

‘The invisible barrier’: Mental illness as a mediator of mothers’ participation in the Victorian Criminal Justice System

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Bachelor of Behavioural Science

Bachelor of Social Work (Honours)

A thesis submitted for the Degree of Doctor of Philosophy

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Monash University, Melbourne Australia

2016

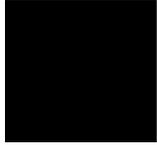
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Alannah Burgess

6th of May, 2016

Dedication

This thesis is dedicated to my grandfather

James McVicar

10th of June, 1923 – 16th of March, 2012

His love, strength, and encouragement helped shape the woman I am today

Acknowledgements

First and foremost, I'd like to thank the 40 imprisoned mothers who sat down with me, and over the course of a year, let me have a glimpse into their lives. This experience not only provided me with an opportunity to research an area of interest and obtain a PhD qualification, it allowed me to self-reflect and grow as both a researcher and as a human being.

This study could not have been completed without the help of the staff at the Dame Phyllis Frost Centre (Aneta Domazetovska, Samantha Ryan, Elissa Simon and Regina Kostyk), Tarrengower Prison (Ellen Storey and Emma Cole), and at Thomas Embling Hospital (Lisa Wright and Martine Bramwell) who took time out of their day to assist this study, and answer all my questions. I'd also like to thank Melanie Field-Pimm and Genevieve Anderson from VACRO, Ben Thompson from Prison Fellowship Victoria, and Michael Wells from SHINE for Kids who provided a wealth of information. Thank you all.

I would also like to thank my three supervisors, Catherine Flynn, Chris Trotter, and Kay McCauley. Catherine, who found a young social work student with a very slight liking of research, and through her patience and direction, turned this into a love. Words cannot express how much I appreciate all that you have done for me. Thank you to Chris Trotter who provided invaluable direction on the analysis for this study, and to Kay who assisted me in writing my methods chapter and directed me to some wonderful resources for mixed methods research.

I am incredibly grateful for the Australian Postgraduate Award Industry (APAI) Scholarship I received for the first three years of this PhD. I am also incredibly grateful to my aunty Jean who proofread this thesis.

I would also like to thank my family, especially my mum. Without her love and support there is no way that I could have undertaken this PhD, especially after the scholarship ended. This PhD is every much hers as it is mine. To my brother Tom and his wife Elise who provided little surprise presents over the years that often brought me to tears. Thank you. 'Pleasant Alannah' will finally be back!

A special mention should go to my friends, especially Katie and Adrienne, who put up with a lot over the duration of this PhD. Thank you for providing a listening ear and for all the hugs.

I feel that I should also conclude these acknowledgements with mentioning a special thank you to Loudon Swain, whose music kept me company while this thesis was written. As the lead singer Rob Benedict once said, “writing is hard” but it’s manageable with company.

Abstract

In line with international trends, women represent Australia's fastest growing prison population. They also represent a resource intensive population as women who enter the criminal justice system come with a wide variety of interlinked individual, social, and systemic challenges, most notably high rates of mental illness. Furthermore, a large number of imprisoned women will also be mothers to dependent children. Despite the growing body of knowledge surrounding imprisoned mothers and women who have a mental illness, knowledge about women who straddle this divide appears to be missing. They are relatively invisible in terms criminal justice policy, and practice as well as research.

In order to address this gap, this study examines the experiences of mothers with a mental illness, as they navigate Victoria's criminal justice system, to plan the care of their children. This study focuses on mothers' experiences at the critical care planning decision-making points of pre-prison, arrest, sentencing, and imprisonment. An exploratory embedded mixed methods approach was used, gathering both quantitative and qualitative data from mothers using a structured interview schedule. Data gathered from 21 imprisoned mothers with a mental illness was triangulated with data gathered from 19 imprisoned mothers without a mental illness. Interviews took place at Victoria's two female prisons, the Dame Phyllis Frost Centre and Tarrengower Prison, and within the community. The quantitative data was analysed using descriptive, non-parametric statistics, and Chi-square tests. The qualitative data was analysed using thematic and content analysis in order to develop themes and map the women's experiences.

The findings show that mothers with a mental illness, especially those who have severe mental health issues, have lower levels of involvement in planning their children's care, compared to mothers who do not have a mental illness. This is due to the individual issues experienced by these mothers intersecting with a criminal justice system that typically does not acknowledge or respond to them in any significant way. This group of women are therefore disadvantaged by both their gender and their mental health status. With mothers typically remanded into custody, this represents a crisis for the family unit; there is no time to plan, and significant others have to step in to make the care decisions. The majority of children have no care plans in place at the time of their mother's imprisonment. Arrangements that are made often become unstable over time. This study shows that mental

illness has a significant impact on this group of mothers' engagement with and participation in the criminal justice system to plan their children's care.

This study has important implications for criminal justice policy and procedure. It highlights the importance of responding to complexity within correctional populations, and provides evidence for the need to incorporate gender-responsive practice at the stages of arrest and sentencing. This study represents the first Australian study to examine the experiences of mothers with a mental illness as they intersect with and move through the criminal justice system.

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Chapter One: The Introduction

“It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones.”

Nelson Rolihlahla Mandela

1.1 Study background

Over the past decade, women have represented Australia’s fastest growing prison population. Since 2005 the total number of Australian female prisoners increased by 66% (from 1,735 in 2005 to 2,876 in 2015). In contrast, the total number of male prisoners increased by 41% for the same time period (from 23,624 to 33,256) (Australian Bureau of Statistics [ABS] 2015). This trend mirrors that in other jurisdictions around the world (Walmsley 2015). Despite these increases, female prisoners continue to make up a smaller proportion of any given prison population (between 2% to 9%) (Walmsley 2015), with Australia’s female prisoners representing approximately 8% of the total prison population (ABS 2015). Yet female prisoners are a resource intensive population despite their small size. This is because women enter with a wide variety of interlinked individual, social, and systemic challenges (McIvor 2007). For example, research has documented high levels of social exclusion (Murray 2007), economic marginalisation (Baldry et al. 2006; Holtfreter, Reisig & Morash 2004), substance use (Johnson 2004a), poor mental and physical health (Australian Institute of Health and Welfare [AIHW] 2010; Tye & Mullen 2006), and childhood and adulthood trauma (DeHart 2008; Greene, Haney & Hurtado 2000; Johnson 2004a; Messina & Grella 2006; Messina et al. 2007). Medlicott (2007, p. 250) calls these the “multiplicity of disadvantage and damage,” noting that the challenge of responding to such multiple and often interlinked issues is “both immensely difficult and immensely sad” (p. 253). Indeed, the high level of mental illness found within this population represents one area of concern.

