that incarceration impacts negatively upon the mental health and wellbeing of Aboriginal and Torres Strait Islander people, and that culturally capable mental health assessment and preventative care services are required.

The unique opportunity to undertake research in this area was fortuitous given the current state of mental health needs for Indigenous prisoners, the national agenda in relation to the Closing the Gap campaign, and the priority to support effective mental health services for Aboriginal and Torres Strait Islander people as part of the *Queensland Health Forensic Mental Health Strategic Framework 2011* and the *Queensland Plan for Mental Health 2007–2017*.

We have now increased our understanding of the true mental health challenges faced by Aboriginal and Torres Strait Islander people in Queensland prisons. By increasing our knowledge of the ways in which Indigenous people in custody believe their wellbeing can truly be improved, we are better prepared for the development of future services. This surely brings us one step closer to delivering culturally capable mental health services to Aboriginal and Torres Strait Islander people across Queensland both inside custody and out.

Finally, I would like to extend my congratulations to Dr Edward Heffernan, Kimina Andersen and Abhilash Dev who have written this report and all those involved in this collaborative research project that adds an important piece to our understanding of the mental health and wellbeing of Aboriginal and Torres Strait Islander people.

Dr Bill Kingswell
A/ Executive Director
Mental Health Alcohol and Other Drugs Directorate

Preface

Social and emotional wellbeing, and mental health has significant impact on the lives of Aboriginal and Torres Strait Islander people, particularly those in custody who are isolated from their family and community, and those they approach or rely on for support.

It is 'deadly' that Aboriginal and Torres Strait Islander people not only had the opportunity to tell their story, but have had their stories, including their hard times, recorded in their own words alongside the facts and figures. This research paper, the first study of its kind in Australia, provides personal experiences and information about the extent of mental health problems within the Aboriginal and Torres Strait Islander population in our prisons.

As a Queensland Murri with over 26 years in the public service, I can confidently say the Inside Out Research Project is a great example of the achievements that can be made from working directly with Aboriginal and Torres Strait Islander people in a spirit of collaboration.

Policy makers and service providers should find it incredibly useful to inform the planning of strategies to improve mental health services for Aboriginal and Torres Strait Islander people in custody in Queensland.

Congratulations to everyone who has played a part in the development of the report. I commend the effort of the project team who initiated and undertook the investigation into this important area and the culturally respectful approach used in conducting the research is 'too deadly'! No doubt the partnerships and relationships that have evolved during this project will continue.

Finally I would like to show appreciation to the Aboriginal and Torres Strait Islander men and women (brothers and sisters) who participated in this research. Your contribution, time and willingness to share your stories are very much appreciated.

Haylene Grogan
Senior Director
Aboriginal and Torres Strait Islander Health Branch

Acknowledgements

The project team would like to thank the Queensland Health Mental Health Directorate who provided the financial support to enable this research. A particular thanks goes to the Executive Director, Dr Aaron Groves, who supported this research proposal from its inception and provided advice and assistance throughout the project.

The team also wish to express their sincere appreciation to the 419 Aboriginal and Torres Strait Islander men and women in custody who participated in this research. They have helped progress the understanding of the mental health needs of Indigenous people in custody. Recognition and appreciation goes to the many Indigenous community members who attended consultation meetings and contributed to this research project.

This project spanned a period of 18 months and would not have succeeded without the valuable input of a large number of people. The project team is grateful to those who have contributed at various stages: Professor Theo Vos, Professor Harvey Whiteford, Dr Andrew Page, Professor Philip Burgess, Coralie Ober, Bryan Kennedy, Dr Trisha Johnston, Professor Gavin Andrews, Elizabeth Arnold, Carla Schlesinger, Daniel Ngweso, Taku Endo and Mary Stewart.

The team would also like to thank Sandra Garner for her contribution in the planning, development of methodology and data collection stages of the project.

Thank you to Queensland Corrective Services for their cooperation and contribution throughout this project, particularly Di Taylor, former Executive Director, Offender Programs and Services, the correctional centre general managers and the Queensland Corrective Services Research Committee.

The project team acknowledges the expertise and contribution from the expert reference group members: Dr Stuart Kinner, Coralie Ober, Professor Ernest Hunter, Dr Melissa Haswell-Elkins, Noritta Morseu-Diop, Dr Mark Wenitong and Dr Noel Hayman.

Recognition goes to the staff of Queensland Forensic Mental Health Services, in particular, Associate Professor Don Grant, Queensland Director, Michelle Denton, Manager Southern and Central, Gillian Yearsley, Manager (Northern Region), Georgia Sakrzewski, Queensland Co-ordinator Prison Mental Health Service (PMHS) and the psychiatrists Dr Katrina Chiu, Dr Cassandra Griffin, Dr Velimir Kovacevic, Dr Peter Fama, Dr Sean Tracey, Dr Dominique Hannah and Dr Mark Schramm. Thanks also to Dr Alun Richards, Senior Director, Offender Health Services, Queensland Health.

Project Team

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The project managers would like to acknowledge with sincere thanks Queensland Health's Aboriginal and Torres Strait Islander mental health staff who, supported by their respective health service districts, gave their time and energy to this research. Their efforts were critical to the success of this project, and reflect their commitment to Aboriginal and Torres Strait Islander health in Queensland.

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About this report

This report was designed to provide an overview of the background literature, method and findings of the Inside Out Research Project.

Note on terminology

The authors of the report acknowledge the diversity that exists among Aboriginal cultures in Australia, and the language and cultural practices of different Torres Strait Islander people.

This report uses the term 'Indigenous' to describe Aboriginal and Torres Strait Islander people; this is in part because reference articles and government departments apply this term more regularly.

This term is based upon the legal definition of Indigenous that relates to the relationship of aboriginal people to the territory from which they originate. The United Nations High Commissioner for Human Rights recognises this relationship:

> Indigenous or aboriginal peoples are so called because they were living on their lands before settlers came from elsewhere; they are the descendants—according to one definition—of those who inhabited a country or geographical region at the time when people of different cultures or ethnic origins arrived, the new arrivals later becoming dominant through conquest, occupation, settlement or other means… Indigenous peoples have retained social, cultural, economic and political characteristics which are clearly distinct from those of the other segments of the national populations.[1]

As a sign of respect this paper uses capital letters when using the words 'Aboriginal', 'Torres Strait Islander' and 'Indigenous'.

The use of the term 'community' is in accordance with the NHMRC definition:

> Community is recognised as a complex notion that can be invoked in relation to cultural groups, geographic groups or communities of interest.[2]

The authors acknowledge that the participants in this research activity form a community of Aboriginal and Torres Strait Islander people within each custodial centre, but are also members of their community of origin, as well as belonging to the broader Aboriginal and/or Torres Strait Islander communities within the region of their community of origin.

Summary

This is the first Australian study that comprehensively examines key aspects of the social and emotional wellbeing, and particularly, the mental health of Aboriginal and Torres Strait Islander people in custody. The study was funded by Queensland Health with the goal of obtaining information to ultimately help improve the provision of mental health services to Indigenous people in custody in Queensland. It is recognised that the mental health problems of people in custody are a significant public health challenge. Obtaining information about the nature, type and extent of mental health problems amongst Indigenous people in custody is an important step toward addressing this problem.

This research indicates that Indigenous people in custody experience extremely high rates of mental illness, substance use problems and social adversity. The findings have helped define the mental health needs of this group, and the participants and their communities have identified a number of strengths and priorities critical to the development of mental health services for incarcerated Indigenous people.

Background

People in custody report high rates of social adversity, mental illness, substance use and general health problems. This has been well described for the general custodial population, but not for the Indigenous custodial population.

The rate of incarceration of Aboriginal and Torres Strait Islander people in Australia is 14 times higher than the rate of the non-Indigenous population. Indigenous people represent approximately a quarter of the Australian custodial population.

Despite their vast over-representation in custody, and the well recognised health gaps between Indigenous and non-Indigenous Australians, surprisingly little is known about the mental health and broader social and emotional wellbeing of incarcerated Indigenous people.

Purpose of this study

To describe the demographic, social, cultural and mental health characteristics of Indigenous people in Queensland custody.

Cultural context

The authors acknowledged that any research involving Aboriginal and Torres Strait Islander people must respect their diversity, culture and right to self determination, and also embrace the values of reciprocity, respect and equality.

The majority of the project team were Aboriginal and/or Torres Strait Islander and were involved in the management, reference group, steering committee, data collection and the writing of this research report.

This study involved extensive consultation with Indigenous communities and Indigenous health and justice stakeholders.

The authors also acknowledge with gratitude and respect the incarcerated Indigenous men and women who volunteered their time to participate in this research.

Method

This research was a cross-sectional survey of of male and female adults in Queensland custody who self identified as Indigenous.

At the time of this research, it was estimated that 1300 Indigenous males and 115 Indigenous females were in custody in the state of Queensland. The project team interviewed 347 males and 72 females across six correctional centres during an eight week period in May and June 2008.

All interviews were conducted by Indigenous mental health staff from across Queensland who undertook specific training for this research. Interviews were conducted face-to-face in confidential settings in correctional centres across the state of Queensland and took one to two hours to complete. Both qualitative and quantitative data were collected.

Detailed information regarding the participants' demographic, social and cultural circumstances was obtained using a questionnaire. Detailed diagnostic information about anxiety, depressive and substance use disorders was obtained using the Composite International Diagnostic Instrument (CIDI) and a diagnosis of psychotic illness was determined through psychiatrist interviews and the use of a diagnostic panel.

Qualitative information was obtained through consultation with Indigenous communities.

Findings

General

Most of the participants were young and unemployed prior to incarceration and reported not having completed a Year 12 education. Two thirds of the male and half of the female interviewees were sentenced prisoners and the remainder were on remand. More than 80 per cent of males and around 75 per cent of females had been in custody on more than one occasion. Many had been in custody as a youth and most had family in custody. Around twenty-five per cent of participants believed they were destined to return to custody again after their release. Many participants reported exposure to traumatic experiences, including being the victim of racism.

Mental health

Most participants screened as high risk for mental health, drug and alcohol problems using the Indigenous Risk Impact Screen (IRIS).

The 12 month prevalence of mental health disorders* was approximately 73 per cent in males and 86 per cent in females. The 12 month prevalence of mental illness was extremely high: anxiety disorders (males 20 per cent, females 51 per cent); depressive disorders (males 11per cent, females 29 per cent); and psychosis (males eight per cent, females 25 per cent).

The 12 month prevalence of substance use disorders was also extremely high among both men (66 per cent) and women (69 per cent). Almost two thirds of the interviewees were dependent on alcohol or cannabis, with smaller proportions dependent on amphetamines, opioids or other drugs prior to custody. More than two thirds of the interviewees reported being under the influence of alcohol at the time they offended (males 71 per cent, females 70 per cent).

For both males and females the estimated prevalence of mental health disorders was much larger than the estimated prevalence for the Australian community. In males the prevalence was nearly two times higher for anxiety disorders, nearly three times higher for depressive disorders, nine times higher for substance use

* The term 'mental health disorder' is used in this research to describe both mental illnesses (such as depressive, anxiety and psychotic disorders) and substance use disorders.

disorders and 17 times higher for psychotic disorders. In females the prevalence was nearly three times higher for anxiety disorders, more than four times higher for depressive disorders, more than 20 times higher for substance use disorders and more than 50 times higher for psychotic disorders.

Suicide

More than 25 per cent of all men and 50 per cent of all women had thought about suicide at some stage during their life. Suicide attempts and suicidal thoughts were described as 'worse' in the community than in custody.

Culture

Participants described a strong cultural identity and frequent participation in cultural practice. They viewed cultural values and practice as important in any rehabilitation process.

Transition to the community

The transition period from custody to the community is recognised as a high risk period for morbidity and mortality related to mental health problems. Returning to the community was identified as a challenging experience. However, most participants expressed positive views about addressing social, health and substance use difficulties if able to access appropriate supports.

Cultural context

Aboriginal and Torres Strait Islander people have been subjected to trauma through their experience of colonisation, and the loss of land, lives, family and cultural practices. Although the effects remain difficult to quantify, the consequences of these historical experiences are relevant to the lives of Aboriginal and Torres Strait Islander people and impact significantly on their social and emotional wellbeing. One of the most prominent manifestations of these problems is the rate of incarceration for Aboriginal and Torres Strait Islander people and the impact this has on individual and community wellbeing.

The mental health needs of Aboriginal and Torres Strait Islander people must be considered within a cultural context. In 1995, *The Ways Forward Report* [3] recognised the need for research to identify the nature and extent of mental health problems and mental disorders among Aboriginal people. Importantly, Pat Swan and Professor Beverley Raphael stressed that any research of this kind be done in close consultation with Aboriginal and Torres Strait Islander communities.

They argued that, to ensure correct interpretation and understanding of research and ensure effective responses to research findings, 'The Aboriginal community must actively participate in the research process, be kept fully informed and have a say in how the research findings are publicised and used'[3].

The National Health and Medical Research Council (NHMRC) Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research[2], and the Cooperative Research Centre for Aboriginal Health (CRCAH)[4], has also established guidelines and principles fundamental to conducting ethical and culturally appropriate research with Aboriginal and Torres Strait Islander people.

A key consideration that arises in any research undertaken with Aboriginal and Torres Strait Islander people is the issue of 'difference blindness'. Failing to understand difference in values and culture can jeopardise the ethics and quality of the research. This presents many challenges for ensuring the cultural integrity of such research. The Inside Out Research Project established review and assessment processes from the outset to monitor and address these issues. This was considered a priority during the project and was one of the key roles of the second author, the project manager.

A number of processes and mechanisms were established to support the cultural integrity of the project and the research. This included a steering committee with Aboriginal and Torres Strait Islander members as well as an expert reference group with Aboriginal and Torres Strait Islander members who had experience in conducting research in cultural heritage and Indigenous mental health. The project employed Indigenous research assistants to undertake all interviews and data collection. These were recruited from the Queensland Health Indigenous mental health workforce and were trained in preparation for the interviews and data collection period. They also provided significant methodological input, particularly in relation to the interview process. The project acknowledged the challenges for the research assistants who may interview individuals with whom they might have family, community or cultural connections. This was discussed, monitored and all research assistants had on-site support and opportunities for de-briefing by an Indigenous clinician throughout the research project. It was found that relationships, language, common experience and respect for cultural practice appeared to enhance rapport and enable participant disclosure. The belief is that this resulted in more informed and detailed responses.

Consultations with Indigenous communities and groups took place both prior to the commencement of the research, and throughout the project. Aboriginal and Torres Strait Islander community members, representatives of community and government agencies across Queensland were consulted. Key to the consultation process was the men and women in custody, who were visited prior to data collection commencing. Time and resource limitations meant that each individual community could not be targeted, but further opportunities to

communicate with these communities should be made available. This project developed a methodology based on the need to be culturally capable in its approach to research. By incorporating methods and adapting tools and processes the research was able to capture information from a social and emotional wellbeing perspective.

The Inside Out ReseachProject made every attempt to ensure the research process maintained cultural integrity and adhered to NHMRC Guidelines[2] for ethical conduct in Aboriginal and Torres Strait Islander health research. The project team was very fortunate to receive the support of Aboriginal and Torres Strait Islander community members, organisations and individuals. The team hope to repay the faith and respect bestowed upon them.

Introduction

The health inequalities of Aboriginal and Torres Strait Islander people, relative to non-Indigenous Australians, have been well described [5]. It is argued that social disadvantage is largely responsible for the disparity in outcomes that see Indigenous people suffer a far greater health burden than non-Indigenous people [6, 7]. Addressing this issue in 2005, the social justice commissioner [1] recommended all governments of Australia commit to a campaign to achieve Indigenous health equality within 25 years. In a positive step in 2008, the *Close the Gap Statement of Intent* [8] proposed to achieve equality in health status and life expectancy between Indigenous and non-Indigenous Australians by the year 2030. It has been argued that such a goal may take much longer to achieve[9]. Nevertheless, similar initiatives have led to significant narrowing of Indigenous health gaps in other countries [10]. High incarceration rates are a major health and social issue faced by Indigenous people in Australia [11]. The Royal Commission into Aboriginal Deaths in Custody found that 'too many Aboriginal people are in custody too often' (s1.3.3), and concluded that custody should be a sanction of last resort [12]. Since this enquiry nearly two decades ago, incarceration rates of Indigenous people have continued to rise. At the last published prison census of 30 June 2008, Indigenous people represented 24 per cent of the entire custodial population and were 13 times more likely (age adjusted) to be incarcerated than non-Indigenous people [13].

Incarceration and its correlates, including experiences of trauma, discrimination, domestic violence, substance misuse, mental health problems and mental illness, impact significantly on the broader social and emotional wellbeing of Indigenous people and their communities [14]. One of the leading contributors to poor social and emotional wellbeing and a major contributor to the Indigenous health gap is mental health problems [15]. There is an unmet mental health service need for Indigenous people in the community [16], and it is likely this is equal or greater in custodial settings. Rates of mental illness amongst people in custody are significantly higher than the general population, and Indigenous people are likely to be at high risk of mental health problems. Mental health is an important component of social and emotional wellbeing for Indigenous people, yet little is known about the mental health of Indigenous people in custody in Australia [14].

The extent of mental health problems for Indigenous communities has been partly articulated through the major population surveys. High rates of psychological distress, life stressors, problematic drinking and contact with the criminal justice system, have been identified amongst adults [17, 18]. Even amongst children, rates of significant emotional and behavioural difficulties, and serious suicidal ideation have been reported to be high [19]. It is not surprising that mental illness, substance misuse and suicide are key national strategic priorities for Indigenous health [14].