1.1.1 From the asylum to prison: Imprisoning women with a mental illness

Reflecting both Australian and international research, the rates of psychiatric morbidity in the criminal justice populations are higher than the rates found within the general community (Butler et al. 2006; Tye & Mullen 2006). This trend is evident at all stages of the criminal justice process: in arrestees (Baksheev, Thomas & Ogloff 2010; Ogloff et al. 2011), those who appear before the court (Richardson & McSherry 2010; Ross & Graham 2012), and those who are remanded and imprisoned (AIHW 2010; Butler et al. 2005, 2006; Fazel &

Danesh 2002; Fazel & Seewald 2012; Fries et al. 2013). Some researchers now describe prisons as proxy mental health institutions (Dalley 2014; Kinsler & Saxman 2007; van Wormer 2010), with Dalley (2014) attributing this rise to the deinstitutionalisation of those who have a mental illness, poor social policy, as well as the increasingly punitive response to offending. Kinsler and Saxman (2007) also suggest that under-funded and under-resourced community mental health services may also contribute to the re-institutionalisation of those with a mental illness into prisons.

More specifically, the rates of psychiatric morbidity is higher in female prisoners than male prisoners (AIHW 2010; Butler et al. 2005; Fries et al. 2013; Magaletta et al. 2009; Steadman et al. 2009; Tye & Mullen 2006). According to Mills et al (2012, p. 52) women “have more complex levels of mental health needs”. Indeed, a review of prisoner health within all Australian state and territory prisons found that female prisoners, compared to their male counterparts, are more likely to report a history of mental health issues; a history of self-harm; be currently on medication for a mental health issue; have higher levels of psychological distress upon entry into prison; and have higher overall levels of distress relating to their current imprisonment (AIHW 2010). In addition, mental illness is also interlinked with substance abuse and experiences of victimisation (Greene, Haney & Hurtado 2000; Johnson 2004a; Langan & Pelissier 2001; Lynch et al. 2012). Therefore, women are thought to experience prison more intensely than men (Mills et al. 2012) as the prison environment with its removal of autonomy, readjustment of social identities, and prison rules and procedures can exacerbate distress (Medlicott 2007). This is because mental health is not the core business of prisons, and thus often not able to effectively respond to the mental health needs of prisoners (van Wormer 2010). Mills et al. (2012) also highlighted that being in the role of primary caregiver to children may contribute to the high levels of distress experienced by female prisoners.

1.1.2 From the family home to prison: Imprisoning mothers

Approximately, one-half to two-thirds of imprisoned women are mothers (Glaze & Maruschak 2008; McIvor, Trotter & Sheehan 2009; Sheehan 2010). These women are more likely than imprisoned fathers to be living with their children prior to their arrest, be sole parents, rely on a wider network of people to care for their children during their imprisonment, and will typically resume the care for their children post-release (Glaze & Maruschak 2008). Therefore, imprisoned mothers have a greater level of direct parental responsibility (Glaze & Maruschak 2008; Healy, Foley & Walsh 2000, 2001), and for some,

imprisonment may represent the first time they are separated from their children (Medlicott 2007). Research has highlighted the extensive implications of parental imprisonment on a child's biological, psychological, cognitive, and social health and wellbeing (Murray & Murray 2010; Woodward 2003). With parental imprisonment associated with antisocial behavioural, substance use, poor mental health, and low educational achievement in children, amongst other issues (Murray, Farrington & Sekol 2012).

These poor outcomes may be associated with the cumulative nature of experiences prior to, and as the mother navigates the criminal justice system (Moses 2010). For example, studies have noted that when compared to children who experience their father's imprisonment, children of imprisoned mothers are more likely to witness their mother's arrest (Dallaire & Wilson 2010; Dallaire, Zeman & Thrash 2015; Kampfner 1995; Stanton 1980). The arrest process is often unexpected and chaotic, with little time to say goodbye, or plan children's short or longer term care (Dallaire & Wilson 2010; Phillips & Zhao 2010). Children are also more likely to witness their mother being sentenced and taken away to serve their sentence (Dallaire & Wilson 2010; Dallaire, Zeman & Thrash 2015). This experience may represent another stressor for children and their families (Dallaire & Wilson 2010), particularly because they may not understand the process (Murray & Murray 2010). Murray and Murray (2010) note that uncertainty around the outcome of the trial often ensures that families do not adequately plan for the future. This may explain why children are also more likely to experience vulnerabilities associated with their mother's incarceration as opposed to when their father is incarcerated (Murray & Murray 2010). They are more likely to experience disrupted care arrangements, be separated from siblings, and experience difficulties maintaining ties with their mother during her incarceration (Enos 2001; Flynn 2008; Poehlmann et al. 2008). Not only do children represent an additional source of stress for mothers, alongside mental health challenges, as they navigate the criminal justice system (Lilburn 2000a; Loper 2006; McIvor, Trotter & Sheehan 2009), children also come with their own unique needs and issues (Murray, Farrington & Sekol 2012; Murray & Murray 2010). Therefore, how the criminal justice system responds to mothers with a mental illness and their children becomes important. However, their distinct experiences represent a significant gap within the existing literature.

1.2 Significance and utility of this study: Calling attention to the intersections

This current study is part of an Australian Research Council (ARC) funded Linkage project (LP1101100084) 'The impact of incarceration on children's care: A strategic framework for

good care planning’ which examines the experiences of and responses to children when their primary carer mother or father is arrested, sentenced, and incarcerated in Victoria and New South Wales (NSW) (this study will now be referred to throughout as the ‘broader study’ for brevity). The overarching aim of the broader study is to develop best practice principles for care planning for children whose primary carers face imprisonment. This ARC project was supported by the Monash University Criminal Justice Research Consortium (CJRC) and a number of partner organisations: the Department of Justice Victoria¹, the Department of Human Services Victoria², the Commission for Children and Young People Victoria, the Victorian Association for the Care and Resettlement of Offenders (VACRO), SHINE for Kids, and Prison Fellowship Victoria. These partner organisations contributed financial resources to the broader study, and were involved in the conception, design, and implementation of both projects.