However, these population surveys exclude Indigenous people in custody, and it may reasonably be concluded that the process of incarceration may only compound experiences associated with mental health problems [3]. For the general custodial population the prevalence of mental illness is much higher than for the general community [20, 21]. Despite this, few studies have focused on the prevalence of mental health problems among Indigenous people in custody. Such research is imperative given that this high risk group represents approximately 25 per cent of the Australian custodial population [22] and have been subject to a royal commission related to high custodial death rates [12].

The available literature related to the mental health of Indigenous people in custody in Australia has been systematically reviewed [23]. This literature indicates Indigenous people in custody have high rates of complex mental health problems, social adversity, substance misuse, trauma and general health problems both prior to and after leaving custody. The data suggests Indigenous people in custody are likely to have high mental health treatment needs while incarcerated, and that the transition back to the community is a particularly vulnerable period. However, this is a marked shortfall in both the quantity and quality of research in this area. The existing data is piecemeal, and there is very limited detailed information that considers mental health and the broader social and emotional wellbeing challenges faced by Indigenous people in custody.

Goals of the Inside Out Project

The Inside Out Research Project included two main components:

1. **Research that aimed to use representative cross-sectional sampling to examine the mental health status of Indigenous people in custody from a clinical, social and cultural perspective. The key objectives of this research were to achieve the following:**
    - describe the prevalence of mood, anxiety, substance use and psychotic disorders
    - describe the social circumstances and patterns of health care utilisation in the two months prior to entering custody
    - identify the self-reported contribution of substance misuse to offending and the perceived likelihood of substance use relapse following release from custody
    - identify the prevalence of suicidal ideation and any significant mental health correlates of this
    - describe the incarceration history, and experiences of custody, and identify any significant mental health correlates
    - determine the self-reported involvement with Indigenous culture and participation in cultural practice
    - describe the release plans and release-related concerns of incarcerated Indigenous people who expect to be released from custody in the two years following the interview.

2. **Using the research findings and through consultation with key stakeholders the team planned to identify components that could contribute to the development of a model of service delivery for the mental health needs of Indigenous people in custody.**

Method

Design

This research was a cross-sectional survey of male and female adults in Queensland custody who self identified as Indigenous.

Study locations

Data collection occurred in six correctional centres throughout Queensland. Queensland Corrective Services (QCS) provided a centre-by-centre breakdown of the Indigenous custodial population in Queensland on 1 January 2008. At that time there were approximately 1270 males and 95 females who identified as Indigenous in six low security and nine high security centres (Figure 1).

Six correctional centres were included as study sites. These six centres were chosen as they were accessible, were judged representative in terms of custodial status (remand or sentenced) and correctional centre status (mainstream or protection) and contained approximately 75 per cent of Indigenous males and 90 per cent of Indigenous women that were incarcerated within Queensland correctional centres at the time. The six study sites were: Lotus Glen (LG); Townsville (TV); Arthur Gorrie (AG); Woodford (WD); Wolston (WL); and Brisbane Women's (BW) Correctional Centres. Although identified as high security centres, they contained people with a mix of security classifications (low and high).

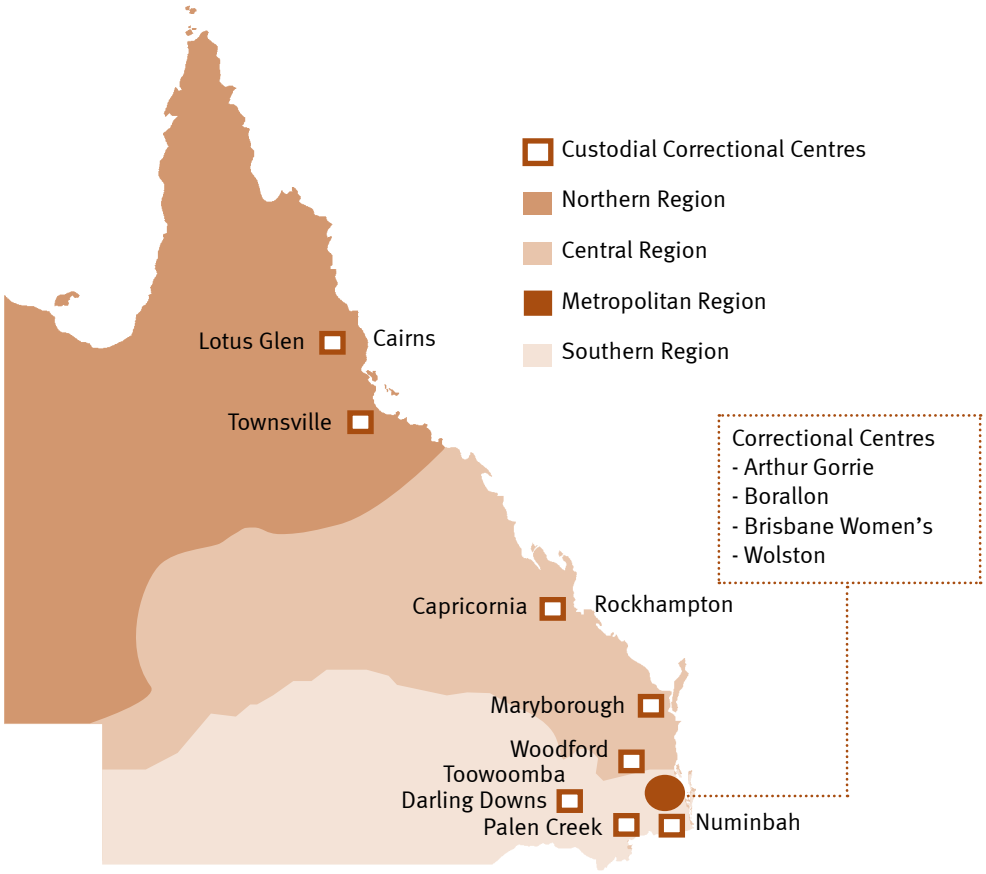

Figure 1: Location of major correctional centres across Queensland [24]

Sampling strategy

The intention was to interview a 25 per cent cross-sectional sample of Indigenous males and all consenting Indigenous females detained in high secure custody (a small number of women were in low security centres) in Queensland. The sample frame for each individual centre was determined by use of the nominal role obtained on day one of data collection at that centre. The sampling strategy was to approach every third male to participate, under the assumption that a proportion may not consent and to approach all females to participate.

Inclusion criteria: All males and females in custody who were aged 18 years or over, who identified themselves as an Indigenous Australian, and who were judged by a trained interviewer, and to have the capacity to consent to participate.

Exclusion criteria: Individuals who did not consent to participate, those who were less than 18 years of age and those who were judged as unfit or unsafe to be interviewed. Those whose English language skills were considered insufficient to enable informed consent or participation in the interview were excluded, with the exception of Torres Strait Islanders who spoke Kriol, as trained interviewers who spoke Kriol were available.

Ethics

Participation in the research was voluntary, participants had the right to withdraw from the research at any stage, and the information collected was confidential and de-identified. Ethical clearance for the study was provided by the West Moreton Health Service District Human Research Ethics Committee and the Queensland Corrective Services Research Committee.

All interviews were conducted in confidential interview rooms in the health centres of the correctional facilities. Data was recorded by the interviewer and were not available to correctional staff. Any information the interviewer considered relevant to ensure the necessary treatment of participants was discussed with the project manager and when considered appropriate, was made available to health staff with the participant's permission. If consent was not provided and the information was not considered to place the individual or others at significant risk (this determination was made in consultation between the project manager and principal investigator) then that information was not disclosed. There were certain circumstances that were considered to require mandatory disclosure of information to relevant health professionals, consistent with a duty of care, such as if it was determined that an individual was an imminent risk of significant harm to themselves or others. Decisions about mandatory disclosure of such information were the responsibility of the principal investigator. Any participant who required immediate medical or mental health treatment was referred to relevant health staff. All participants were provided with an opportunity for debriefing or referral for further mental health consultation, if concerns were raised during the interview.

Key elements of ethical research with Indigenous communities include reciprocity, respect and equality [2]. This research involved Indigenous people in project governance, data collection, report writing and in the development of recommendations. The research was also informed, monitored and supported via a comprehensive consultation process designed to ensure the partnership of Aboriginal and Torres Strait Islander community members.

Procedures and measures

All interviewers were Indigenous mental health staff who were trained in the use of the research tools, consent and ethical procedures and emergency treatment procedures. On site the team of interviewers was supervised by a senior clinician (project manager), and had access to advice from the principal investigator (a forensic psychiatrist).

Data was collected by face-to-face interviews conducted in the health centres of the relevant correctional centres. Information was recorded on paper using a questionnaire (see Appendix 2) and on laptop computers for the Composite International Diagnostic Instrument (CIDI) component of the interview. Interviews were

conducted in a manner that ensured flexibility in the delivery in order to meet the needs of the participant. Interviews took 60 to 150 minutes to complete, depending on the complexity of the issues identified.

Interviews were conducted in five parts:

Part 1: Introduction, provision of information about the research and consent process*

Part 2: Interview using the questionnaire*. Questions covered four domains:

- Pre-custody (quantitative)
- Custody (quantitative and qualitative)
- Culture (quantitative)
- Post-release plans (quantitative).

In addition, the Psychosis Screener (PS) was administered and anyone who screened positive to any of the questions was identified as requiring a clinical interview (see Part 3).

*(Note: available online—refer to Technical Report Appendices)

Part 3: Clinical diagnostic interviews

The CIDI version 2.1 was used to determine the prevalence of mood, anxiety and substance use disorders. The CIDI is a comprehensive, well validated, fully standardised interview that can be used to assess mental disorders according to ICD–10 and DS–IV criteria [25]. In this study the ICD-10 was chosen to report findings to be consistent with other major national and international surveys [26–28]. While use of the CIDI has not been validated with Aboriginal and Torres Strait Islander people, it is validated internationally in numerous cultures and languages. It is the standard for conducting epidemiological mental health surveys and has been used in the largest Australian survey of prison mental health [28] and the National Survey's of Mental Health and Wellbeing [29]. Both of these surveys included Indigenous Australians in their sample. The project team chose to use the 12 month rather than the lifetime version of the CIDI.

The CIDI was not used to establish the prevalence of psychotic disorders, because it was recognised that some reported experiences that are considered culturally congruent experiences may be misinterpreted as symptoms of psychosis [30, 31]. Given the potential risk for cultural bias in the diagnosis of psychotic illness in Indigenous people using standard instruments, this research used a three part method for establishing the presence or absence of a psychotic disorder.

First, participants were screened for symptoms of psychosis using the self-report psychosis screener, a well recognised and valid screening instrument for detecting risk of psychotic illness [26]. Those who screened positive were invited to participate in a clinical interview.

Second, clinical interviews were conducted by forensic psychiatrists experienced in working in a custodial setting. Detailed information from the interviews was recorded on a proforma*. The diagnostic process was based on the clinical interview and the longitudinal history, expert opinion and all data (LEAD) process for diagnosis [32].

Third, information recorded on the proforma was reviewed by a diagnostic panel comprised of two forensic psychiatrists and a cultural advisor (an Indigenous mental health clinician). If required, the psychiatrist who conducted the interview was also consulted by the panel. A consensus diagnosis was reached.

Part 4: Information about mental health service provision

Using a qualitative approach, participants were asked to share their views about elements they saw as important to the development of mental health services for Indigenous people in custody. These were recorded directly onto the questionnaire.

Part 5: Closure

Following completion of the questionnaire, the interviewer provided the participant with an opportunity to raise any concerns or problems that may have arisen as a result of the interview.

Qualitative data

The survey included open-ended questions about the needs of Aboriginal and Torres Strait Islander people in custody. Participants were encouraged to provide information about mental health challenges they experienced in the custodial setting and in the community, and also to provide advice about ways to best deliver mental health care to Indigenous people in custody. Their comments were recorded by the interviewers in the questionnaire and later transferred verbatim into Microsoft Word by the researchers.

As part of the community consultation process, questions were also asked about the communities' views on key issues related to the incarceration of Indigenous people, their mental health care in custody and in transition to the community. The feedback received through community consultation was again collated and entered into Microsoft Word by the researchers.

Qualitative data was analysed using an approach known as 'template analysis', which is a way of thematically analysing data [33]. Template analysis involves the development of a coding template which summarises themes identified as important in a data set, and organises them in a meaningful and useful manner [33].

Results

Sampling

Information was collected from participants over an eight week period across six correctional centres in Queensland. Of the 575 individuals approached to participate in the research 419 consented to participate. Most completed both the questionnaire and CIDI survey (Table 1.1).

Table 1.1 Comparison between participants and non-participants by gender

Gender	Population	Participants			Non-participants	
		No.	Mean age	Completed CIDI and Questionnaire	No.	Mean age
Male	487	347	31.4	331	140	28.8
Female	88	72	29.1	65	16	30.4
Total	575	419	31.0	396	156	28.9

The participation rate of females was 83.7 per cent compared to males at 71.2 per cent. The 156 non-participants included those who were not in the centre, for example, released or at court (50), those who were considered unfit for interview (4) and those who did not consent to take part in the interview (102) (Table 1.1). Four people were deemed ineligible to participate as they were identified on the correctional role as Indigenous but when approached they did not identify themselves as an Indigenous person.

Given the vast number of movements, receptions and releases that occur within custodial centres in any given week, the Indigenous custodial population from which the sample was drawn changed daily. For the purposes of comparisons between the Inside Out sample to the Indigenous custodial population, a particular census day was selected that fell during the data collection period. The data used for this purpose was collected by QCS on 30 June 2008 (the last day of the data collection period) for the purpose of the 2008 Australian Bureau of Statistics prison census [13]. The census reports the sex and age of all those who identified as Indigenous (Table 1.2).

Table 1.2 Comparison of sample with 2008 Queensland Indigenous prisoner population by gender

	Prison population		Participants	
	Male	Female	Male	Female
Count	1381	116	347 (25%)	72 (62%)
Mean age in years	30.6	30.4	31.4	29.1

Demographics

Table 2.1 summarises the demographic characteristics of the sample by gender. The majority of both males and females identified as Aboriginal, with approximately one in five identifying as either Torres Strait Islander or both Aboriginal and Torres Strait Islander. The majority of both males and females were aged between 18 and 29 years (Figure 2). Just over 25 per cent of participants (26.5 per cent of males and 26.3 per cent of females) were married or in a de-facto relationship at the time of the interview. However, more than 20 per cent of males and females were single in the 12 months before they came into custody. Less than half of the sample had completed school to a Year 10 level or higher and only 5 per cent reported completing Year 12. Nearly a quarter of males and a fifth of females had not completed Year 8 (Table 2.1).

Table 2.1 Demographic characteristics of participants by gender

(%)	Male (n=347)	Female (n=72)	Total (n=419)
Mean age in years (range)	31.4 (18-62)	29.1 (18-57)	28.8 (18-62)
Indigenous status (%)			
Aboriginal	79.5	80.6	79.7
Torres Strait Islander	9.5	5.5	8.8
Aboriginal and Torres Strait Islander	11.0	13.9	11.5
Pre-custody marital status (%)			
Married/de facto	26.5	26.3	26.4
Widowed	0.2	2.7	0.7
Divorced/separated	9.2	4.1	8.3
Never married	32.5	37.5	33.4
Girlfriend/boyfriend	23.6	13.8	21.9
Single	20.7	25.0	21.4
*some categories may not be mutually exclusive			
Education (%)			
Year 8 not completed	23.0	19.4	22.4
Completed Year 8	16.7	19.4	17.2
Completed Year 9	17.3	25.0	18.6
Completed Year 10	22.5	19.4	22.0
Completed Year 11	8.0	4.2	7.4
Completed Year 12	4.9	5.6	5.0
Tertiary qualification	2.0	2.8	2.1
Technical/trade qualification	4.6	2.8	4.3
Not known	1.0	1.4	1.0

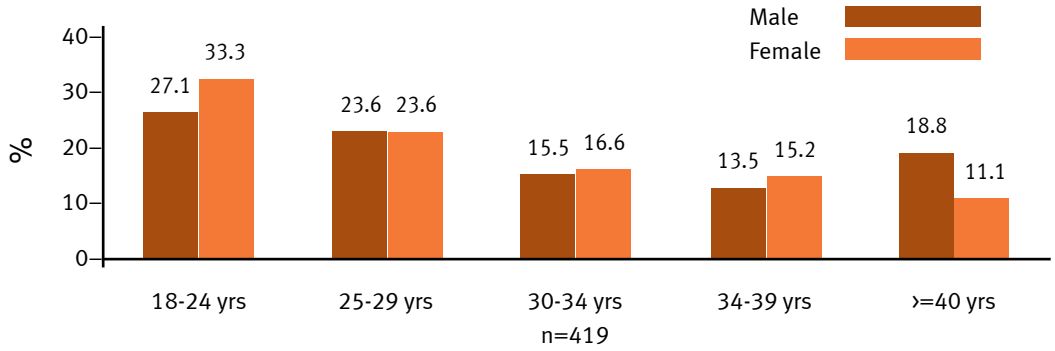

Figure 2. Age distribution of participants by gender

Table 2.2 summarises the living circumstances of participants in the 12 months prior to incarceration, by gender. Geographical location was recorded in accordance with the Accessibility and Remoteness Index of Australia [34], widely adopted as the standard classification of remoteness in Australia. Around a third of participants had lived in major cities before coming into custody, while more than a third (41 per cent) had lived in inner or outer regional areas. Just over 20 per cent of males and females described themselves as having lived in remote or very remote areas before coming into custody. Prior to entering prison the majority of participants reported: living with family (50 per cent), a partner/spouse (20 per cent) or a partner and child/ren (17 per cent), living in community housing (40 per cent), rental accommodation (28 per cent), and less than 5 per cent were homeless.

Sixty-three percent of male participants and 90 per cent of female participants were unemployed in the 12 months before coming into custody, with most of these identifying Centrelink payments as their main source of income. More than 1 in 10 participants reported criminal activity as their main source of income, although this was more common among men (12 per cent) than women (4 per cent).

Table 2.2 Pre-custody living circumstances by gender

(%)	Male (n=347)	Female (n=72)	Total (n=419)
Geographical location (%)			
Major city	38.0	33.3	37.2
Inner regional	10.9	22.2	12.9
Outer regional	29.7	22.2	28.4
Remote	5.2	8.3	5.7
Very remote	15.6	14.0	15.3
No fixed location	0.6	0	0.5
Living situation (%)*			
Alone	7.8	11.1	8.3
With non-family	4.3	13.9	6
With family	49.0	52.8	49.6
With partner/spouse	21.6	13.9	20.3
With partner and child	18.4	9.7	16.9
Other living situation	3.7	5.6	4.1
*some categories may not be mutually exclusive			

Type of accommodation (%)			
Community housing	41.8	31.9	40.1
Rental	27.9	26.4	27.7
Own home	8.4	8.3	8.3
Homeless	4.3	6.9	4.8
Hostel	3.5	13.9	5.2
Supported and other accommodation	15.6	15.3	15.5
*some categories may not be mutually exclusive			
Source of income (%)*			
Centrelink	56.8	86.1	61.8
Full-time work	23.3	6.9	20.5
Part-time work	13.5	2.8	11.7
Family	2.6	5.6	3.1
Criminal activity	12.1	4.2	10.7
*some categories may not be mutually exclusive			

Custodial status and sentence characteristics

Table 2.3 summarises the custodial status (remanded or sentenced) and the incarceration characteristics of participants by gender. For logistical reasons, it was necessary to identify custodial status by self report. Around two thirds of male participants and half of female participants reported they were serving a sentence, with the remainder either on remand or (rarely) unsure of their custodial status. Over 80 per cent of males and nearly 75 per cent of females reported having been in adult custody prior to their current incarceration. More than one in four participants (27 per cent) had been in adult custody more than five times at the time of interview. Overall, the majority of participants (65 per cent) reported having spent more than two years in adult custody over their lifetime (Table 2.3).

Table 2.3 Custodial status and sentence characteristics by gender

(%)	Male (n=347)	Female (n=72)	Total (n=419)
Custodial status			
Sentenced	66.6	50.0	63.7
Remanded	31.4	44.4	33.7
Unknown	2.0	5.6	2.6
Number of incarcerations			
First time	17.5	26.4	19.1
2–3 times	32.6	30.6	32.2
4–5 times	20.2	15.3	19.3
›5 times	27.1	25.0	26.7
Unknown	2.6	2.7	2.7

Total time in custody			
‹6 months	8.3	31.9	12.4
6–12 months	7.7	12.5	8.5
12–18 months	4.6	2.7	4.3
18–24 months	7.2	1.3	6.2
›24 months	70.0	43.0	65.3
Unknown	2.2	8.6	3.3

Participants were also asked about the length of their current sentence, nearly 50 per cent of participants were serving a sentence of less than six months at the time of interview, this being most common amongst females (Figure 3).

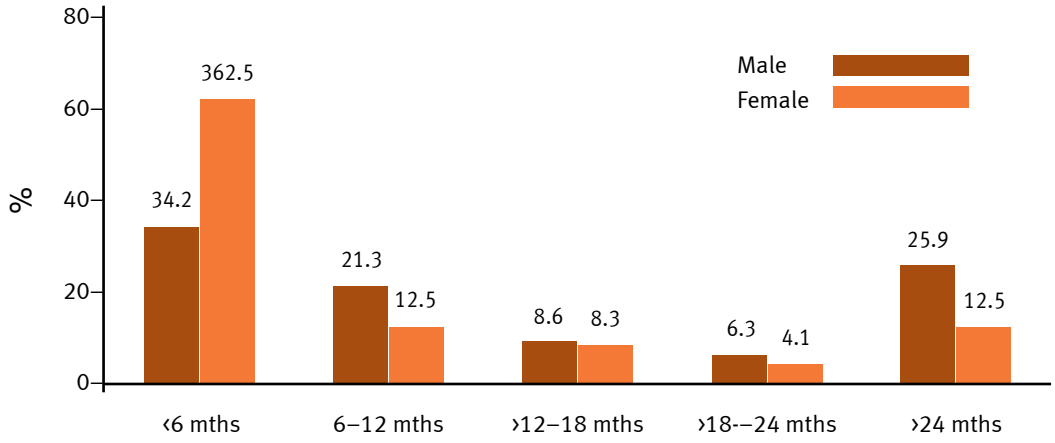

Figure 3. **Length of sentence by gender**

Other experiences of custody

Over half of the males (52.2 per cent) and a third of the females (37.5 per cent) reported having spent time in youth custody. Males reported having spent longer in youth custody. Almost a quarter of males (23 per cent) and 10 per cent of females had spent more than a year in youth custody. Participants were also asked whether they expected to return to custody in the future. Over a quarter of males (28.7 per cent) and females (27.7 per cent) were either unsure or expected that they would be re-incarcerated at some stage in their life. Nearly 65 per cent of participants stated they had a family member in custody, more males (74 per cent) than females (56 per cent) reported having a family member in custody.

Mental health

Mental health screening

The IRIS was developed as part of a risk screen and brief intervention package for Aboriginal and Torres Strait Islander people [35]. The IRIS has two sections: the first screens for risk related to alcohol and other drug use; the second screens for emotional wellbeing and mental health problems.

Alcohol and other drug use

Participants were assessed for alcohol and other drug risk based on their substance use in the 12 months before they came into custody. Based on responses to the IRIS, more than 80 per cent of both males and females scored in the 'high risk' category, indicating a need for intervention (Table 3.1).

Table 3.1 IRIS alcohol and other drug risk score category by gender

(%)	Male (n=335)	Female (n=72)	Total (n=407)
High risk	84.4	82.0	84.1
Low risk	15.6	18.0	15.9

Emotional wellbeing and mental health

Current emotional wellbeing and mental health was assessed using the IRIS. Based on responses to the IRIS, a significant proportion of males (44 per cent) and two thirds of females (63 per cent) were classified as high risk for mental health problems (Table 3.2).

Table 3.2 IRIS emotional wellbeing risk score category by gender

(%)	Male (n=347)	Female (n=72)	Total (n=409)
High risk	44.0	62.5	47.2
Low risk	56.0	37.5	52.8

Mental disorders

The 12 month prevalence of selected mental disorders (substance use, depressive, anxiety and psychotic disorders), was determined using the CIDI-A. Five participants who suffered a psychotic illness were unable to participate in the CIDI-A interview and were not able to be assessed for other mental health disorders. The results are reported using the ICD-10 classification system [36], to be consistent with other major surveys [37, 38].

The majority of females (86.1 per cent) and males (72.8 per cent) had a diagnosis of a mental disorder (Table 4.1). While both groups had extremely high rates of mental health disorders, females were more likely than males to be diagnosed with a disorder in the preceding 12 months (RR=1.18 , 95 per cent CI 1.05-1.33).

Table 4.1 Twelve month prevalence of any mental disorder by gender

Disorder (%)	Male (n=331)	Female (n=65)	Total (n=396)
Any mental disorder	72.8	86.1	75.0
Psychosis*	7.5	23.0	10.1
Depressive disorder	11.4	29.2	14.3
Anxiety disorder	20.2	50.7	25.2
Substance use disorder	65.5	69.2	66.1

*The actual prevalence of psychotic illness amongst the sample was higher (males 8.1 per cent, females 25 per cent), however five participants who were identified as having psychotic illness were unable to complete the CIDI and were not included in the analysis above.

Note: 'any mental disorder' includes anxiety, depressive, psychotic and substance use disorders.

To help contextualise the prevalence estimates for mental illness and substance use disorders (outlined in the next section) in this sample, the findings were compared with the 12 month Australian population prevalence estimates for anxiety, depressive disorders (depressive episode and dysthymia) and substance use disorders [26] and with 12 month population prevalence estimates for psychotic illness [39]. The prevalence of these disorders among participants and prevalence estimates among the general population, for males and females separately, appear in Figures 4 and 5 respectively. The total prevalence estimate of mental health problems in this research was similar to the New South Wales Prisoner Study [28] (a relatively large study of predominately non-Indigenous prisoners) and that equally disparate prevalence estimates were noted when the findings were compared to an Australian community sample [20]. For males, the prevalence of mental health disorders in the Inside Out sample was significantly higher than the estimated prevalence among males in the Australian community. It was nearly two times higher for anxiety disorders, nearly three times higher for depressive disorders, nine times higher for substance use disorders and 17 times higher for psychotic disorders (Figure 4). For females, the figures were even more striking with the prevalence of anxiety disorders nearly three times higher, more than four times higher for depressive disorders, more than 20 times higher for substance use disorders and more than 50 times high for psychotic disorders (Figure 5).

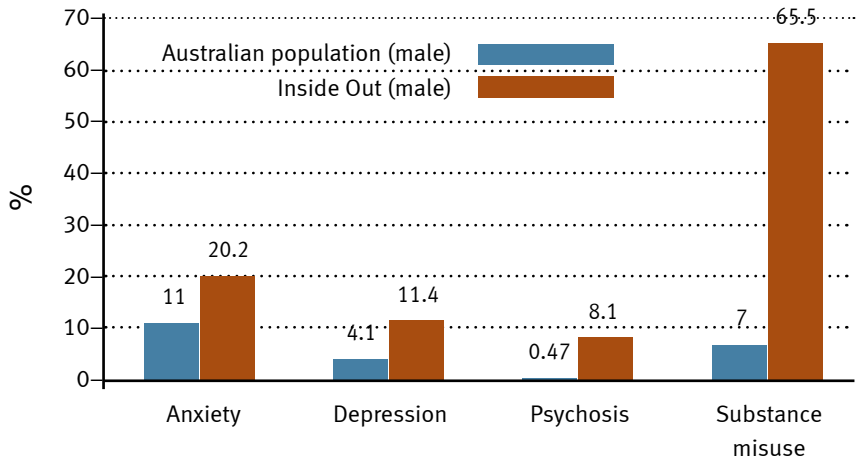

Figure 4. Prevalence of mental disorder among male participants and males in the general community

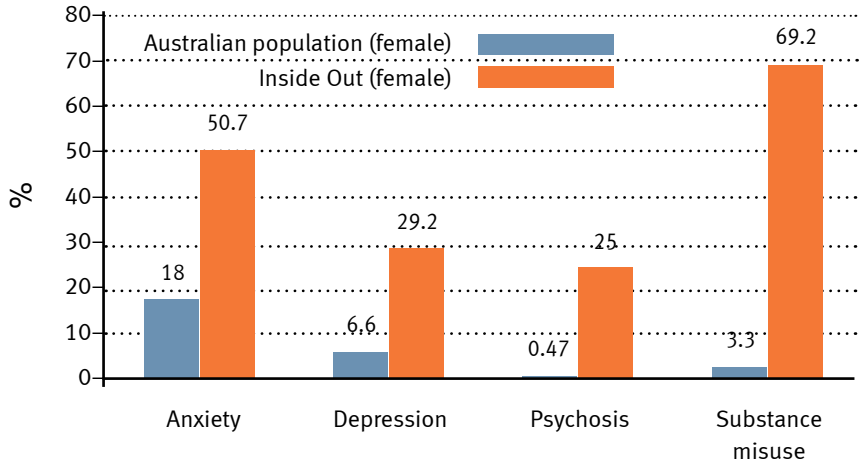

Figure 5. Prevalence of mental disorder among female participants and females in the general community

Figure 6 compares the 12 month prevalence of major mental disorder between participants on remand and those sentenced, by gender. The prevalence of mental illness was higher for those on remand for both males and females.

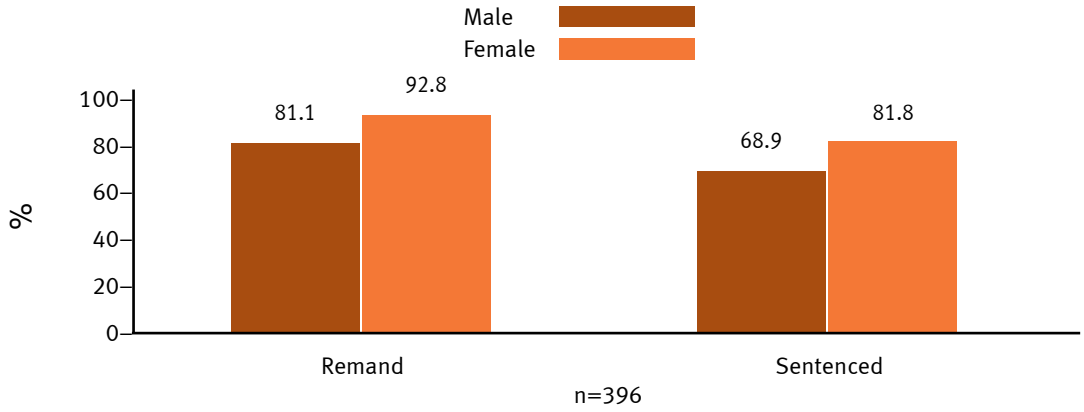

Figure 6. Twelve month prevalence of major mental disorder by custodial status and gender

Anxiety disorders

Diagnosis of an anxiety disorder requires that specific anxiety symptoms are present over a period of time and that these symptoms are accompanied by changes in thoughts, emotions and behaviour that substantially interfere with the person's ability to live and work. Seven anxiety disorders were assessed by the CIDI-A: social phobia, agoraphobia, panic disorder, generalised anxiety disorder, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and specific phobias.

Persons who have panic disorders have repeated experiences of sudden, sometimes unexpected, attacks of disabling fear or anxiety. Agoraphobia is the avoidance of situations in which help is not available, or in which escape is impossible, for fear that a panic attack or panic like symptoms may occur. Social phobia is the avoidance of situations in which one is perceived to be the centre of attention in case of embarrassment or humiliation. Generalised anxiety disorder refers to months of irrational worry about everyday things. Obsessive compulsive disorder is characterised by repeated, intrusive, unwanted thoughts, and/or by repeated acts to neutralise the anxiety generated by the obsessions (e.g. repeated checking or hand washing). Persons with post-traumatic stress disorder suffer from a number of symptoms including the continuing intrusion of emotionally laden memories of a previous traumatic event (e.g. combat experience, car accident etc) [36].

Table 4.2 shows the 12 month prevalence of anxiety disorder among Indigenous people interviewed for this research. The 12 month prevalence of anxiety disorder was 25.2 per cent. The prevalence of anxiety disorders was high among males (20 per cent) and particularly high among females, with one in two Indigenous females (51 per cent) experiencing an anxiety disorder. Female participants were significantly more likely than male participants to have an anxiety disorder (RR=2.50, 95 per cent CI 1.81-3.45).

The most common anxiety disorder among both men and women was PTSD experienced by 12 per cent of males and 32 per cent of females. Among females, specific phobias was 22 per cent and social phobia was 12 per cent were also common (Table 4.2).

Table 4.2 Twelve month prevalence of anxiety disorder by gender

Disorder (%)	Male (n=331)	Female (n=65)	Total (n=396)
Panic disorders	0.6	4.6	1.2
Agoraphobia	1.5	6.1	2.2
Social phobia	1.2	12.3	3.0
Generalized anxiety disorder	2.4	4.6	2.7
Specific phobias	4.5	21.5	7.3
OCD	1.2	0.0	1.0
PTSD	12.0	32.3	15.4
Total anxiety disorder*	20.2	50.7	25.2

*Some individuals had more than one anxiety disorder.

Figure 7 compares the 12 month prevalence of anxiety disorder between those on remand and those serving a sentence, by gender. Males on remand had a higher 12 month prevalence of anxiety disorders compared to those sentenced (27.7 per cent and 16.5 per cent respectively). In females, there was very little difference in the prevalence rates of these disorders when compared to their custodial status.

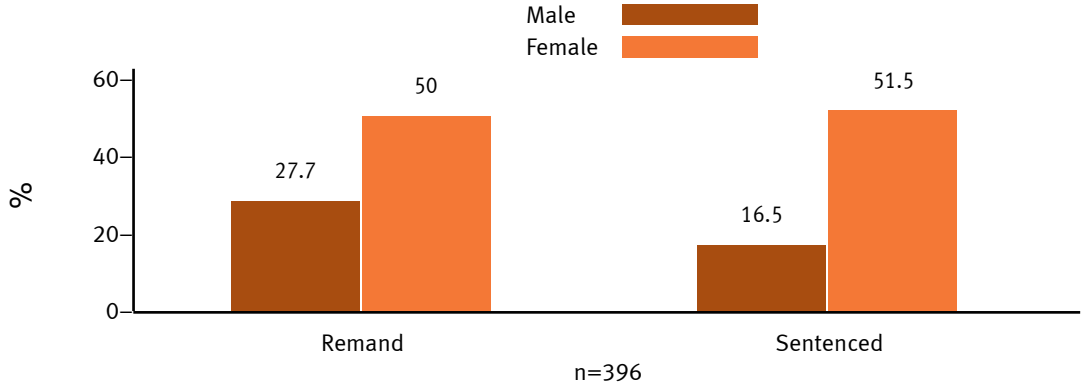

Figure 7. Twelve month prevalence of anxiety disorder by custodial status and gender

Depressive disorders

Two types of depressive disorder were assessed in the study using the CIDI-A. These were:

- Major depressive episodes: a mood disturbance characterised by being persistently and markedly depressed for at least two weeks, with an associated neuro-vegetative disturbance.
- Dysthymia: a longstanding, lower-grade mood disturbance that has persisted for years. It is distinguished from depression by its duration and relatively less severe disturbance in functioning and is characterised by hopelessness, loss of self esteem and feelings of being unable to cope [36].