Building upon that broader study, this research looks exclusively at the experiences and responses to imprisoned mothers with a mental illness when they are arrested, sentenced, and imprisoned in Victoria. To date, their distinct experiences have received negligible attention within the research. For example, the issue of mental health is typically not considered in research investigating the experiences of imprisoned mothers and their children (Laux et al. 2011; Loper 2006). Similarly research into the experiences of mental health issues for female prisoners is often conducted independent of the woman’s’ mothering role; this is because the focus of such research has predominantly been on describing the prevalence of mental illness in the criminal justice system (Butler et al. 2005; Laux et al. 2011) as well as the associated programs and treatment needs (Laux et al. 2011). In this research, children typically represent another demographic characteristic of the woman (For example: Tye & Mullen 2006, p. 268), or an afterthought in the discussion. Whilst this focus has been important for understanding the overall numbers of prisoners presenting with mental health needs in order to inform service provision, research fails to consider the intersectionality and complexity that underpins this group of mothers. Addressing their parenting needs may smooth the transition into prison, reduce their levels of distress, and improve outcomes for their children (Lilburn 2000a; Loper 2006).

¹ The Department of Justice is now called the Department of Justice and Regulation as a result of the 2014 state election. However, this present study will continue to refer to it as the Department of Justice as this was the department’s title during this study.

² As the result of the 2014 state election, the Department of Health, and the Department of Human Services was combined to form the Department of Health and Human Services (DHHS) (DHHS 2015). However, this present study will continue to refer to the Department of Human Services as that was its title during the duration of this study.

Recognising the impact of mental illness as an additional stressor during this transition is highly relevant given that the 2012 review into Victoria's system for protecting children highlighted "children are most vulnerable when parents or carers suffer from mental illness, or drug or alcohol problems or are subject to... family violence" (Cummins, Scott & Scales 2012, p. xxxv). Reupert and Maybery (2007, p. 64) acknowledge that parents with a mental illness "require support and sometimes guidance with their parenting behaviours". Mothers with a mental illness may be less emotionally available, experience difficulties communicating and responding to children, and have difficulties setting boundaries, amongst other issues (Reupert & Maybery 2007). Their ability to parent is mediated by the severity of symptoms, medication use and the associated side effects, relapses, and hospital admissions (Blegen, Hummelvoll & Severinsson 2010). Similar to mothers who offend, parenting also occurs within a number of challenges such as economic marginalisation, stigma, and social isolation (Reupert & Maybery 2007). In response, the past two decades have witnessed the gradual incorporation of the needs of families where a parent has a mental illness into Victorian law, policy, and practice of the mental health system (Cowling 2004; Goodyear et al. 2015; Reupert & Maybery 2007), with a particular focus on assisting parents to develop care plans for their children in case of hospitalisation (Reupert, Green & Maybery 2008). Despite the sharing of similar characteristics such as shame and stigma, poor mental health, and separation from children due to institutionalisation (Moses 2010), only the parenting needs of those in the community are systemically responded to.

This provides a rationale for the focus of this study: the examination of the intersection of motherhood and mental illness for women facing imprisonment. This focus is supported by the broader study's partner organisations who as a result of their direct practice observations and experiences, identified that maternal mental illness was a major concern for service delivery. The rationale behind this study is that the criminal justice system cannot adequately respond to both the mental health and parenting needs of justice-involved mothers if they fail to take into consideration the complexity found within this group. Therefore, the underpinning aim of this study is to improve responses to mothers with a mental illness as they engage with and move through the criminal justice system. To formulate improved responses to this group, there is a need to understand their experiences within the criminal justice system. Therefore, this study represents the first step in this process. The core research question is: *What are the experiences of mothers with a mental illness as they navigate the criminal justice system?* With four subsidiary questions:

1. What are the similarities and differences in the experiences of mothers with or without a mental illness as they navigate the criminal justice system?
2. What is the relationship between mental illness and motherhood as women intersect with the criminal justice system?
3. What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system?
4. How does the criminal justice system respond to this group of imprisoned mothers with a mental illness?

1.3 Researcher position

This study is the product of the researcher's social work background, as well as experience as a research assistant on a three-year study that examined the experiences of women as they transitioned out of the prison system. Social work provided the ethical framework and shaped the methodology, while the research experience provided invaluable knowledge regarding the individual, social, and systemic challenges faced by imprisoned women, as well as skills in conducting research within the prison setting.

The researcher's social work background informed the study's methodology, particularly through the use of the Australian Association of Social Workers (AASW) (2010) Code of Ethics to guide the study's axiology and the use of pragmatism as the underlying worldview. The AASW (2010) code makes a commitment to the values of 'respect for persons', 'social justice' and 'professional integrity' (reflective self-awareness, empathy, and transparency). It draws attention to the "needs, rights and aspirations of individuals, groups and communities who are disadvantaged and discriminated against" (Smith 2012, p. 445), including imprisoned mothers with a mental illness. Within this ethical context, good social work research is research that is concerned with social issues and with the lived reality of experiences (action-orientated), examines the intersectionality and complexity within these experiences, and incorporates different research orientations underpinned by a strong value base (Humphries 2008; Smith 2012). This background ensures that the ethical considerations involved in criminal justice research are acknowledged, incorporated, and attended to, and draws attention to "complexity and diversity in the social work domain" (Smith 2012, p. 436) such as mothers who experience both mental illness and imprisonment.

Social work research is also concerned with the practical consequences of research (Smith 2012), as the AASW (2010, p. 36) Code of Ethics notes, research must have "merit and

integrity by demonstrating its potential benefit". Indeed, the overall aim of this study is to improve current practices with imprisoned mothers with a mental illness, as this area remains under-examined, despite the growing body of knowledge around cumulative harm and intersecting issues. Borden (2013) argues that there are clear links between social work practice and research and the pragmatic worldview that underpins the methodology of this study (see: 'Chapter Four: The Methodology and Associated Methods'). For example, Rylander (2012) outlines that the common principles of pragmatic research are the focus on experience, the evolving nature of research, and the interaction between the person and their environment. Indeed, pragmatic research places emphasis on practicality, contextual responsiveness, and the consequences of a study (Biesta 2010; Creswell & Plano Clark 2011; Datta 1997; Johnson & Onwuegbuzie 2004; Tashakkori & Teddlie 1998, 2003, 2010). This worldview reflects the social work background of the researcher, and influenced the design, implementation, and interpretation of this study. This is evident below in the summary of the thesis structure.

1.4 The thesis structure

This thesis is divided into eight chapters, with each chapter outlining the journey from what is currently known about mothers with a mental illness in the criminal justice system, to how they are currently responded to as they navigate this system, and ending with recommendations for future research with this group of women.

This first chapter introduces and provides the context for this study. Acknowledging the increase in women being imprisoned, the high prevalence of mental illness in the criminal justice system, and the impact of this on primary carer mothers and their children. This chapter also outlines the significance and utility of this study, and the aims. Given the lack of attention to the specific experiences of imprisoned mothers with a mental illness, the second chapter examines the context for how the criminal justice system currently responds to this group of women.