Among those interviewed for this research, depressive disorders were the third most common type of mental illness, with over 14 per cent of Indigenous prisoners experiencing a depressive disorder in the past 12 months (Table 4.3). The 12 month prevalence of depressive disorder was significantly higher among women (29 per cent) than among men (11 per cent) (RR=2.54, 95 per cent CI 1.57-4.12). For both males and females, depressive episodes were more common than dysthymia (Table 4.3).

Table 4.3 Twelve month prevalence of depressive disorder by gender

Disorder (%)	Male (n=331)	Female (n=65)	Total (n=396)
Depressive episode	10.2	23.0	12.3
Dysthymia	2.7	10.7	4.0
Total depressive disorder*	11.4	29.2	14.3

*Some individuals had both a depressive episode and dysthymia.

Figure 8 compares the 12 month prevalence of depressive disorder between remandees and those serving a sentence, as a function of gender. The prevalence of depressive disorder was higher among remanded males, than those sentenced, while for females it was highest amongst those sentenced.

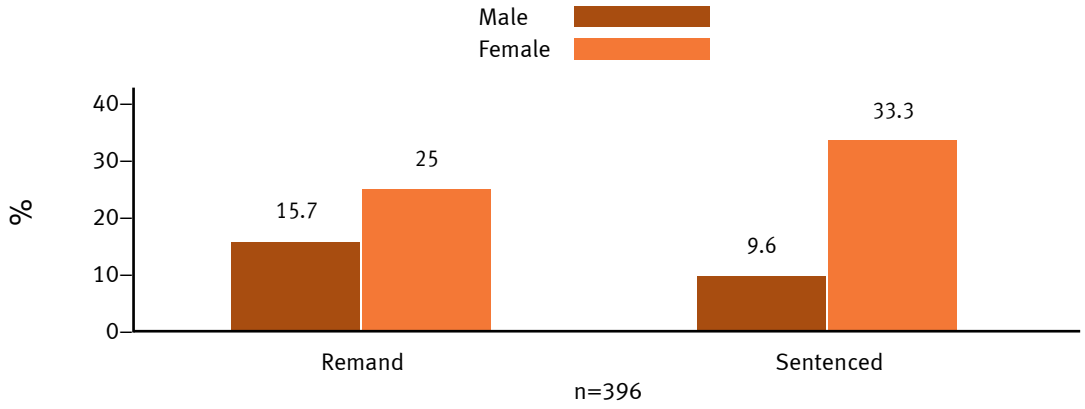

Figure 8. **Twelve month prevalence of depressive disorder by custodial status and gender**

Psychotic disorders

Psychosis is characterised by impaired reality testing, hallucinations and delusions [40]. Psychosis is a core feature of psychotic disorders. Using the psychosis screener [29], 17 per cent of participants (n=72) screened positive for psychosis. The individuals who screened positive were then assessed by a psychiatrist and their diagnostic information reviewed by the diagnostic panel. Seven participants (six males and one female) were not able to be interviewed as they were released or transferred prior to the interview process.

After eliminating false positives, the prevalence of psychosis was found to be 8.1 per cent amongst the male participants and 25 per cent amongst females. The prevalence of particular psychotic disorders, by gender, is summarised in Table 4.4. The most common psychotic disorder was schizophrenia, the prevalence of schizophrenia was higher among females than amongst males (12.5 per cent and 4.3 per cent respectively). Substance induced psychosis (SIP) was the second most common psychotic disorder. The prevalence was almost five5 times higher amongst females than amongst males (9.7 per cent and 2.0 per cent respectively).

Table 4.4 Twelve month prevalence of specific psychotic disorders by gender

Disorder (%)	Male (n=347)	Female (n=72)	Total (n=419)
Any psychotic disorder	8.1	25.0	11.0
Schizophrenia	4.3	12.5	5.7
SIP	2.0	9.7	3.3
Schizoaffective disorder	1.2	0	0.9
Psychotic disorder NOS	0.6	2.8	0.9
No diagnosis	91.9	75.0	89.0

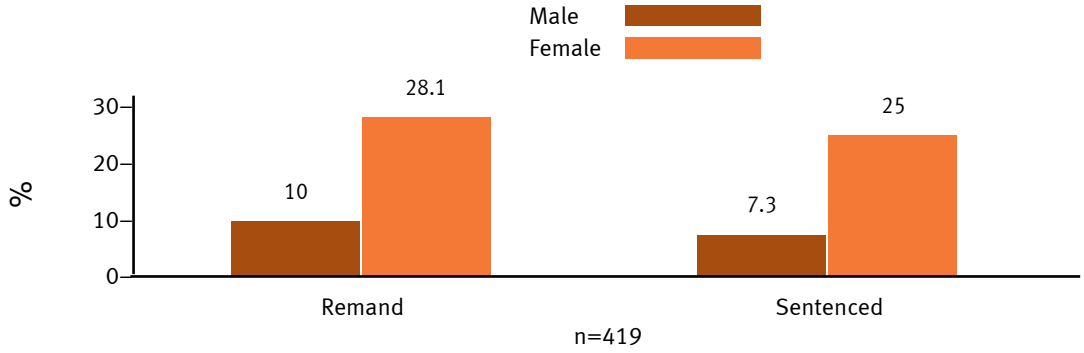

Figure 9. **Twelve month prevalence of psychotic disorder by custodial status and gender**

Substance use disorders

The 12 month prevalence of substance use disorders in the sample was determined using the ICD-10 criteria for harmful use and dependence. Individuals may have more than one substance use disorder. To cater for an incarcerated population, the standard CIDI-A questions were modified by asking about substance use history in the 12 months before incarceration.

An ICD-10 harmful use diagnosis requires a pattern of substance use that is causing damage to health. The damage may be physical (e.g. hepatitis from self-administration of injected drugs) or mental (e.g. depression secondary to heavy consumption of alcohol).

An ICD-10 dependence diagnosis requires the presence of three or more indicators of alcohol or other drug dependence. These indicators are:

- a strong desire to take the substance
- impaired control over drug use
- the occurrence of a withdrawal syndrome on ceasing or reducing use
- tolerance to the effects of alcohol or other drugs, as indicated by needing larger doses to achieve the desired psychological effect
- obtaining, using, and recovering from alcohol or other drugs take up a disproportionate amount of the user's time
- the user continues to drink alcohol or take other drugs despite associated problems.

The problems must be experienced for at least one month during the previous year to qualify for a diagnosis [36].

Two thirds of participants had a substance use disorder in the 12 months prior to incarceration (Figure 10). Sixty-three per cent of participants were substance dependent, while seven per cent experienced a harmful use disorder.

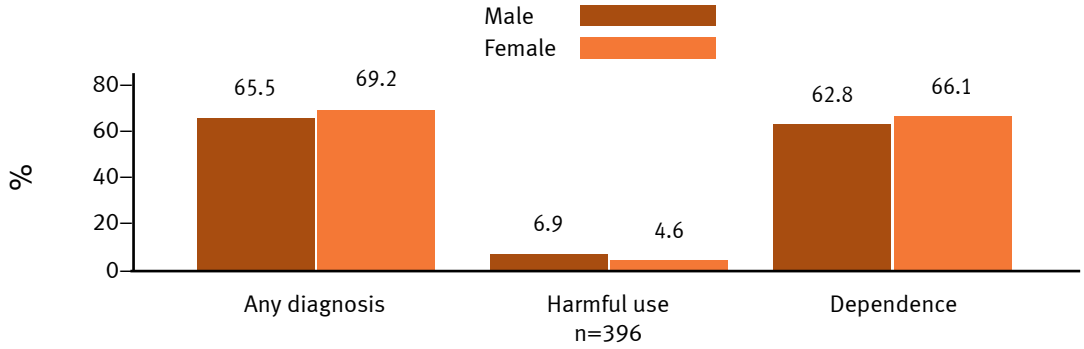

Figure 10. Twelve month prevalence of substance use disorder by gender

The most common substance use disorders were alcohol, cannabis, amphetamines and opioids. Females were more likely than males to have an alcohol or cannabis use disorder, and males were more likely than females to have an amphetamine use disorder (Figure 11).

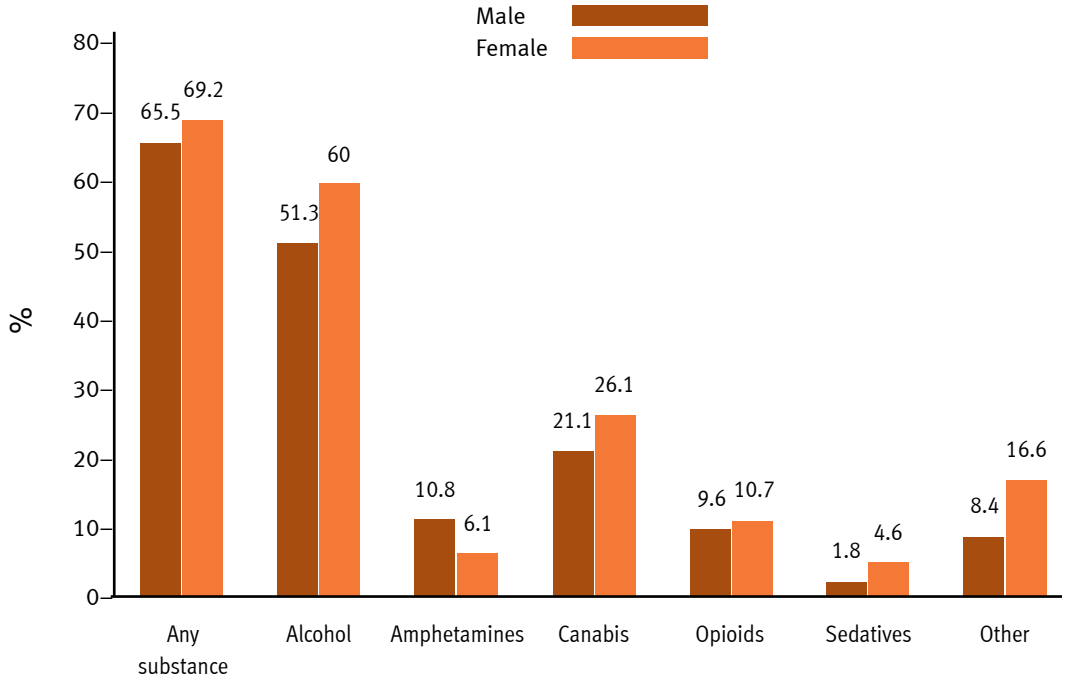

Figure 11. Twelve month prevalence of substance use disorder by substance and gender

Just over one in five participants had a cannabis use disorder (21.9 per cent). The prevalence estimate for cannabis use disorders amongst Australian adults was 1.7 per cent [26]. Around 1 in 10 participants had an amphetamine use disorder (10.8 per cent), an opioid use disorder (9.8 per cent) and/or an 'other' drug use disorder (9.7 per cent). The latter category included inhalants, hallucinogens and psycho stimulants other than 'speed'.

Although a significant proportion of the sample had an illicit drug use disorder, the most common substance related diagnosis was an alcohol use disorder. More than half (53 per cent) of participants had an alcohol use disorder in the past 12 months (males 51 per cent, females 60 per cent), 48 per cent had a diagnosis of alcohol dependence and seven per cent had a diagnosis of harmful use. By contrast, among the general population in Australia it is estimated that 2.9 per cent of adults have an alcohol use disorder (males 3.8 per cent, females 2.1 per cent). Among Australian adults the 12 month prevalence estimate for alcohol dependence was less than 1 per cent [26].

Table 5.1 Twelve month prevalence of substance use disorder by gender

Diagnosis (%)	Male (n=331)	Female (n=65)	Total (n=396)
Any substance	65.5	69.2	66.1
Dependence	62.8	66.1	63.3
Harmful use	6.9	4.6	6.5
Alcohol	51.3	60.0	52.7
Dependence	46.8	55.3	48.2
Harmful use	4.5	4.6	4.5
Amphetamine	10.8	6.1	10.1
Dependence	10.2	6.1	9.6
Harmful use	0.6	0.0	0.5
Cannabis	21.1	26.1	21.9
Dependence	19.9	26.1	20.9
Harmful use	1.2	0.0	1.0
Opioids	9.6	10.7	9.8
Dependence	9.6	10.7	9.8
Harmful use	0.0	0.0	0.0
Sedatives	1.8	4.6	2.2
Dependence	0.0	1.5	0.2
Harmful use	1.8	4.6	2.2
Others*	8.4	16.6	9.7
Dependence	7.2	16.9	8.8
Harmful use	1.2	0.0	1.0

*Includes hallucinogens, volatile solvents and psychoactive substances and other stimulants.

The prevalence of substance use disorders was higher among the remanded sample than the sentenced sample (Figure 12).

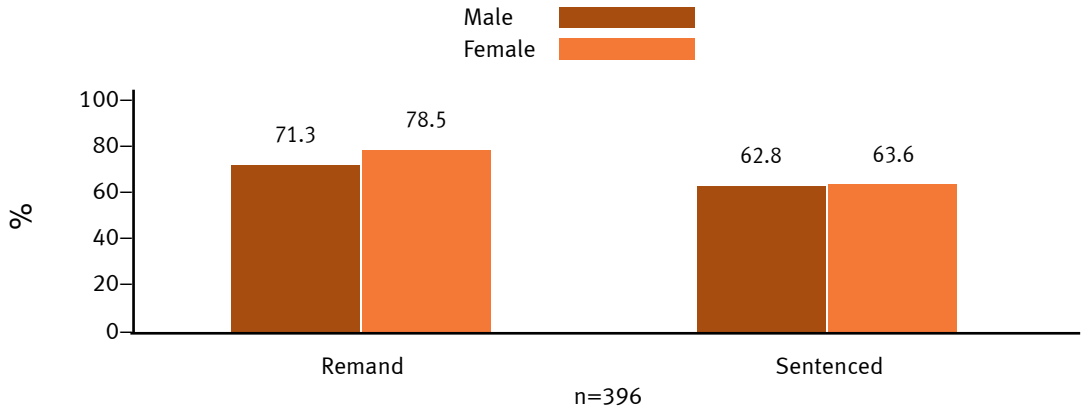

Figure 12. **Twelve month prevalence of substance use disorder by custodial status and gender**

Substance use and offending

Participants were asked about the role that alcohol or drug use played in their offending*, the effect that alcohol or drug use had on their offence*, and whether they had ever offended to support their alcohol or drug use. Participants were also asked if they were under the influence of alcohol at any time during the offences leading up to their imprisonment. Nearly 70 per cent reported they were under the influence of alcohol at the time they offended (Table 5.2).

*Note: The terms 'offending' and 'offence' are broadly used in this report to refer to the event/s that led to a participant's incarceration. As both remanded and sentenced individuals have been surveyed, for some the appropriate descriptor may be charges or alleged offence/s. For the convenience of reporting findings, however, the term 'offence' has been used.

Alcohol

Table 5.2 Proportion of participants under the influence of alcohol at time of offence by gender

(%)	Male (n=347)	Female (n=72)	Total (n=419)
Yes	68.0	62.5	67.0
A little	2.8	2.8	2.8
No	28.2	33.3	29.1
Don't know*	1.0	1.4	1.1

*Includes three males for whom no response was recorded.

Of those who were under the influence of alcohol at the time of their offence, the vast majority (81 per cent) stated alcohol contributed to their offence and more than one in five (22 per cent) reported they had offended on this occasion to support their alcohol use. Nearly 40 per cent of those who were under the influence of alcohol at the time they offended had offended in the past to support their alcohol use (Table 5.3).

Table 5.3 Role of alcohol in offence by gender

(%)*	Male (n=259)	Female (n=50)	Total (n=309)
Alcohol contributed to offence			
Yes	72.5	82.0	74.1
A little	7.7	4.0	7.1
No	17.7	14.0	17.1
Don't know	1.9	0	1.6
Current offence/s support alcohol use			
Yes	20.4	28.0	21.6
A little	1.1	0	0.9
No	76.0	70.0	75.0
Don't know	1.1	2.0	1.2
Offended in past to support alcohol use			
Yes	38.9	34.0	38.1
A little	3.4	2.0	3.2
No	55.9	66.0	57.6
Don't know	0.7	2.0	1.2

*Due to rounding estimates may not sum to 100 per cent.

Drugs

Table 5.4 Under the influence of drugs at time of offence by gender

(%)	Male (n=347)	Female (n=72)	Total (n=419)
Yes	47.5	50.0	47.9
A little	2.0	2.7	2.1
No*	50.5	47.2	50.0

*Includes four males for whom no response was recorded.

Almost 50 per cent of participants, reported being under the influence of drugs at the time of the offence(s) that led to their incarceration. This finding was similar between males and females (Table 5.4). Among those reporting being under the influence of an illicit drug at the time of offending, the drug most commonly involved was cannabis (70 per cent), although a substantial minority reported being under the influence of amphetamines (38 per cent) or opiates (20 per cent). Females were more likely than males to report being under the influence of benzodiazepines or inhalants at the time of offending (Table 5.5).

Table 5.5 Drugs used at the time of offending by gender

(%)	Male (n=172)	Female (n=38)	Total (n=210)
Cannabis	70.9	68.4	70.4
Amphetamines	37.7	39.4	38.0
Opiates	19.7	23.6	20.4
Benzodiazepines	5.8	13.1	7.1
Inhalants	1.1	7.8	2.3
Other	4.6	10.5	5.7

*Some individuals were using more than one drug.