Chapter Two therefore provides the theoretical, political, and social context of imprisoned women, illuminating how the issue of the parenting needs of mothers with a mental illness has been framed and responded to. Included in this chapter is a discussion of the impact of feminist theory on correctional responses. What emerges from this discussion is a lack of unified responses to the mothering needs of women as they navigate the criminal justice system.

The third chapter presents Australian and international research that examines responses to imprisoned mothers with a mental illness, from their pathways into criminal behaviour, and at arrest, sentencing, and imprisonment. What becomes clear as this discussion progresses is that the issues of mental illness and mothering are often examined separately, with scant research regarding the mothers who straddle this divide. Only six articles directly relevant to mothers with a mental illness were able to be located.

Chapter Four outlines the study's methodology and associated methods. Underpinned by a pragmatic worldview, this study uses an exploratory mixed method investigation influenced by feminist intersectionality and complexity theory. Justification of this methodological approach is included, with an acknowledgement of the study's strengths and limitations.

The study's findings in relation to the core research question and the four subsidiary questions are discussed in the three subsequent chapters. Chapter Five provides a broad description of the characteristics of the mothers with a mental illness, with comparisons made between the mothers without a mental illness and wider data on imprisoned women in Victoria and Australia. This chapters shows that on the surface these groups share similar challenging issues, with the main distinctive difference being the mothers' mental health status. It is not until the following chapter that the differences become apparent in how mothers with a mental illness navigate the criminal justice system to plan the care of their children. Chapter Six examines *how* the mothers with a mental illness navigate the criminal justice system. It focuses on their pathways into prison and capacity to engage with and participate in this system at the critical decision-making points of arrest, sentencing, and imprisonment. Chapter Seven provides an examination of the differences evident within the study's sample of mothers with a mental illness, showing that understanding and responding to these women goes beyond their mental health status.

The final chapter discusses these results and presents the study's conclusions in regards to the needs of mothers with a mental illness as they navigate the criminal justice system. This chapter concludes with a discussion of the strengths and weakness of the study, and highlights areas for future research.

1.5 Defining key terms

Throughout this thesis a number of key terms are used, therefore it is important that these terms are clarified. The term *mother* represents a primary carer female who at the time of her arrest, remand, or imprisonment had dependent children whose residence changed, and/or a

new carer was introduced, and/or the children were left with no adult carer. This pragmatic definition of the term *mother* represents the complexity of family life at this current age. All table and figures presented in this report use the term *mother* for simplicity. The terms *child*, *children*, and *adolescent* represent children aged birth to 18 years affected by the imprisonment of a mother with a mental illness. All tables and figures presented in this report use the term *children* for simplicity.

The terms *mental health*, *mental illness*, and *mental disorder* refers to:

“Clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities” (American Psychiatric Association 2013, p. 20)

Mental illnesses include Affective Disorders, Bipolar and Related Disorders, Anxiety Disorders, Trauma- and Stressor-Related Disorders, Substance-Related and Addictive Disorders, Personality Disorders, and Schizophrenia Spectrum and Other Psychotic Disorders (American Psychiatric Association [APA] 2013). Whilst these definitions are used, it is important to note that this study relied on the participants self-reporting their mental illness. The limitation of this is discussed in the fourth chapter.

In addition, individuals can have the co-occurrence (or comorbidity) of more than one mental illness. This co-occurrence can occur across diagnostic groups (e.g. one Affective and one Anxiety Disorder) or within each diagnostic group (e.g. two Affective Disorders) (ABS 2008). The term ‘dual diagnosis’ is used to represent individuals who have the co-occurrence (or comorbidity) of mental health and substance use disorders (Canaway & Merkes 2010). Whilst the aim of this study was not a gendered or feminist analysis but an examination of a specific sub-group of imprisoned women, this study acknowledges that the definitions of mental illness have a gendered component (Broverman et al. 1970; Eriksen & Kress 2008; Miller & Prosek 2013; Phillips & Gilroy 1985; Seem & Clark 2006). This could result in what Eriksen and Kress (2008, p. 152) call the “pathologizing of behaviours that may be normative within particular gendered contexts”. Indeed women in the community, like their imprisoned counterparts, have higher rates of psychiatric morbidity compared to men (ABS 2008). Therefore, this study is aware of the ‘politics’ of labelling, however the decision to use the APA (2013) definition of mental illness was purely a pragmatic one. This classification

manual is routinely used within Australia's mental health system. Furthermore, this study refrains from classifying the women by their disorders. Labels such as 'depressive mother' are not used. Instead, this study uses 'a mother with a mental illness', which is more accurate.

All tables and figures presented in this thesis will use the term *mental illness* for simplicity, with the three results chapters labelling mothers with a mental illness as *primary mothers*, and the broader sample of mothers without a mental illness as *comparison mothers*, for brevity.

The term *criminal justice system* refers broadly to the criminal justice system of Victoria, and includes: "policymaking and law reform, policing, courts and tribunals, dispute resolution, penalties and fines, prisons, corrections and parole, legal assistance and victim support" (Victoria State Government Justice and Regulation 2015). Given the specific focus is on the responses to and experiences of mothers as they are imprisoned, this focus has been refined to the stages of arrest, sentencing, and imprisonment and thus incorporates policy making and law reform, policing, courts and tribunals, and prisons. These stages are classified as important care planning decision-making points for mothers. Furthermore, the term *navigate* is also used to describe the women's movement through the criminal justice system at these important key decision-making points.

The terms *female offenders*, *imprisoned women*, *incarcerated women*, and *justice-involved women* are used interchangeably throughout this thesis. These terms have been used to refer to women who are arrested, sentenced, and imprisoned. It is acknowledged that the first three terms are value-laden, but they are terms most often used in the literature by both researchers and government departments (van Wormer 2010).

1.6 Summary and conclusion

This chapter highlights the increase in the number of women being imprisoned across both Australian and international criminal justice jurisdictions, with many of these women having a mental illness, and being mothers to dependent children. Thus, this specific group of women – imprisoned mothers with a mental illness – represents a complex population in terms of their general health and wellbeing, but also in terms of their parenting needs. Yet, an understanding of their distinct experiences as they transverse the criminal justice system represents a significant gap within the research. Whilst a considerable amount is known about the prevalence of mental illness in prison and the associated treatment needs, as well as the experiences of imprisoned mothers and their children, very little is known about this

intersection. This indicates the significance and utility of this study: to improve the systemic responses to primary carer mothers with a mental illness as they engage with and move through the criminal justice system, with a specific focus on the critical decision making points of arrest, sentencing, and imprisonment. In light of this gap the following chapter, 'Chapter Two: The Theoretical, Political, and Social Context', explores current understandings of and responses to this population.

Chapter Two: The Theoretical, Political, and Social Context

“Study the past, if you would divine the future”

Confucius

The issue of crime and offending is distinctly gendered. A universal finding within criminological research is that men offend at much greater rates than women and are more likely to be imprisoned (known as the ‘gender ratio problem’) (Daly & Chesney-Lind 1988). Paradoxically however, and as previously mentioned, women now represent one of the fastest growing prison populations (ABS 2015; Walmsley 2015). This paradox is attributed to a number of factors: gendered pathways into crime and offending, the androcentric structure of the criminal justice system where women are often an ‘afterthought’, and lastly, to a range of complex social and political factors (Daly & Chesney-Lind 1988; Malloch & McIvor 2013). Compounding this, there are differences in the individual, social, and systemic vulnerabilities of imprisoned men and women. For example, and as introduced in the previous chapter, women are more likely to be the primary carer of children prior to and following incarceration (Glaze & Maruschak 2008; McIvor, Trotter & Sheehan 2009; Sheehan 2010), and will have higher rates of mental illness compared to their male counterparts (AIHW 2010; Baksheev, Thomas & Ogloff 2010; Butler et al. 2005; Glaze & Maruschak 2008). To formulate improved responses to mothers with a mental illness requires development of knowledge about this specific group, including an understanding of the theoretical, political and social context of the Victorian correctional system. This shows how the ‘problem’ of imprisoned women has been framed, and how the system responds to the needs of mothers and women with a mental illness.

As such, this chapter focuses on influential frameworks which have shaped both the understandings of and the current responses to imprisoned women (notably feminism), examining the link to gender-responsive practice within the Victorian correctional and forensic systems. This chapter concludes with a discussion and analysis of the current socio-political climate. This provides the necessary context to how the criminal justice system currently responds to the parenting needs of mothers with a mental illness, as well as to the needs of their children.

2.1 Feminist criminology: 'Seeing' women in prison

Prior to the emergence of feminist criminology in the late 1960s women were relatively invisible within mainstream 'or male-stream' theories of crime and offending (Daly & Chesney-Lind 1988; Gelsthorpe & Morris 1988). Traditionally, theories were based on "samples of white, working class or impoverished men and boys" (Sokoloff & Burgess-Proctor 2011, p. 237) and then later generalised to their female counterparts (Daly & Chesney-Lind 1988). Daly and Chesney-Lind (1988) labelled this the 'generalisability problem'. For example, this invisibility is evident in the 'Cambridge Study in Delinquent Development', a foundational study underpinning many crime and offending theories, especially the theories about developmental and life-course criminology (DLC) (Farrington 2003a, 2010). This longitudinal study surveyed 411 South London boys from 1961 to 2002 in order to identify the factors associated with offending (Farrington 2003b). It was not until mid-2000 when gender differences were examined using the female siblings of the original cohort (Farrington & Painter 2004a, 2004b). Despite this, the findings from the Cambridge study are often discussed in gender-neutral terms (i.e. 'boys' taken to mean 'children') (Farrington 2003a, 2010); with Farrington (2010) acknowledging that he did not include unchangeable variables like gender during the development of the DLC theories. Governed by a prevention perspective, he worked from the assumption that changeable risk factors mediate antisocial behaviour (Farrington 2010) and thus, calling into question the applicability of these theories to women (Block et al. 2010) given their distinctive needs. Indeed, Naffine (2014, p. 26) in her critique of Farrington's work, and others like him, calls treating the results of "one population as equally valid to another (without checking whether that is so), or failing to see that there is something quite particular about the people selected for investigation" (e.g. all men) as poor science. Sentiments echoed elsewhere (for example: Flavin 2001; Gelsthorpe & Morris 1988).

Feminist scholars therefore sought to make the invisible visible within criminology (Flavin 2001). At the risk of oversimplifying these perspectives, the second wave of feminism, that of Marxist, radical, socialist, postmodern and liberal feminism, situated crime and offending within gendered inequalities. Marxist feminism located women's crime and offending within class-based inequality (e.g. poverty, unemployment and debt). Alternatively, radical feminism focused on the gendered nature of men and women's victimisation, highlighting the high proportion of women who enter the criminal justice system as victims as well as offenders. Similar to Marxist ideas, socialist feminism examined crime occurring within

gender and class based systems of power, whilst postmodern feminism challenged the existence of one universal experience of ‘female’, highlighting that experiences differ on class, race, sexual orientation, and culture (Belknap 2007; Burgess-Proctor 2006; Daly 2010; Daly & Chesney-Lind 1988). Liberal feminists took a different approach, calling for equality through ‘just’ and bias free practices (Belknap 2007).

In order to address the noted invisibility of women in the prison system, early liberal feminist critiques called for legal equality between men and women (Covington & Bloom 2000), advocating for males and females to be treated identically (Belknap 2007). This approach failed however, to consider that the very structure of the criminal justice system assumes that men’s lives are the standard, whereby women often represent the ‘other’ (Belknap 2007). The criminal justice system was established and traditionally organised to meet the needs and requirements of male offenders; designed by men for men whereby, ‘what works’ for men was extended to women (Bartels & Gaffney 2011; United Nations Office on Drugs and Crime 2014). It assumed that the experiences and treatment needs of women were the same as men, thus prison models did not provide female prisoners with the support and services needed for successful reintegration into the community (Bartels & Gaffney 2011). In many respects, Daly and Chesney-Lind’s (1988) ‘generalisability problem’ was also evident at the treatment and service levels; showing the on-ground impact of ‘male-stream’ research and theories. Thus, gender-neutral legislation, guidelines, policies, systems and programs when applied to female offenders yielded “equality with a vengeance” (Daly & Chesney-Lind 1988, p. 525), evident in the steadily rising female prison population (ABS 2015; Walmsley 2015).

In light of this, contemporary (or third wave) feminism moved to examine crime and offending within three major areas of inquiry: ‘gendered pathways’ (using biographical and life course narratives to examine the factors that influence men’s and women’s pathways into crime and re-offending), ‘gendered crime’ (examining the situational and organisational contexts of men’s and women’s crime) and more broadly, ‘gendered lives’ (examining the intersectionalities that underpin male and female experiences) (Belknap 2007; Daly 2010; Kruttschnitt 2013). This wave advocates for a multi-focused conceptualisation of crime and offending. It highlights the intersecting roles of gender, race, class, and system-based inequalities in the understanding and management of female offenders (Sokoloff & Burgess-Proctor 2011). The concept of intersectionality moves the understanding of crime away from the individual, to outcomes based on social and/or systemic conditions rather than biological

or psychological processes (Belknap 2007). This was important, as initially criminology viewed women who offended as driven by biology (e.g. hormonal or biological imbalance) rather than motivated by the social factors (e.g. class, status, power, age, and culture), to which male offending was often attributed (Smart 2008). Indeed, Gelsthorpe noted (2004, p. 83) the terms “bad, mad, or sad...” were traditionally used to characterise women and girls in the criminal justice system. Therefore, intersectionality represents a move from formal to substantive equality, recognising the different needs of women. In practice, this means ‘gender-sensitive’ or ‘gender-responsive’ correctional systems (Covington & Bloom 2000; Daly & Chesney-Lind 1988; Hannah-Moffat 2010).