Of those who were under the influence of drugs while offending (n=210), almost three quarters (73 per cent) stated their drug use contributed to their offence. Forty-five per cent stated their current offence was committed to support their drug use and 64 per cent reported offending in the past to support their drug use (Table 5.6).

Table 5.6 Role of drugs in offence by gender

(%)	Male (n=172)	Female (n=38)	Total (n=210)
Drugs contributed to offence			
Yes	70.3	73.6	70.9
A little	3.4	0	2.8
No	26.1	26.3	26.1
Don't know	1.1	0	0.9
Current offence/s to support drug use			
Yes	42.5	44.7	42.9
A little	2.9	2.6	2.9
No	56.4	52.6	538
Don't know	0.5	0	0.5
Offended in past to support drug use			
Yes	58.7	65.7	60.0
A little	2.9	7.8	3.8
No	40.1	26.3	37.6
Don't know	1.3	0	0.4

*Due to rounding estimates may not sum to 100 per cent.

Among those who were under the influence of drugs while offending, 46 per cent reported remembering only a little or nothing of the events that led to their offence. Almost one in five (18 per cent) female participants stated they have no recollection of the events that led to them offending (Table 5.7).

Table 5.7 Memory of events leading up to offence by gender

(%)	Male (n=172)	Female (n=38)	Total (n=210)
A lot	57.5	39.4	54.2
A little	34.5	42.1	35.7
Nothing at all	9.8	18.4	11.4

*Due to rounding estimates may not sum to 100 per cent.

Substance use (post release)

Participants who anticipated being released from custody within two years from the time of interview were asked if they considered themselves likely to use substances within two months after their release. Among this group, 48 per cent believed they would be using substances within two months of release (Table 5.8).

Table 5.8 Likely substance use (post release) by gender

(%)	Male (n=210)	Female (n=44)	Total (n=254)
Yes	46.7	52.3	47.6
No	40.5	40.9	40.6
Don't know	12.8	6.8	11.8

Among those who expected to use a substance within two months of release, the vast majority (90 per cent) expected to use alcohol. However, a substantial minority expected to use cannabis (44 per cent) or speed (18 per cent) within two months of release from custody (Table 5.9).

Table 5.9 Expectations of drug use within two months of release by gender

(%)	Male (n=123)	Female (n=28)	Total (n=151)
Alcohol	88.6	96.4	90.0
Cannabis	47.9	53.5	44.0
Amphetamines	16.2	25.0	17.8
Opiates	5.6	10.7	6.6
Benzodiazepines	2.4	10.7	3.9
Inhalants	0.8	3.5	1.3
Other illicit drug	0.8	0	0.6
Other	3.2	3.5	3.3

Suicide

Participants were asked about their experience of suicidal thoughts and attempts and their experience of suicide amongst family and friends. More than a quarter of males (28 per cent) and more than half of females (53 per cent) reported suicidal ideation at some time in their life (Figure 13).

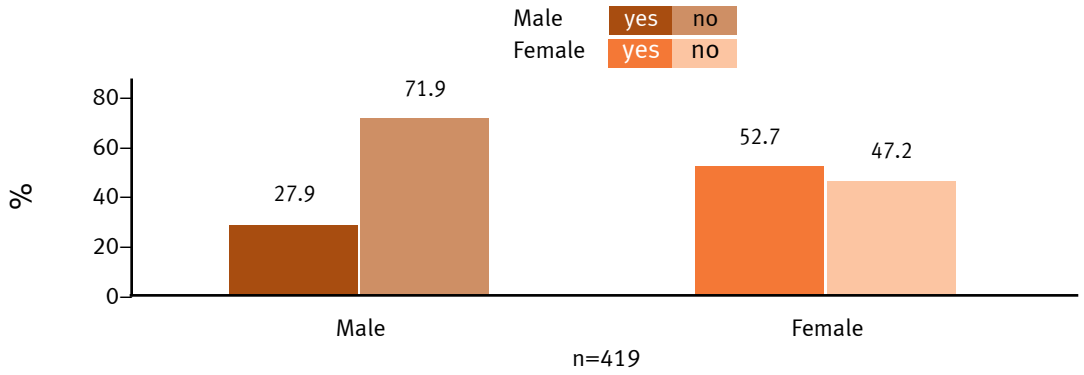

Figure 13. Lifetime suicidal ideation by gender

Participants who had experienced suicidal ideation at some time in their life were asked if the thoughts had been worse in custody or in the community. Of the 135 individuals who reported suicidal ideation 127 responded (six males and two females had no response recorded). Around half of those who responded (54.3 per cent) indicated that their suicidal thoughts had been worse when they were in the community, smaller proportions indicated that the thoughts had been worse in custody (25.9 per cent), or that the thoughts were equally bad in both locations (Figure 14).

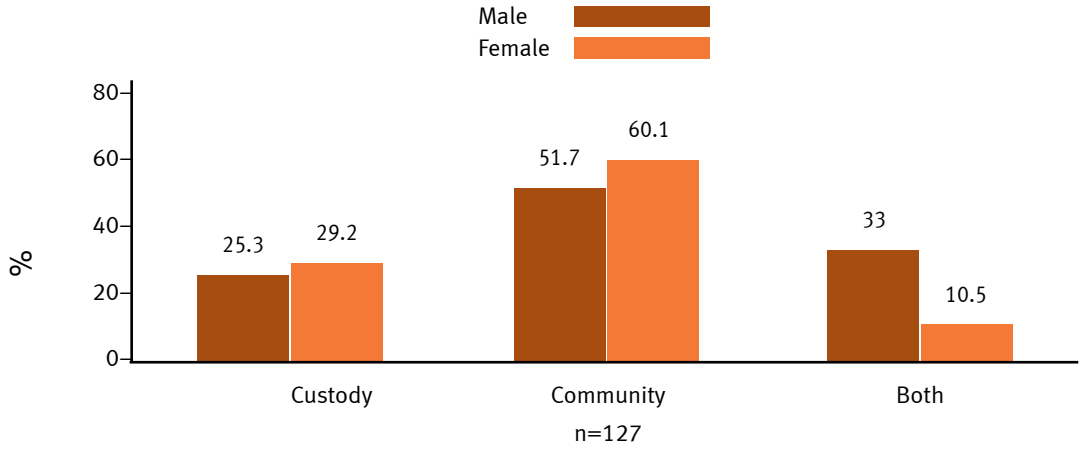

Figure 14. Location where suicidal thoughts were 'worst' by gender

Participants were also asked about their lifetime history of suicide attempts. Almost one quarter of participants had attempted suicide. Suicide attempts were more common among female participants (30.5 per cent) than male participants (17.8 per cent) (Figure 15).

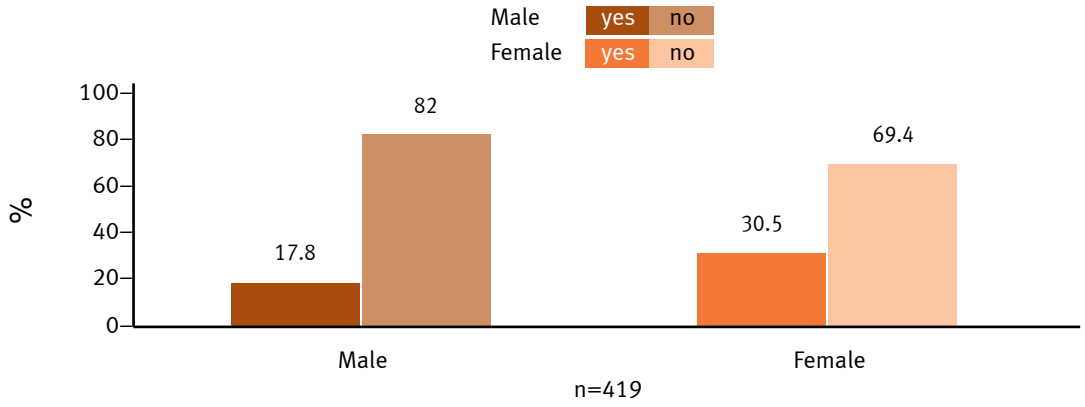

Figure 15. Lifetime history of suicide attempt by gender

Among those participants who had attempted suicide (males n=62, females n=22), more than two thirds said that they had attempted to end their life when they were in the community. Custodial suicide attempts were more common among females (Figure 16).

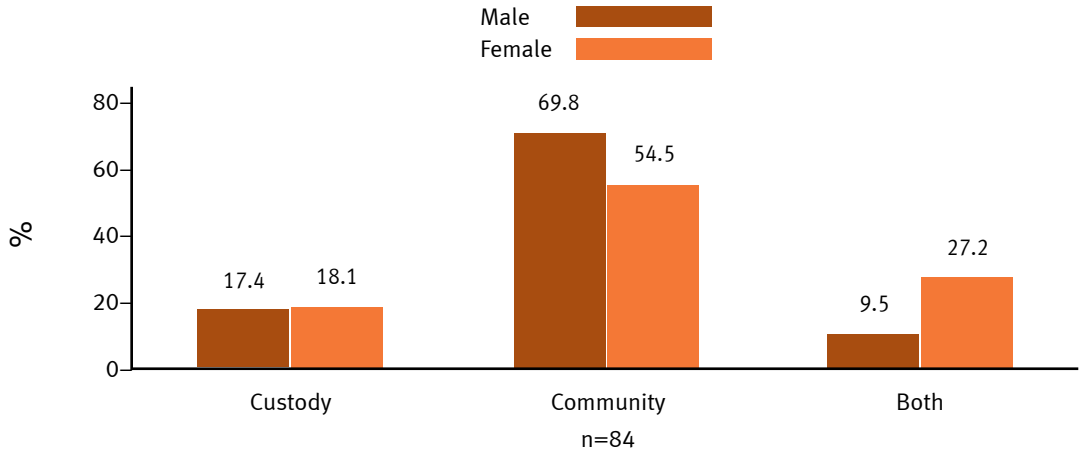

Figure 16. Location of suicide attempt by gender*

*No response was recorded for two male participants.

Almost one in five participants (18 per cent) reporting having thought about suicide in the preceding 12 months, this was more common among females (26.3 per cent) than among males (8.6 per cent) (Figure 17).

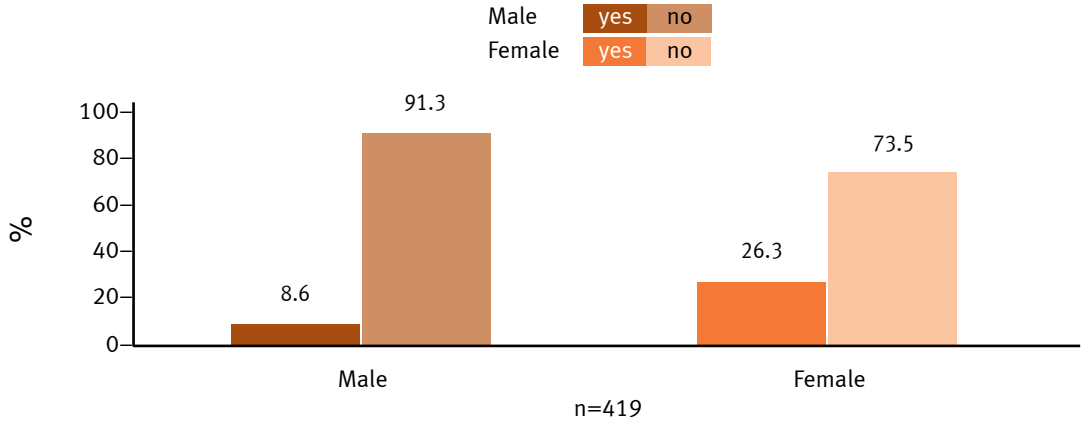

Figure 17. Suicidal ideation in the past 12 months by gender

Participants were also asked if they had ever experienced a close friend or relative commit suicide. Almost two thirds of participants reported that a relative or friend had committed suicide (Figure 18).

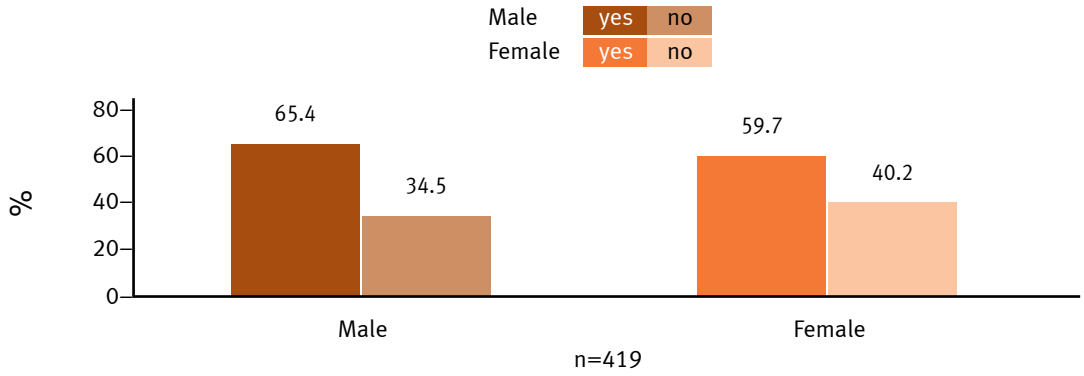

Figure 18. **Suicide among family and friends by gender**

Social and emotional wellbeing

Aboriginal definitions of health require a holistic and whole of life view: this concept encompasses the social, emotional and cultural wellbeing of the individual and the whole community and includes their experience of mental health issues [14]. The questions in this section of the survey were designed to consider aspects of social and emotional wellbeing. Questions focused on emotional and traumatic experiences, emotional coping mechanisms and aspects of cultural identity.

Participants were asked if they had undergone any traumatic experience in the past 12 months. Overall, more than two thirds of participants (69 per cent) had experienced at least one traumatic event in the last 12 months. Experiences of recent trauma were more common among males (72 per cent) than among females (58 per cent). More than one in four participants (27.4 per cent) reported that they had experienced the death of a loved one and almost a third (28.1 per cent) had undergone more than one traumatic experience (Figure 19).

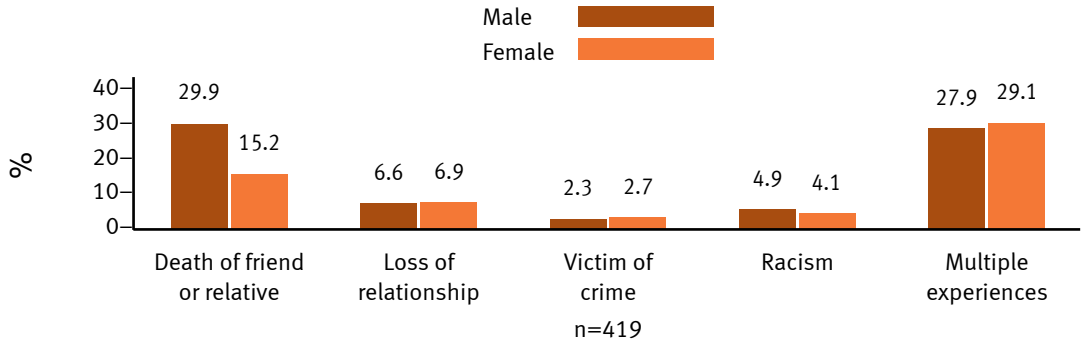

Figure 19. **Traumatic experiences in the past 12 months by gender**

Participants were asked if they always identified themselves as an Aboriginal and/or Torres Strait Islander person. The vast majority of participants responded in the affirmative, although males were more likely than females to do so (96 per cent versus 78 per cent). More than 1 in 10 females only rarely or sometimes identified themselves as an Aboriginal and/or Torres Strait Islander person (Figure 20).

*Note: Apart from Figure 19, in the following section some percentages do not total 100 per cent, this is because not all participants from the group surveyed (n=419) answered all questions.

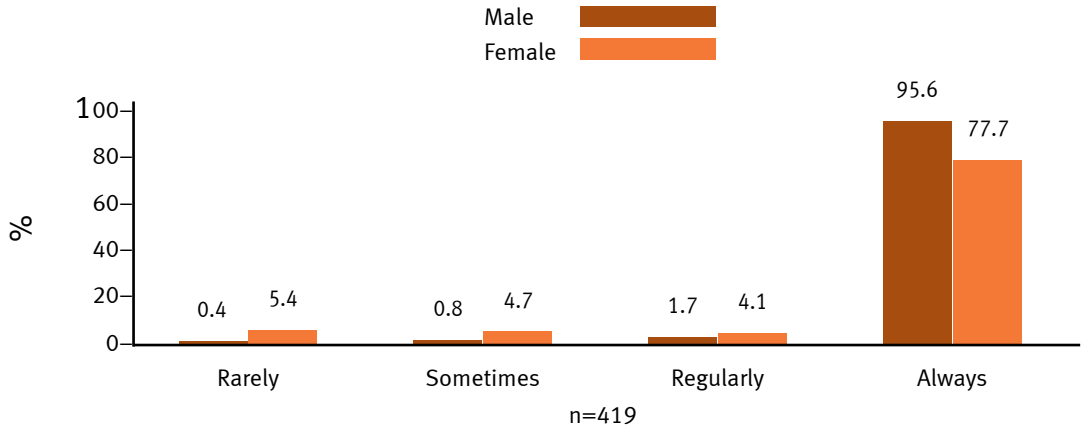

Figure 20. Proportion of participants identifying as Aboriginal and/or Torres Strait Islander by gender

Although some participants reported they did not always identify themselves as an Aboriginal and/or Torres Strait Islander person, almost all participants stated that they were proud to be an Aboriginal and/or Torres Strait Islander person (Figure 21).