In many respects however, feminism still seems to have a peripheral relationship with criminology (Flavin 2001). Gelsthorpe and Morris (1988, p. 103) highlighted that feminism “is viewed as the property of ‘others’, ‘outsiders’ even” within criminology scholarship. This issue seems not to have improved over the past two decades, as both Flavin (2001) and Sharp and Hefley (2006) note feminist criminological scholarship is often published within specialised journals and books, isolating it from mainstream research (Flavin 2001; Sharp & Hefley 2006). Indeed, Sharp and Hefley (2006) in their literature review of three major criminology journals, found that gender was typically used simply as a control variable, with researchers failing to meaningfully examine gender, instead assuming theories and models based on male participants are gender-neutral. This is in spite of decades of feminist research highlighting that both ‘gender-blind’ and later ‘gender-neutral’ correctional theory, laws, and policies negatively affect women. Whilst the second and third wave of feminist perspectives contributed to how female offenders are now ‘seen’ and responded to within Australian and other western criminal justice systems, moving correctional theory and practice from the continuum of ‘gender blind’ to ‘gender-responsive’, such developments occur within particular political, historic, and economic contexts.

2.2 Gender-responsive practice within the criminal justice system

In response to feminist scholarship, the past two decades have shown an uptake of ‘gender sensitive’ practice and policies within the correctional systems of many western countries such as Canada, the United States of America (US), Australia, and the United Kingdom (UK) (Hannah-Moffat 2010). Canada introduced ‘Creating Choices’ in 1990, which provided a woman-centred policy to the management of female prisoners (Correctional Service of Canada 2015; Hannah-Moffat 2010). This policy had a contested history however, with very few recommendations actually implemented (Hannah-Moffat 2001, 2010), resulting in more

‘refinements’ to Canada’s policy responses (Correctional Service of Canada 2006, 2013a, 2013b). Twelve years later, the US National Institute of Corrections introduced the term ‘gender-responsiveness’ within correctional policies and practices with the ‘Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders’ (Bloom et al. 2002). This represented one of the first empirically-based and comprehensive correctional policies, inspired by feminist scholarship and grounded within theory and research, for the management of women in the correctional system (Hannah-Moffat 2008). This document operationalised gender-responsive practice, and provided a set of best practice principles for female correctional systems, which have been further refined over the years (Bloom et al. 2002; Bloom, Owen & Covington 2005; Hannah-Moffat 2010). Following on, the Australian state of Victoria developed and implemented ‘Better Pathways: An Integrated Response to Offending and Reoffending’ in 2005 (Corrections Victoria 2005), with other Australian states and territories later following suit (Bartels & Gaffney 2011). In the UK, Baroness Jean Corston acknowledged the concept in her report ‘A Review of Women with Particular Vulnerabilities in the Criminal Justice System’ (known as the Corston report) (Corston 2007). Gender-responsive practice is also evident in many Nordic and European countries (Grimm 2011; Jokinen 2011; MacDonald 2013). However, such policies and practices are still needed in countries such as Nigeria, Russia, and India (United Nations Office on Drugs and Crime 2014).

Gender-responsive service delivery means a correctional context (e.g. architecture, environment, and staff) and content (e.g. program development, content, and material) that comprehensively reflects the experiences of female offenders and addresses their distinct needs (Bloom et al. 2002; Bloom, Owen & Covington 2005; van Wormer 2010). In practice, this means drawing on concepts such as feminist intersectionality as well as relational, pathway, trauma, and addiction theories to inform practice and policy. Services should promote empowerment and self-efficacy; be culturally aware and sensitive; hire staff that reflect the client population (e.g. gender, language/ethnicity, sexual orientation); use gender-responsive tools and individualised treatment plans; and lastly, develop programs that meet the distinctive needs of female offenders (e.g. mental health, victimisation, children, and substance use) (Bloom et al. 2002; Hannah-Moffat 2010). Bloom et al. (2005) claim that gender-responsive correctional policies, procedures, and programs can improve the management of female prisoners, both in prison and at a community corrections level, enable facilities to be appropriately funded and staffed, reduce staff turnover and prevent sexual

misconduct, and importantly improve program and service delivery. However, the evidence base behind these claims is unclear, and may relate to the conceptual, practical, program, and systemic challenges that underpin gender-responsive correctional practice.

At a conceptual level, gender-responsive practice often fails to attend to the complexity of imprisoned women (Hannah-Moffat 2001; Malloch & McIvor 2013). Hannah-Moffat (2001) highlights that government reports and policies often assume that all imprisoned women have the same experiences, ignoring the heterogeneity evident within this population. For example, not all imprisoned women have mental health or drug and alcohol issues. She argues this is because priority is given to gender over other important factors such as class, ethnicity, and sexual orientation. Indeed, a recent examination of the research indicated the need for correctional services to be holistic, addressing the multiple issues faced by imprisoned women (Trotter & Flynn 2016). In addition, Hannah-Moffat (2001, p. 192) argues that policies are often informed by “white, middle class sensibilities”, and while gender-responsive policies discuss cultural sensitivity, this sensitivity is often limited to majority populations who are assumed to be homogenous. Gender-responsive practice also has the potential to create a false dichotomy between men’s and women’s prisons. The image that women’s prisons are therapeutic, empowering, and supportive suggests that women will experience their confinement as less oppressive. This dichotomy also has the potential to deny male prisoners the same opportunities (Hannah-Moffat 2001). However as van Wormer (2010) advocates, gender-responsive practice is not solely for females (e.g. Covington, Griffin & Dauer 2011).

At a practical level, challenges to implementing a gender-responsive approach relate to access to funding for programs, staff training, as well as dealing with prison overcrowding and the resulting reduced access to programs (Lowthian 2002; McCampbell 2005). At a program level, there are issues around disclosure and safety within programs. For example, disclosing experiences of victimisation requires a safe and supporting environment, which conflicts with the prison setting. In this sense, group work which dominates correctional setting programs, can also be difficult (Strathopoulos et al. 2012). In addition, many prison-based programs are not systematically or independently evaluated, or alternatively, research on these programs has a number of methodological weaknesses (e.g. small sample sizes, little use of comparison groups, little to no use of longitudinal designs) (Bartels & Gaffney 2011; Burgess & Flynn 2013). This means that such programs are difficult to implement, with little known about what specifically works.