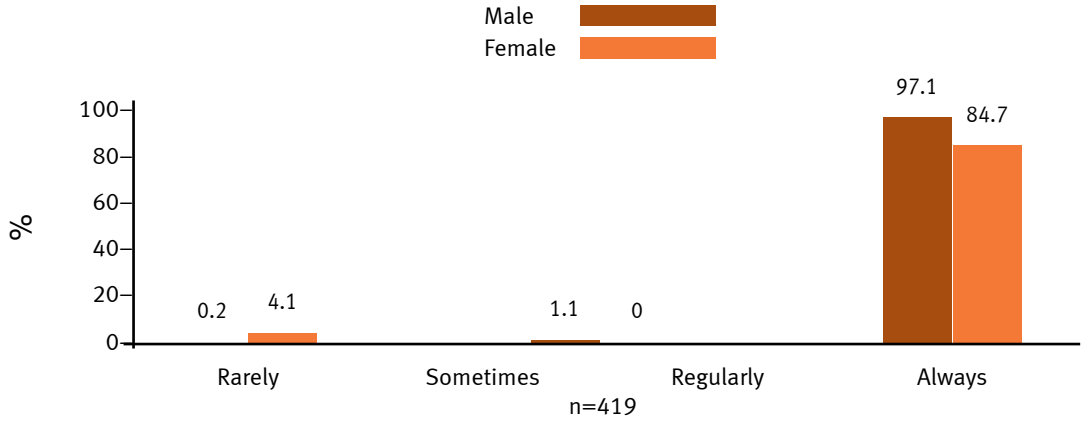

Figure 21. Proportion of participants reporting being proud to be an Aboriginal and/or Torres Strait Islander person by gender

Almost two thirds of participants stated they had been a victim of racism or discrimination because of their Indigenous identity (Figure 22).

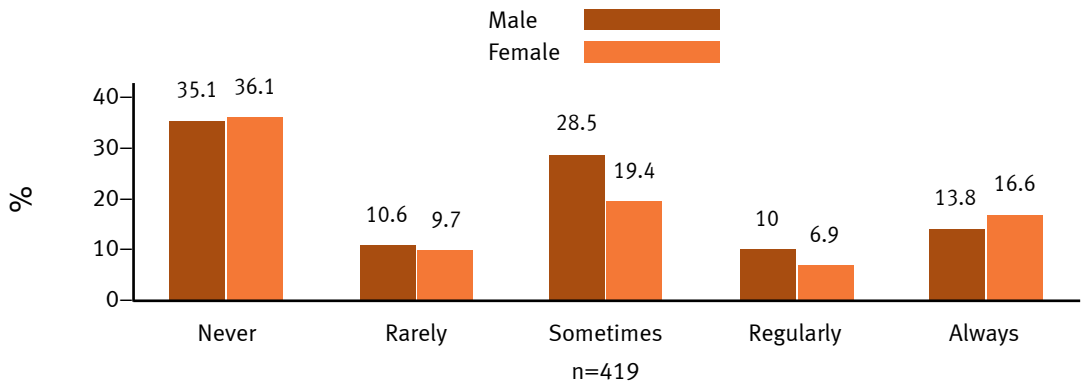

Figure 22. Proportion of participants reporting being a victim of racism or discrimination because of Aboriginal and/or Torres Strait Islander Identity by gender

Participants were asked to answer questions relating to their anger and sadness based on their experiences both in custody and in the community. Nearly two in five males (39 per cent) and more than one in five females (21 per cent) stated they never shared their anger by speaking to someone about it. Just over one in five participants stated that they always spoke to others about their anger (Figure 23).

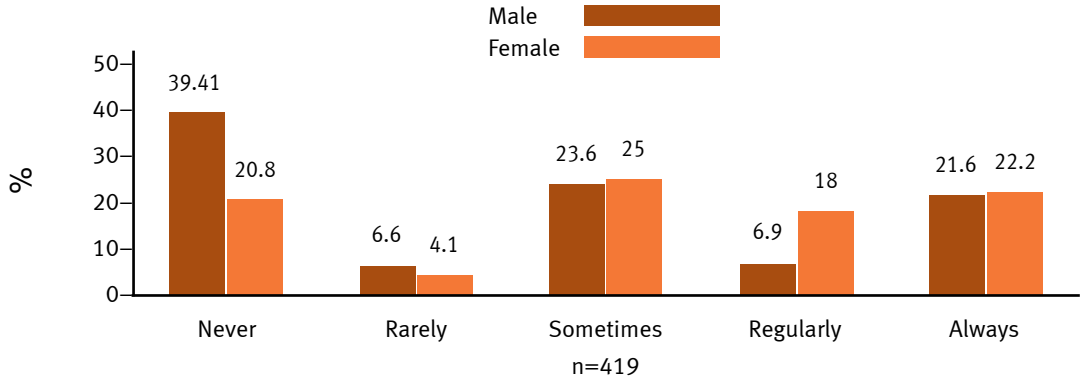

Figure 23. Proportion of participants who reported sharing their thoughts when angry by gender

Similarly, participants were asked to report how often they shared their thoughts when feeling sad. More than a third of males (38 per cent) and more than one in five females (21 per cent) reported never sharing their feelings when sad (Figure 24).

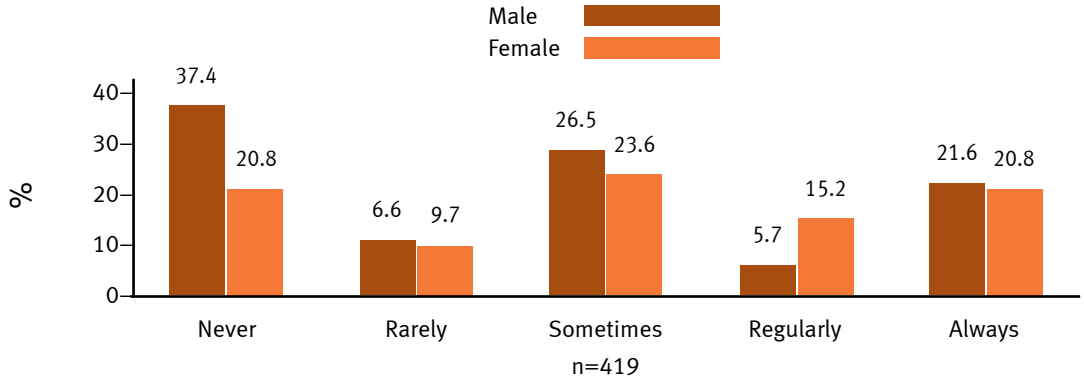

Figure 24. Proportion of participants who reported sharing their thoughts when sad by gender

More than 50 per cent of participants felt helpless and did not know what to do when they felt angry or sad, with more than a quarter of males (27 per cent) and nearly one in five females (18 per cent) feeling this way every time they felt angry or sad (Figure 25).

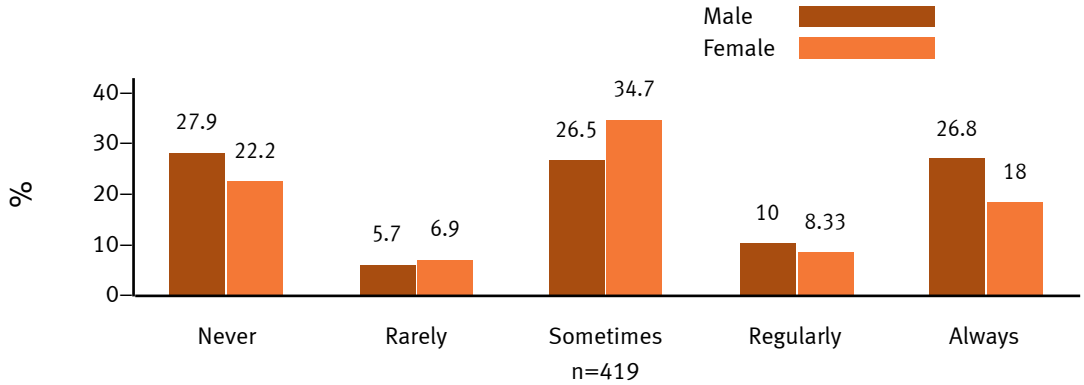

Figure 25. Proportion of participants who reported feeling helpless when angry or sad by gender

Participants were also asked whether, when feeling angry or sad, they would like to have someone from their own culture with whom to talk. The majority of participants, almost two thirds of males (62 per cent) and almost half of females (47 per cent) stated they would always prefer to have someone from their own culture to talk to when angry or sad (Figure 26).

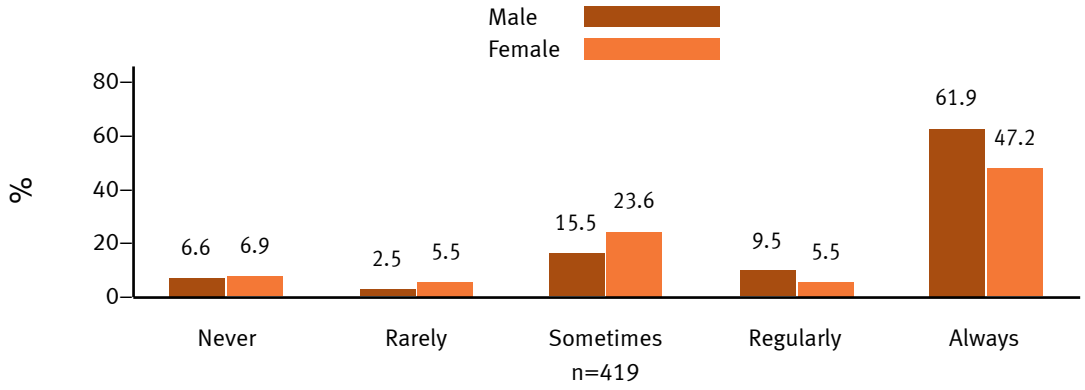

Figure 26. Proportion of participants who reported a preference for talking to someone from their own culture when angry or sad by gender

Participants were asked about their knowledge of culture as an Aboriginal and/or Torres Strait Islander person; their responses were recorded by asking them to rate their understanding and knowledge of their culture ranging from extensive knowledge (strongly agree) to no knowledge (strongly disagree). Nearly 70 per cent of participants either agreed or strongly agreed that they had extensive knowledge of their culture and that they were confident to teach the younger members of the family (Figure 27).

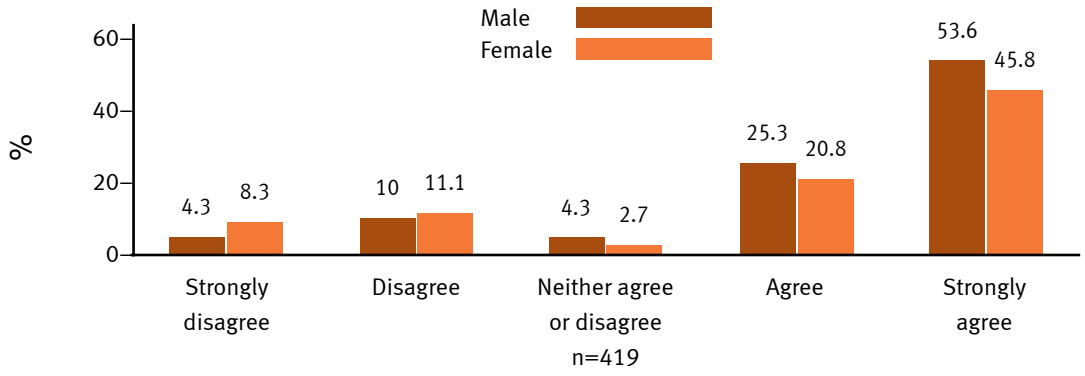

Figure 27. Participants' knowledge of Aboriginal and/or Torres Strait Islander culture by gender

Participants were asked whether they learned about their culture from family and/or community. The vast majority of participants reported they had learnt about their culture from their family or community (Figure 28).

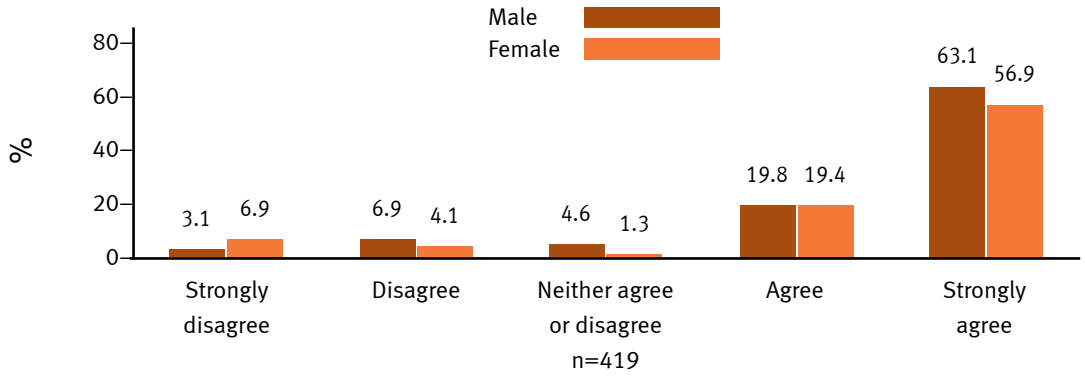

Figure 28. Proportion of participants who learnt about their culture from family or community by gender

Participants were asked about their knowledge of reconciliation. Around two thirds of participants either agreed or strongly agreed that they had knowledge of reconciliation (Figure 29).

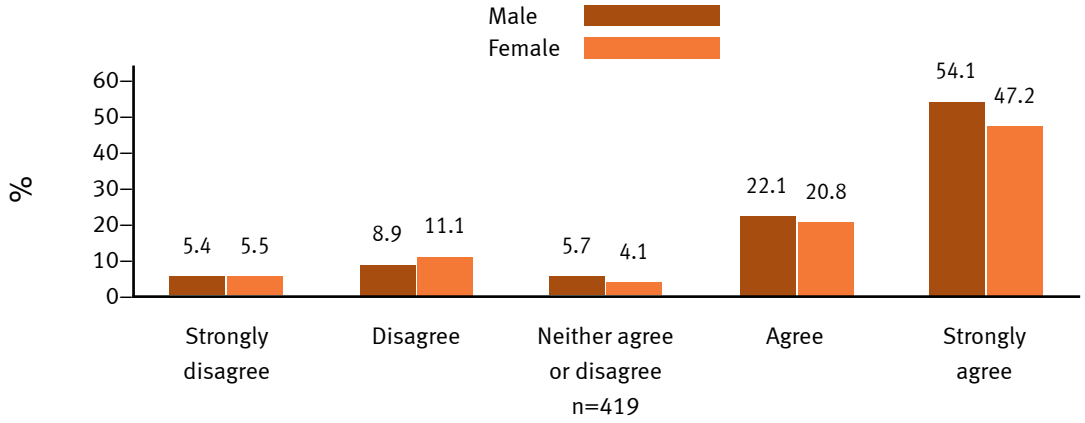

Figure 29. Participants' knowledge of reconciliation by gender

Participants were also asked about their knowledge of the stolen generation. Again, the vast majority of participants either agreed or strongly agreed that they had knowledge of the stolen generation (Figure 30).

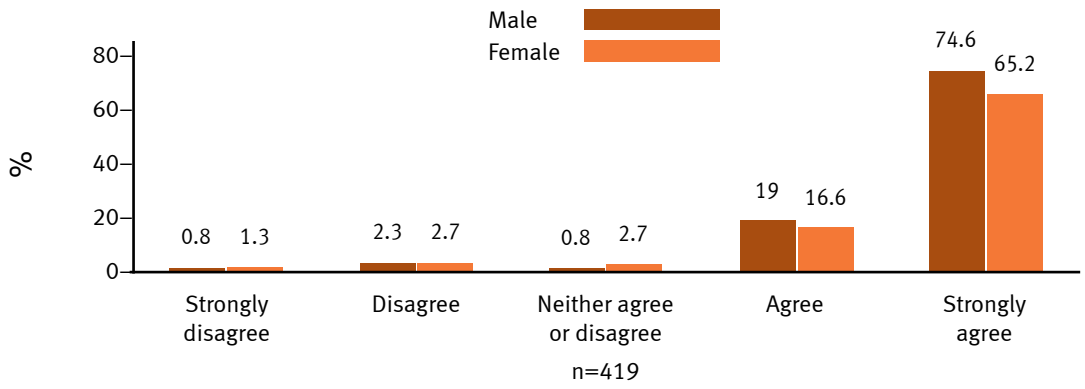

Figure 30. Participants' knowledge of the stolen generation by gender

Participants were asked if things would have changed for the better when they returned to their community. The vast majority of participants agreed with this statement, with almost half of males (47 per cent) and more than two thirds of females (35 per cent) strongly agreeing.

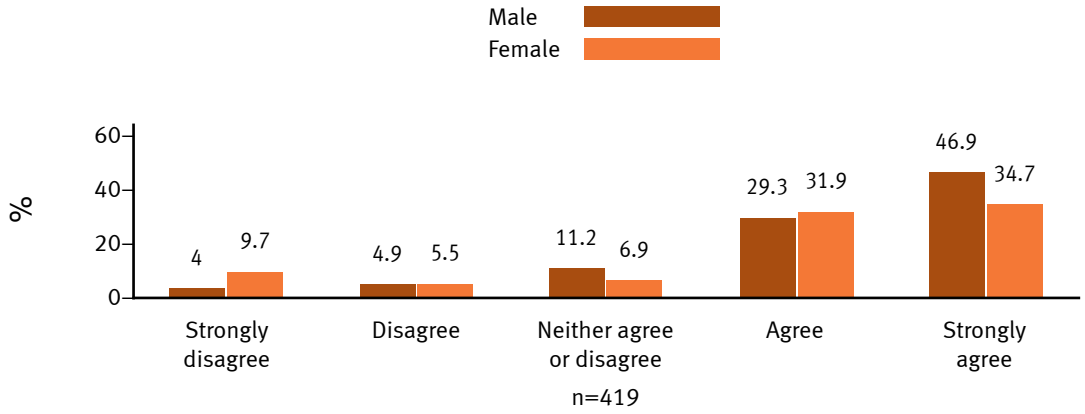

Figure 31. Participants' expectations of change after return to community by gender

Health service use

Participants responded to a number of questions about their use of general and mental health services in the 12 months prior to coming into custody. Almost all participants (95 per cent) said that they understood how to access health care in the 12 months prior to coming into custody (Table 6.1).