At a systemic level, Lowthian (2002) further notes barriers to reform relate to the disconnection between policy and practice, the bureaucratic nature of the criminal justice system, and the gap between custody and the community services. Malloch and McIvor (2013) take a wider and more critical view, arguing that gender-responsive policies and practices, with their focus on the individual women, do not address the structural and power issues reinforcing social problems. Lawston (2013, p. 113) similarly claims that gender-responsive practice in the prison system fails to examine the ways in which social injustices, such as sexism, racism, social marginalisation, and economic inequality, “cause and perpetuate punishment”.

Furthermore, the applicability of gender-responsive policies and practices is hampered by the tension between risk and rehabilitation (Sheehan 2013). Within many western jurisdictions, prisons operate within a retributive justice framework, whereby “offenders should be punished for crimes they have committed” (Hudson 2013, p. 28). Indeed, the prevailing social view, powered by the media, is ‘do the crime, do the time’ (Sheehan 2013). This context is underpinned by a risk paradigm, where offenders are categorised and classified based on their risk factors for offending and re-offending (e.g. high, medium, or low) (Hannah-Moffat 2010; Malloch & McIvor 2013). However, this focus on risk has the potential to redefine needs as offending risk factors. Therefore, women could become seen as a riskier group in terms of their reoffending than they actually are, as they have more needs than men (Trotter, McIvor & Sheehan 2012; Trotter 2008). Trotter (2008) argues that women are often disadvantaged as the criminal justice system punishes offenders classed as high risk, with increased penalties at sentencing and continued surveillance upon release. Thus, current risk-classifying instruments, typically developed using white male correctional samples, may not be able to adequately meet and respond to the needs of female offenders (Sheehan 2013). Gender-responsive researchers in the US continue to challenge and debate this issue (Hardyman & Van Voorhis 2004; Salisbury, Van Voorhis & Spiropoulos 2009; Van Voorhis et al. 2010; Van Voorhis 2012; Wright et al. 2012). Sheehan (2013) argues that the focus on punishment and risk also has the potential to undermine rehabilitation as it draws resources away from programs and leads to high levels of surveillance. For example, legislation underpinning prison practice outlines that prison safety and security override prisoner needs. This issue is discussed further in ‘Section 2.5 Current Victorian practice within prisons’.

The aforementioned conceptual, practical, program, and systemic challenges that underpin gender-responsive correctional practice, highlight the complexities evident within

correctional practice. Suggesting that there is no one perfect response. In light of this, examining current Victorian gender-responsive practice at arrest, sentencing, and imprisonment, as well as examining the intersection between the criminal justice system, wider social systems, and the political context becomes important.

2.3 Current Victorian practice at arrest and sentencing:

Examining the gender implications at arrest and sentencing is made complicated by the numerous pieces of legislation underpinning police and court practice. Thus, this chapter section limits itself to examining the Victorian policing manual, and the associated mental health and child protection protocols, as well as current Victorian sentencing practices and the sentencing manual. Relevant policies and laws from international correctional jurisdictions are examined for comparison. It is acknowledged however that the key pieces of Victorian legislation at arrest and sentencing are: the *Crimes Act 1958*, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, the *Mental Health Act 1986*, *Sentencing Act 1991*, and the *Victorian Police Act 2013*, amongst others.

2.3.1 Victorian policing practice

The Victoria Police Manual (VPM) outlines the behavioural, operational, and administrative standards of the Victorian police (Victoria Police 2013). This manual typically uses gender-neutral language, referring to ‘persons’, ‘suspects’, and ‘family members’. The use of such gender-neutral language fails to acknowledge the plethora of research highlighting the distinctive needs of female offenders. The VPM does however acknowledge gender once in ‘Section 105-1 Searches of Persons’ (p.3): “if reasonably practical, male police members must search males, female police members must search females”. Yet, the availability of female officers is doubtful considering only approximately 26% of the Victorian police force are women (Victoria Police 2015). This has significant implications, as the majority of female offenders have typically experienced victimisation at one point in their lives. Therefore, policies around custodial strip searches, body cavity searches, and warrant-based searches can further exacerbate experiences of victimisation (DeHart 2008; Green et al. 2005; Johnson 2004a; Messina & Grella 2006; Messina et al. 2007). To increase diversity in their workforce, the Victorian police actively recruited women in 2015, with half of all new recruits on the 30th of June being women. This is an increase from the previous year, where only 31% of new recruits were women (Victoria Police 2015). Therefore, over time the availability of female officers will become more common, increasing the potential of the Victoria Police to better respond to the needs of arrested women.

At arrest, one distinctive issue relating to female offenders is mental illness. Research highlights higher prevalence rates of mental illness in police cells, especially for female detainees, compared to the community population (Baksheev, Thomas & Ogloff 2010; Forsythe & Gaffney 2012). Therefore, encounters with people who have a mental illness is commonplace in current policing (Godfredson et al. 2011). In light of this issue, the Victorian Police and the former Department of Health developed 'The Protocol for Mental Health', which outlines police responses to people who have a mental illness (Department of Health 2010). This protocol sets out police responsibilities to those who are a threat to themselves or others, those who have safety and welfare issues, and those who require transport to mental health services. In addition, this protocol also sets out police responsibilities for the mental health needs of those in custody. These include determining fitness for interview, such as the ability to understand and follow questioning, and the provision of an independent third person if someone with a mental illness is assessed as fit for an interview (Department of Health 2010). As such, this protocol represents an important step forward in police responses. However, application of this protocol only seems to apply to those who are displaying signs and symptoms that are easily identifiable or 'outward', such as with Schizophrenia and Substance Use Disorder. Distress as an outcome of Affective and Anxiety Disorders may potentially play a role in offending, as Baksheev, Ogloff and Thomas (2010) found that female arrestees within Victorian police cells had higher rates of these disorders compared to male arrestees. The signs and symptoms of these disorders are not always visible; therefore, this may have implications for police officers responding to the mental health needs of female offenders. In addition, and reflecting the VPM, this protocol also uses gender-neutral language, referring to person/s, suspects, and family members (Department of Health 2010). Once again, the distinctive needs of female offenders are missing from police discourse and responses.