Table 6.1 Understanding of how to access health services before custody by gender

(%)	Male (n=343)	Female (n=71)	Total (n=414)
Yes	95.0	98.6	95.7
No	4.1	1.4	3.6
Don't know	0.9	0	0.7

Table 6.2 details the proportion of male and female participants who reported accessing mental health services in the 12 months before entering custody. Psychiatrists were the mental health service used by the largest proportion of participants (10.5 per cent), followed by community mental health services (8.3 per cent) and counsellors (7.6 per cent). Among females, the mental health service utilised by the largest proportion was a counsellor; accessed by around one in five females (21 per cent) in the 12 months before custody. Overall, more females than males reported accessing a mental health service before custody, although a substantial proportion of males (30 per cent) and females (22 per cent) reported never having accessed mental health care (Table 6.2).

Table 6.2 Mental health service use prior to custody by gender

(%)	Male (n=347)	Female (n=72)	Total (n=419)
Psychiatrist	9.2	16.6	10.5
General practitioner	4.6	9.7	5.4
Community mental health services	7.7	11.1	8.3
Inpatient mental health services	2.5	2.7	2.6
Counsellor	4.9	20.8	7.6
Support group	0.5	2.7	0.9
Traditional healer/medicine	0.8	0	0.7
Other	2.5	4.1	2.8
None of the above (last 12 months)	55.0	40.2	52.5
Never accessed mental health care	29.6	22.2	28.4

Participants were also asked what services they accessed for any general health needs in the 12 months prior to coming into custody. The general health services used by the largest proportion of participants in the 12 months before entering custody were local doctors and general practitioners (40 per cent) and the local community health centre (31 per cent). More females (21 per cent) than males (11 per cent) reported accessing drug and alcohol services in the 12 months before entering custody, and less than two per cent of participants (n=7 males) reported accessing a traditional healer (Table 6.3).

Table 6.3 General health service use prior to custody by gender*

(%)	Male (n=347)	Female (n=72)	Total (n=419)
General practitioner/local doctor	38.0	47.2	39.6
Local community health centre/clinic	29.6	37.5	31.0
Drug and alcohol services	10.9	20.8	12.6
Traditional healer/medicine	2.0	0	1.6
Other	2.8	9.7	4.0
None of the above (last 12 months)	41.5	30.5	39.6
Never accessed health care	5.1	2.7	4.7
No response	0.5	1.3	0.7

* Individuals could have used more than one health service.

Participants who expected to be released from custody within two years of their interview were asked about their expectations regarding health service use in the first two months after release. Almost all (93 per cent) said they would attend a health professional in the two months following release (Table 6.4).

Table 6.4 Anticipated attendance to a health professional (post custody) by gender

(%)	Male (n=245)	Female (n=45)	Total (n=290)
Yes	94.3	88.9	93.4
No	2.9	8.9	3.8
Don't know	2.8	2.2	2.8

Among participants who expected to be released from custody within two years from their date of interview, nearly 60 per cent stated they planned to access mental health services in the first two months post-release, while just over 40 per cent did not know if they would attend mental health services (Table 6.5). This was higher for men (46.4 per cent) compared with women (20 per cent). One in four (25 per cent) stated that they planned to access a community mental health service (33 per cent of females) and almost one in five (19 per cent) intended to access a counsellor.

Table 6.5 Mental health service use (post custody) by gender

(%)	Male (n=157)	Female (n=40)	Total (n=197)
Psychiatrist	12.7	20.0	14.2
General practitioner	10.1	15.0	11.1
Community mental health services	22.9	32.5	24.8
Inpatient mental health services	1.9	0	1.5
Counsellor	15.9	32.4	19.2
Support group	10.3	15.0	11.2
Traditional healer	1.2	2.5	1.5
Other	7.0	20.0	9.6
Unknown	46.4	20.0	41.1

Similarly, participants who expected to be released within two years from the time of interview were asked if they planned to access general health services within two months of their release. Two thirds (66 per cent) stated that they planned to go to their local doctor/general practitioner, and more than half (57 per cent) planned to access their community health centre. More than one in five (22 per cent) planned to access a drug and alcohol service, although this was more common among females (34 per cent) than males (20 per cent) (Table 6.6).

Table 6.6 General health service utilisation (post custody) by gender

(%)	Male (n=224)	Female (n=44)	Total (n=268)
Local doctor /general practitioner	67.4	59.0	66.0
Community health centre	57.1	54.5	56.7
Local community clinic	17.8	6.8	16.0
Drug and alcohol services	20.1	34.0	22.4
Cultural healer	3.5	0	2.9
Other	1.7	6.8	2.6
Unknown	8.0	9.0	8.2

Post release expectations

Participants who expected to be released within two years of the date of their interview were asked a series of questions about their expectations regarding their release and the post-release period. Specific questions addressed expectations regarding accommodation, employment and income.

Sixty-four per cent of participants expected to be released within two years of the date of their interview. The proportion expecting to be released within two years was similar for males and females however, 30 per cent of females and 19 per cent of males were uncertain about their release date (Table 6.7).

Table 6.7 Expected date of release by gender

(%)	Male (n=347)	Female (n=72)	Total (n=419)
Over 2 years	17.0	7.1	15.3
Within 2 years	64.4	62.8	64.1
Uncertain	18.5	30.0	20.4

Among those who expected to be released within two years (n=290), almost one in five (18 per cent) said that they were worried about returning to the community; similar proportions of men and women expressed worry about their return to community (Table 6.8).

Table 6.8 Worried about returning to community post custody by gender

(%)	Male (n=245)	Female (n=45)	Total (n=290)
Yes	17.6	20.0	18.0
No	80.2	80.0	79.6

Participants who expected to be released within two years were asked what type of accommodation they expected to be living in during the first two months post-release. Just under a third (31 per cent) expected to return to their usual place of residence, and more than a third (36 per cent) expected to live with a relative. More than 1 in 10 said that they either would have nowhere to go, or didn't know where they would be living (Table 6.9).

Table 6.9 Type of accommodation post custody by gender

(%)	Male (n=245)	Female (n=45)	Total (n=290)
Return to usual residence	31.2	26.6	30.5
Home of a relative	37.8	28.8	36.4
Home of friend	5.7	2.2	5.2
Hotel/motel	2.4	8.8	3.4
Have nowhere to go	1.2	2.2	1.3
Other	2.4	11.1	9.3
Not known	8.2	15.5	9.3

Participants were also asked whether they planned to seek employment in the first two months after release from custody, and what source(s) of income they expected to have. More than four out of five participants (83 per cent) stated they would seek employment within two months of their release, although this proportion was higher for males (85 per cent) than for females (73 per cent). More than half (57 per cent) expected to be in full-time work, however more than half also expected to be receiving social security payments (52 per cent). More men than women expected to be in full-time work (63 per cent versus 27 per cent), whereas more women than men expected to be receiving social security payments (67 per cent versus 49 per cent) (Table 6.10).

Table 6.10 Expectations regarding employment and income (post custody) by gender

(%)	Male (n=245)	Female (n=45)	Total (n=290)
Plan to seek employment			
Yes	84.7	73.3	82.9
No	11.1	20.0	12.5
Don't know	5.7	6.6	5.9
Source(s) of income			
Social security payment	49.3	66.6	52.0
Full-time work	62.9	26.6	57.2
Part-time work	15.2	20.0	15.9
Friends or family	1.6	11.1	3.1
Criminal activity	1.2	2.2	1.3
Don't know	3.2	0	2.7
Other	2.0	6.6	2.7

Consultation—qualitative results

Participant consultation

Participants were asked about the impact of the custodial experience on their quality of life and their social and emotional wellbeing. They also provided advice about things that could be done to improve their circumstances. There were six major themes arising from the analysis of their comments.

1. Likes and dislikes of custodial life

There were discordant views and differing perceptions expressed by the participants when it came to the influence of custodial life on social and emotional wellbeing. The main dislikes of custodial life were separation from family in the community, and the lack of intimacy, companionship and freedom, as well as the experience of boredom.

Prisoners emphasised that separation from their family and loved ones was a significant stressor. The experience of a loss of freedom and lack of privacy was distressing. Participants, particularly the remanded population, highlighted the lack of stimulation and capacity to engage in activities, including cultural activities, contributed to distress (Box 1).

Box 1: Dislikes of custodial life

I fear for the safety and health of my family outside....(male prisoner)

I hate being out of control of my own life and the life of my children....(female prisoner)

.....being locked up ....like a cage...screws running my life....(male prisoner)

...not being able to go the movies and having a beer...not being able to work....(male prisoner)

There is nothing to do in here.....not enough courses, not enough work....just stuck in your cell with nothing to do...(male prisoner)

Education in here is more geared towards the western way, when you try and bring culture into educational programs... they say it is an excuse....the system here is back to front. Program facilitators are mostly white, they use big words that puzzle us, they try and trap you with their big words....(male prisoner)

Although participants disliked being in a correctional facility in general, they identified some aspects of custodial life that they found beneficial and enjoyable. This included the relationship with friends and family. Among the 419 participants interviewed, 71 per cent had a family member in custody at that point in time. Participants commented that friends and family was their support network while in custody and that the time in custody provided an opportunity to reunite with family and friends, including people met in juvenile detention.

The benefit of removal from the community environment with ready access to alcohol and drugs, and having time to reflect on past experiences and life choices, was considered to have some positive benefit. A number of participants also identified that they felt less stressed in custody as the difficulties related to access to food and shelter were reduced and having some access to education and sport was enhanced.

Box 2: Likes of custodial life

...having some similar girls to actually listen....(female prisoner)

...having lots of mates here from juvie...I grew up with them....(male prisoner)

....being alive.....away from drugs....(male prisoner)

..keeping myself healthy...away from drugs and alcohol....(female prisoner)

There is a lot of time now to examine life and make clear plans....(male prisoner)

I have a better appreciation for life and better attitude towards other people ....(male prisoner)

No family problem, no domestic violence problem, no female problem, no money problem....(male participant)

I sometimes feel safer in here....(female prisoner)

I like working during the day and studying at night...helps me pass time....(female prisoner)

Have more programs to help people with drug and alcohol programs, help them get jobs, traineeships so that they don't reoffend and help them stay out of jail....(male prisoner)

2. Issues related to mental health workforce and services—general awareness about mental health

Participants expressed a need for programs to create awareness about mental health for both correctional officers and prisoners. They believed misunderstanding of mental health problems could lead to punitive actions from staff and aggression from other inmates (Box 3).

Box 3: Awareness of mental health

Better the perception of mental health to Indigenous people—make it less scary....(female prisoner)

...being allowed to feel sad or upset without being thrown into an observation unit....(female prisoner)

Participants were consistent in the view that access to Indigenous mental health professionals was important and needed as this would enhance engagement with mental health services and the understanding of mental health. Accessibility was another issue that was addressed and many participants complained that there were long wait times for services which made it difficult for them to access mental health care (Box 4).

Box 4: Need for more Aboriginal and Torres Strait Islander mental health professionals

We need more Murri counsellors and psychiatrists in here to talk to us, as they understand where we come from and help deal with language and cultural issues.... (male prisoner)

Need more people who understand language working in here, need Torres Strait Islander workers that know how to speak language....(male prisoner)

3. Support needs and concerns related to the transition of people back to the community

Participants were concerned about lack of preparation for the return to the community in relation to accommodation, finances and travel. They feared that this lack of preparation may be associated with re-offending. Some participants were worried about the reaction of the community when they returned (Box 5).

Box 5: Worries about getting back into the community

Just going home and trying to re-establish myself again....because a lot's gonna be different...it won't be the same....(male participant)

Where will I stay? I don't know my way around.... (female prisoner)

Participants highlighted the desire and need for support in returning to the community. Participants identified support from the community through Elders, community and government organisations, and Indigenous liaison officers as important. Participants on remand also expressed the view that they should be given access to pre-release programs (only available to sentenced prisoners) to help reduce their risk of re-offending (Box 6).

Box 6: Need for support system to assist transition

We need Indigenous transition officers to assist with jobs, housing, and programs to get into the community.... (male prisoner)

Set up a support mechanism outside....where they can feel a sense of belonging...so that they don't see jail as a place for social gatherings.... (male prisoner)

...halfway houses for better transition into the communities....(female prisoner)

4. Issues relating to assistance with legal representation and education

Participants expressed the need more Aboriginal and/or Torres Strait Islander people working within correctional centres to help their understanding of, and interactions with, legal proceedings and parole processes (Box 7).

Box 7: Legal representation and education

We need more Indigenous custodial officers.... (female prisoners)

More field officers from Aboriginal and Torres Strait Islander legal services to come in and help us with legal and family stuff like they used to.... (female prisoner)

We need more courses to educate us on parole and court sentences.... (female prisoner)

5. Role of cultural awareness and cultural services

Most of the participants identified as a priority. The need for cultural awareness programs for custodial officers and health professionals. Many participants also expressed the need for services and programs that were more culturally appropriate in order to improve their capacity to understand and benefit from programs (Box 8).

Box 8: Cultural awareness and cultural services

Cultural awareness training should be given to non-Indigenous staff of corrections....(female prisoner)

Prison staff and health staff need to be given culture education and history lessons as they need to have a better understanding on what we go through as Aboriginal people....(male prisoner)

6. Need for internal and external support systems during time in custody

Separation from family and community was a recurrent concern raised by participants. They highlighted the challenges associated with distance and travel that families and community members faced when trying to visit. It was felt that support was required to facilitate family and community visits. The importance of Elder visits was particularly highlighted. Mentorship programs with prominent members of the communities were considered beneficial by many participants. Participants also expressed that they would like to be housed with people from their own communities, so that internal support networks could be enhanced (Box 9).

Box 9: Support systems during time in custody

Get Elders from all areas to come to centres...not just one specific community....(male prisoner)

We need buddy system like Community + Prisoner and Prisoner + Prisoner.... (male prisoner).

More visits for families...more than once a week ...especially for those with babies more support....(female prisoner)

Consultation with Community

Consultation was undertaken to obtain views from communities about the key challenges faced by Indigenous people in relation to custody and possible and ways to address these challenges. The comments from the communities are categorised into three main themes: mental health issues and awareness; cultural identity and awareness; custody and community support.

1. Mental health issues and awareness

Community members highlighted the lack of access to mental health care available in the communities. They also reported that there was an urgent need for mental health awareness programs to be delivered to the communities, especially for the family members of people with mental illness. They reported the issues of substance misuse, particularly amongst the young, needed to be a focus of intervention (Box 10).

Box 10. Mental health issues and awareness

We need to promote better understanding of what mental illness is about with members of family and community...(Community member B)

...there appears to be an increase in drug-induced psychosis in the community...especially with the young ones. We need support services and facilities to cater for those in need...(Community member C)

2. Cultural identity and awareness

Culture and spirituality were identified as being central to good mental health. Communities wanted culturally appropriate mental health services that used a holistic view of health. Involvement in community cultural activities was seen as central to the healing process (Box 11).

Box 11. Cultural identity and awareness

Culturally designed and culturally accepted programs ...must be long term not short term and have adequate funding and resources to keep them going (Community member A)

Lack of identity—confusion and shame, this needs to be addressed (Community member B)

...issues need to be addressed holistically...(Community member C)

3. Custody and community support

Community members were eager to support people back into the community. They stressed the importance of providing mentorship and Elder support to those returning from custody, particularly younger members of the community. Community members identified an awareness and understanding of the challenges that people face upon their release from prisons (Box 12).

Box 12. Support within communities

Nurturing, guidance and support need to begin with our children, so that they don't end up in custody (Community member A)

...we need better understanding of the concept of jail....need to have empathy not sympathy...(Community member B)

Community members identified the importance of partnerships between justice, community and health organisations in the successful transition of individuals leaving custody. They reported that any government or non-government organisation involved in the transition period needed to consult with community members to engage support. Community members made the point that incarceration rates were symptomatic of the broader social problems faced by Indigenous people and that a focus on the causative factors was central to reducing incarceration. They also expressed the belief that support programs for Indigenous people leaving custody were under funded and would need to seek Indigenous leadership to be successful (Box 13).

Box 13. Support from outside

All key stakeholders, like Queensland Health, Police, non-government organisations such as community justice groups (Lena Passi and Mura Kosker) and community health action groups and government bodies need to get together and work together to address these issues (Community member A)

....need to look at the cause and why or what has affected them that brought them before the court system and criminal justice system....(Community member B)

Discussion

Overview

This report for the first time, has described key aspects of the social and emotional wellbeing of a sample of Indigenous Australians in custody. The knowledge and experience of the Indigenous people in custody and the Indigenous communities has been drawn upon, using both quantitative and qualitative methods to help articulate the challenges faced by people prior to and during incarceration and when transitioning from custody. The research findings and consultation processes have provided critical information that can be used to inform and improve the delivery of mental health services to Indigenous people in custody.

One of the key strengths of this research has been the involvement of Indigenous people in all areas of the research process and the involvement of communities through extensive consultation. This has helped to ensure the research has been conducted in a culturally appropriate and respectful manner. Inevitably the challenge of using methods that have not been specifically designed for Indigenous people had to be faced however, where possible, the research has been adapted to ensure it is culturally congruent, while maintaining methodological rigour. Culturally-based measurement bias is a challenge that many researchers have had to address in order to progress research in this field. It is hoped that through extensive consideration of Indigenous knowledge, and involvement of Indigenous people this research has demonstrated that methodological rigour and culturally appropriate research can co-exist, and indeed that research about Indigenous people should not occur without Indigenous people.

The research identified an extremely high prevalence of major mental disorders, substance use disorders and suicidal ideation amongst the people sampled. Many individuals reported frequent experiences of custody, not only as an adult but also as a youth, and also reported that custody was a common experience amongst their families. Individuals reported high levels of social adversity and limited use of health services prior to custody, high rates of substance use associated with offending, limited benefits from the custodial process, and unresolved challenges when contemplating their return to the community. In all, the findings revealed a group of people for whom poor social and emotional wellbeing was a common experience.

Nevertheless, most participants reported a strong affiliation with their culture and community, and communities reported an eagerness to assist their kin in their transition from custody. While this gives cause for hope, the lack of available services accessible to Indigenous people for both major mental health problems and substance use disorders, was a common theme reported by both the individual participants and their communities. It would appear that, despite recognition of the problems faced by Indigenous people in relation to incarceration, there remain a large number of Indigenous people in custody with major mental health problems and limited access to appropriate care.

Limitations of this research

This sample is likely to be representative of the general Indigenous custodial population in Queensland. A systematic sample of 25 per cent of Indigenous males and nearly a two thirds sample of Indigenous females was obtained. This research had a relatively large sample size for Aboriginals however, the sample size for both Torres Strait Islanders and those who identify as both Aboriginal and Torres Strait Islander was smaller. While this is likely to be a reflection of the general population distribution, it is possible that these populations were under sampled, as they may have been disproportionately represented in the northern Queensland correctional centres. The sampling strategy for males should have led to the appropriate proportional representation of these groups and as all attempts were made to interview all females, it is unlikely that these groups amongst females was under sampled.

It is important to recognise that females represent seven per cent of the custodial population [22]. Thus, despite attempts to ensure that all females in custody during the period of research were included in the research, the sample of females compared to males was relatively small. Any bias inherent in the sample may have been reflected in the findings. This highlights the importance of further research with Indigenous females in custody.

The research team found the use of the CIDI-A was challenging but useful for an Indigenous population in custody. The interview design of the CIDI is not compatible with the 'yarning' style often appropriate in the assessment of Indigenous people [41, 42]. It was the experience of the research team that by using Indigenous interviewers and training them thoroughly in the use of the CIDI-A, they were sufficiently familiar and comfortable with the instrument to explain its style and purpose to the participants, enabling participants to feel comfortable to engage in the interviews. Nevertheless, the use of an instrument that has not been validated amongst an Indigenous population raises the possibility of measurement bias. The research team, like other Australasian researchers studying mental illness in community and custodial settings [26, 27, 38], accepted this limitation as being presently unavoidable.

Conducting research with people in a custodial setting also raises challenges. The issue of false, misleading or inaccurate self report must be considered. Through ensuring that participants understood the issues of confidentiality and the separation of the research process from the custodial process, it was felt that the likelihood of perceived benefit through the provision of misinformation was negligible. The researchers attempted to minimise recall bias by the use of a 12 month prevalence estimate, and most questions related to time frames proximal to the interview. However, given that the research was interested in a number of issues that occurred prior to custody, it was necessary to rely on people's recall, and thus introduce the risk of recall bias. In order to overcome this limitation, longitudinal studies of Indigenous people moving through the criminal justice system will be necessary.

Sampling is a major difficulty in the custodial setting. One way to eliminate some of the difficulty is to sample consecutively only those people who arrive in custody during the period of data collection. This option was not suitable for this study given that samples were required from multiple centres over a vast geographical region at different periods in time. Also, this research was interested in not only the remanded population, but also the sentenced population, as this research was designed to inform models of service delivery to all Indigenous people in custody. It was necessary to investigate issues related to individuals' custodial experiences and pre-release challenges, thus it was critical to sample both sentenced and remand populations.

One of the challenges faced in sampling was the dynamic nature of the custodial population. For example, not all those who appeared on the nominal role at the time the sample was determined were available, or even in custody, during the data collection phase. Nevertheless the participation rate was quite high with more than 70 per cent of males and 80 per cent of females. A limitation of this study was the capacity to compare this sample to the entire Indigenous custodial population. This could not be accurately achieved as data collection occurred over an eight week period and, as is characteristic of custodial populations, new people were recepted, while others were moved and released every day. This challenge and the risk that it posed to the generalisability of our sample had to be accepted. However the research team is confident that a sufficiently large sample size from the major custodial locations was obtained, and the sample size was representative of the Indigenous custodial population.

Research findings

Most participants were young, unemployed, and had not progressed beyond a Year 10 education. Two thirds of the males and half of the females were sentenced; the remainder of the sample were remanded in custody. At the time of interview, more than 80 per cent of males and around three quarters of females had been in custody on more than one occasion; most of the females and nearly half of the males had spent time in custody as a youth (aged 16 or less). Most participants also had family and friends in custody at the time of this survey. Over a quarter of males and females were either confident that they would return to custody, or unsure if they

could remain out of custody. These findings are a sad reflection of the devastating rates of incarceration among Indigenous people in Australia, and the associated social disadvantage.

Mental health

The IRIS is a screening tool that was included in this project not to identify those with mental health or drug and alcohol problems, as every participant underwent mental health and drug and alcohol assessments, but rather to examine its potential use as a screening tool for Indigenous people in the custodial setting. Application of the IRIS found that around half of the male and two thirds of the female sample were high risk in relation to mental health problems and most of the sample was high risk in relation to drug and alcohol problems. The IRIS findings are yet to be compared against the diagnostic findings, however the results appear congruent and while further work is required, the IRIS may be a useful screening tool for the identification of Indigenous people in custody who are at high risk of mental health or drug and alcohol problems.

Mental illness

This research demonstrates that the prevalence of mental illness amongst Indigenous people in custody is much higher than among the general population. To help contextualise these findings were contrasted with the 12 month Australian population prevalence estimates. For both men and women, the prevalence of all mental disorders was markedly higher among Indigenous prisoners than among the general population; this was particularly true for women, and particularly with respect to substance use disorders, and psychotic disorders.

It is acknowledged that the accuracy of any comparison between the Inside Out sample and the national studies is limited by the difficulties of identifying an appropriate comparison group: issues of age standardisation, cultural congruence and controlling for important covariates such as socio-economic position have not been considered. Different methods have also been used to estimate the prevalence of psychosis. Despite these limitations, the differences in gross comparison are so dramatic that they bear examination. Importantly, issues of comparison groups aside, the findings draw attention to the relative mental health needs of Indigenous people in custody.

The prevalence of mental illness in this study was extremely high, but was not unexpected, given the prevalence of mental disorder found amongst other custodial populations [27, 28]. Further work is required to compare the findings of this study with those of other custodial populations. Of particular note in this study were the extremely high rates of alcohol and cannabis misuse, PTSD and psychosis. There was also a disproportionately high rate of mental disorder amongst women, and this has also been observed in other custodial populations [20, 27, 43]. Using a culturally appropriate method, to the Inside Out research confirms that the rates of mental illness amongst Indigenous people in custody are very concerning.

Of particular note in this study is the high prevalence of psychotic disorder amongst both men (eight per cent) and women (25 per cent). Particularly for women, the prevalence is orders of magnitude higher than that reported for the community. We used a gold standard method to determine the presence or absence of a psychotic disorder, with screening merely the first step in a comprehensive three-step method. The researchers are confident that the high rates of psychotic disorder described in this study are not over estimated, and approximate a true or slightly conservative reflection of the prevalence of psychotic illness in this population. There is the suggestion that the findings could be conservative as only those who screened positive were further assessed (false negatives are likely) and some people who were judged too unwell to interview may well have been psychotic.

People with psychotic disorders experience high rates of illness morbidity such as functional impairment and disability, persistent symptoms, drug and alcohol comorbidity, social adversity and illness relapses [44, 45]. Similarly, the demands on services are significant, and require responses and partnerships from multiple services in the community. To compound this, assessing psychotic illness amongst Indigenous people is particularly complex [30, 31] as found in this study, and requires a culturally informed method.

Suicide

This research found that over a quarter of all men (28 per cent) and over half of all women (53 per cent) in the sample had thought about suicide at some stage during their life, by comparison, the prevalence estimate of lifetime suicidality in the Australian population was just over 13 per cent [26]. In the Inside Out sample nearly 20 per cent of men and a third of women had attempted suicide; the estimate for the Australian population was 3.3 per cent [26]. While these figures are very concerning for any mental health service, it must be understood that suicide is a significant public health problem for Indigenous people irrespective of whether they are in custody or not [19, 46-48]. This is reflected in our study in the findings of this research that most of the men and women in the sample had experienced the death of a family member or friend by suicide.

Suicidal ideation was described as 'worst' for the sample when they were in the community, and the majority of people who had attempted suicide did so in the community. These findings, coupled with other findings in this study and the extremely high rates of mortality amongst Indigenous people in the period shortly after their release from custody [49], support the premise that the transitional period from custody to the community is a period during which individuals are particularly vulnerable from a mental health perspective.

Substance use disorders

Not surprisingly, the research found an extremely high prevalence of substance use disorders among the sample, with the vast majority experiencing substance dependence. The major contributor to this was alcohol dependence. While further analysis is required, the preliminary findings suggest that co-morbidity between mental illness and substance use disorders is likely to be high. While there is a clear need for culturally appropriate alcohol and drug services for Indigenous people in custody the findings suggest that this cannot be separated from mental health services.

The problems associated with relapse of substance misuse following release from custody [49] for Indigenous people are substantial and cannot be ignored. This was evident in this study as very few participants reported accessing alcohol and drug services in the community, most participants attributed alcohol and drug use to their offending and most anticipated returning to substance use after their release.

Social and emotional wellbeing

Some of the aspects of social and emotional wellbeing not covered in other areas, such as culture, exposure to significant upsetting experiences, and expressing emotions, were addressed in this section. Like many Indigenous people in the community, many participants in this survey reported exposure to upsetting experiences and racism. Many described sharing emotions as difficult, and most reported a preference to have someone from their own culture to do this with (over 70 per cent of males and 50 per cent of females). It was encouraging to note, however, that most participants indicated a strong sense of cultural identity and practice, a finding that supports the importance of culturally appropriate services, a theme that was clearly articulated in the Royal Commission into Aboriginal Deaths in Custody [12] nearly two decades ago.

Health service access and transition to the community

Participants were asked about their access to health services prior to custody. While most reported that they knew how to access health services, relatively few were accessing these services. Given that this study found a very high prevalence of major mental illness amongst the sample, it is concerning that fewer than 10 per cent of males and just over 15 per cent of females had seen a psychiatrist in the community (particularly given the high prevalence of psychotic disorders) and also that only around two per cent had accessed inpatient mental health treatment in the 12 months before they came into custody. It is encouraging that around 40 per cent of participants had attended a general practitioner, and 30 per cent had attended a community health clinic however, an equal proportion reported no health service contact.

Importantly, many participants planned to use general health and mental health services when released. Many reported the desire to seek work and most had accommodation plans. These findings are positive as they support the well established view that culturally appropriate transition support programmes for Indigenous people leaving custody have significant potential [50].

Consultation

Participants were generally eager to share their views about custody and mental health services. The inclusion of qualitative data and community consultation was important; qualitative research offers unique insight into social, emotional and experiential phenomena in health care [51]. The qualitative data enhanced our capacity to construct a social reality for the participants. Not surprisingly, people described the boredom and isolation of custody as extremely challenging. Many reported enjoying access to education programs. A theme congruent to other findings in this report was the desire to access mental health services, but difficulties negotiating this process. People also emphasised the need for culturally appropriate services, cultural awareness training for non-Indigenous staff, and a clear concern and desire for support during the transition process back to the community.

The community consultation process highlighted several key themes that were consistent with many of those raised by the individual participants, and evident in the research findings. People described an eagerness to assist others from their communities who have been incarcerated; for many, this included close family members. Key issues included the strong view that culture was important to the healing process, and must be incorporated in a positive manner into the custodial experience. Support through Elder visits and community participation in cultural activities with people in custody were examples described of how this could be achieved. An emphasis was also placed on community mental health awareness programs and support for people when they are transitioning back to the community.

Summary

This study has described in detail for the first time, using a culturally appropriate method, many of the social and emotional wellbeing challenges faced by Indigenous people in custody. The nature of the findings are not only consistent across the quantitative and qualitative areas of this research, but echo the views of others who have worked with Indigenous people in custody and their communities, or with Indigenous people in the justice and mental health systems.

There is an extremely high prevalence of mental illness and substance use disorders amongst Indigenous people in custody. This is the case for males and females of all ages, however, females stand out as a particularly vulnerable group. The research highlights some key themes including the high rates of co-occurring mental health and drug and alcohol problems, the importance of culture in the health context and the critical nature, from a mental health perspective, of the transition period between leaving custody and returning to the community. The findings of the research also reinforce the need for a holistic mental health perspective as it seems simplistic to isolate the issues of social adversity, cultural needs, mental illness and substance misuse.

This research and other epidemiological studies of the health of people in custody and in their transition back to the community have described the overall nature, type and extent of health challenges for people in custody. It is the view of the researchers that future research initiatives must be based on assessing interventions targeted at improving the health outcomes for people, both in and leaving custody.

The findings of this research have been used to articulate key areas that should be considered in service planning for Aboriginal and Torres Strait Islander people in custody in Queensland and will inform the development of a model of mental health service delivery to Indigenous Australians in custody in Queensland. The unique information gathered by this research can also be used more broadly to help inform service planning for Indigenous people in custody across Australia.

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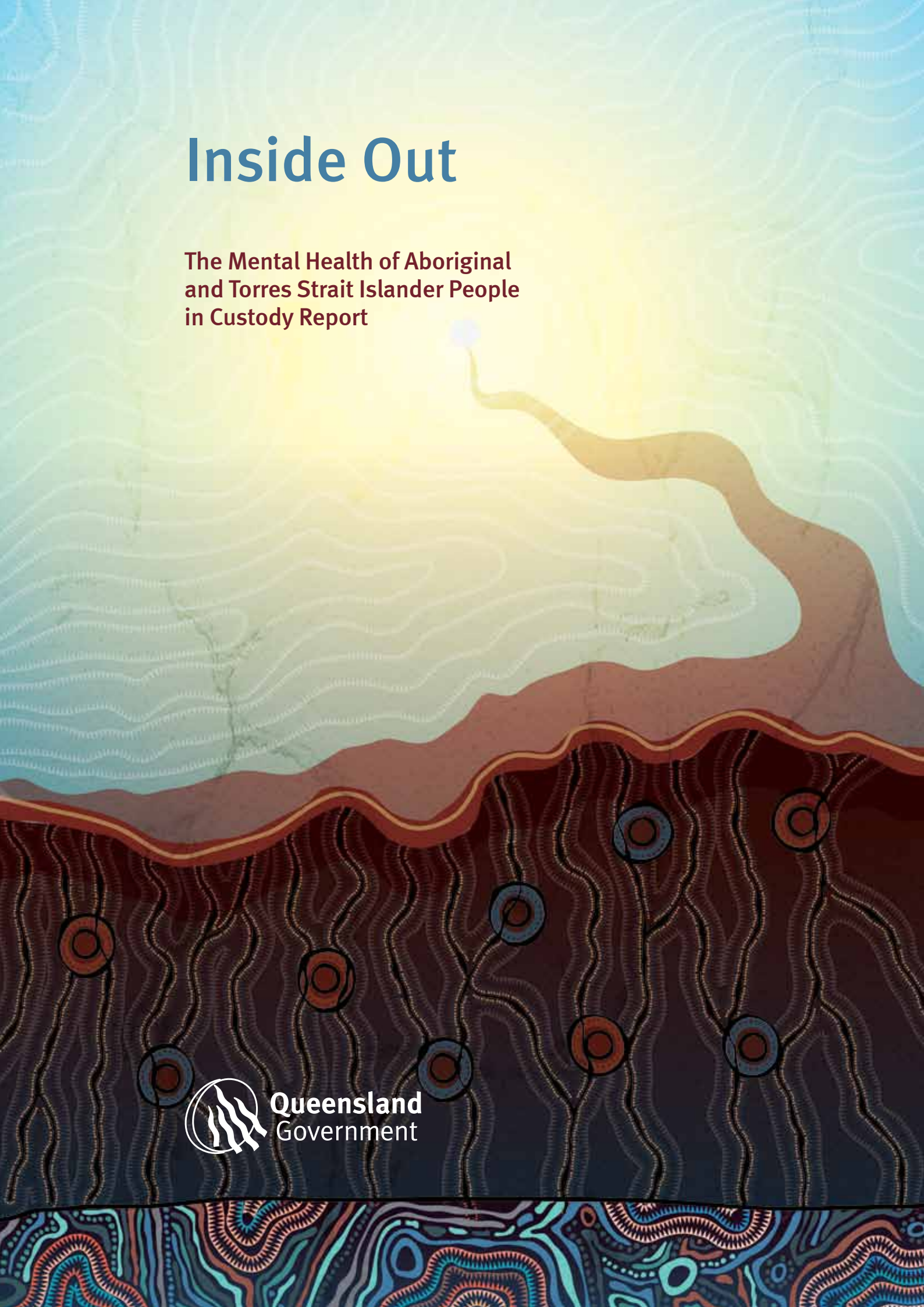
Notes

Notes

Inside Out

The Mental Health of Aboriginal and Torres Strait Islander People in Custody Report



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