Gender-responsive practice often relates to acknowledging motherhood and children, as the majority of female offenders are primary carers (Glaze & Maruschak 2008; McIvor, Trotter & Sheehan 2009; Sheehan 2010). Within the VPM, children are given attention as victims, as witnesses to family violence situations, and as offenders themselves. The VPM does specify a protocol with the Victorian Department of Human Services (now called DHHS), the lead agency for protecting children against abuse and neglect. However, one important limitation of the VPM is that it does not specify what to do when a primary carer parent comes into contact with police. Compounding this, the VPM does not discuss dependent children in its

protocols relating to arrest, bail, and treatment of suspects who are parents. Reflecting the VPM, the ‘Protocol for Mental Health’ only acknowledges children as victims of crime, therefore issues pertaining to police assistance for mothers who have a mental illness is not addressed (Department of Health 2010).

The ‘Protocol between the Department of Human Services (Child Protection) and the Victorian Police’ (2012) provides some guidance for both Child Protection and the Victorian Police in their roles and responsibilities to vulnerable children, particularly in inter-agency collaboration. Whilst the focus of this protocol is on children as victims or as offenders, this protocol acknowledges in ‘Section 8.2 Non-mandated abuse types’, children whose parents are ‘incapacitated’, such as:

“situations where a primary carer of dependent children is in custody and incapable of caring for their child during this period and there is no other suitable person willing or able to care for the child” (Victorian Government 2012, p. 11).

Incapacitation could include parental arrest, however this is not directly specified and is thus open to interpretation. The only pathway seemingly available to police in this guideline is to make a report to child protection. This protocol does not provide guidelines for what the police should look for, or ask about when arresting or interviewing a primary carer. Furthermore, it does not address who constitutes a ‘suitable’ carer for children. The Victorian police now have an electronic referral system. This service allows police to refer individuals and families, typically victims of crime, to support agencies (Loncaric 2015; Victorian Police 2015). Trotter et al. (2015) recommends that this referral pathway be used to refer families of offenders, including children, to appropriate services in order to improve early intervention and police responses.

The gaps discussed above in relation to police procedures for responding to women and children, may be related to the copy of the VPM examined, which was obtained from the Victorian Police in 2011 by the broader study. The researcher was unable to locate a freely accessible online copy, current or otherwise. Furthermore, the ‘Protocol for Mental Health’ is currently being updated to reflect the *Mental Health Act 2014* (Department of Health 2014). Based on the information available regarding these changes to the Act (see: Department of Health 2014), it is doubtful that the issues surrounding dependent children are being addressed, despite this Act formally acknowledging the place of dependent children and families within mental health treatment and care (s.11(j) of the *Mental Health Act 2014*).

There have been recent developments in the international area regarding police responses to arresting primary carers. For example, in 2006 the US California Penal Code (known as Assembly Bill (AB) 1942 (Nava)) was amended to encourage the development of guidelines, policies and training for law enforcement agencies when they encounter children during an arrest of a parent or guardian (Nava et al. 2006). As an outcome of this law, the Anaheim Police Department, for example, has a specific ‘Child safety policy 380’ for children “who are subjected to traumatic events, such as the arrest of a parent” (Anaheim Police Department 2013, p. 209). This policy provides specific directions for arresting police officers, at arrest (e.g. ask about location of children, and look for evidence of children), after an arrest (e.g. assist with finding a suitable child-care solution), during the booking (e.g. providing a phone call to arrange the care of children), and contacting child protection services if needed (Anaheim Police Department 2013). More recently, the US International Association of Chiefs of Police (IACP) (2014) developed a protocol to assist law enforcement in responding to children during parental arrest. This protocol provides concrete guidance in the key areas of building inter-agency partnerships, and providing training in child development and communication, as well as law enforcement responsibilities. This protocol provides similar guidance to that of the Anaheim Police Department, but also includes pre-arrest planning. For example, asking if children are present when the initial contact is made to the police for assistance, and when an arrest is planned, determining if children are likely to be present and when possible, delaying until they are not present (e.g. at daycare or school). This protocol also includes police follow-up such as coordinating and referring to partner organisations, and documenting children in police reports (IACP 2014). Furthermore, the UN Commission on Women and the Criminal Justice System (2009) examined criminal justice practice around the UK, and highlighted the provision of parent and child rooms at Sussex Police Stations, whereby parents and their children can wait together until suitable care arrangements are made. These examples show how the needs of dependent children of arrestees can be addressed at the legislative, policy, and practice level. Examples that are currently not evident within Victoria (Flynn et al. 2015), or in other Australian states or territories.

2.3.2 Victorian court practices

Given the high rates of people with a mental illness encountering the police, it is also unsurprising that there is a high prevalence of mental illness within the court defendant population. As an outcome, a number of programs, such as mental health courts and court mental health workers, were developed to address this issue (Hean et al. 2010; Hiday & Ray

2010; Lim & Day 2013; Richardson & McSherry 2010; Richardson, Thom & Brian 2013; Sarteschi, Vaughn & Kim 2011). Whilst such programs represent one way to connect the mental health and the criminal justice system, they are however only a recent development within Australia. They are currently operating within Victoria, Tasmania, South Australia, and Western Australia (Almquist & Dodd 2009; Lim & Day 2013, 2014; Richardson & McSherry 2010; Richardson, Thom & Brian 2013). These courts are underpinned by the concept of therapeutic jurisprudence, developed by David Wexler and Bruce Winnick, which focuses on the therapeutic impact of the court on offenders, as well as all court participants, including victims and judicial officers (Richardson, Thom & Brian 2013).

To provide an example, the Magistrates' Court of Victoria has a number of programs for accused persons who have a range of health and social needs. These programs include the Court Integrated Services Program (CISP), which commenced in 2006, and provides case management for those on bail or summons; and the CISP Remand Outreach Pilot (CROP), which commenced in 2014, and identifies remand prisoners who could receive bail with the appropriate community supports in place (The Magistrates' Court of Victoria 2014). Importantly, this court has the Assessment and Referral Court List, which began operating in 2010. This program assists accused individuals who have a mental illness and/or cognitive impairment in addressing the issues underlying their offending. The hearings in this list work from a treatment-orientated and problem solving approach (The Magistrates' Court of Victoria 2014). While such courts are associated with reduced recidivism, reduced days spent in prison, and improved access to psychiatric treatment amongst participants (Hiday & Ray 2010; Lim & Day 2014; Petrila 2013), what remains unclear is the success of such courts within an Australian criminal justice system (Richardson, Thom & Brian 2013), and the role gender (Kothari et al. 2014) and parenting responsibilities play in these courts. Indeed, the Magistrates' Court of Victoria does have a Court Support Service, which provides a number of services and programs in order to improve the court's responsiveness to court users who experience social and cultural disadvantage. Whilst underlying issues such as mental illness are acknowledged, it is unclear whether this service addresses parenting concerns (The Magistrates' Court of Victoria 2012). There is however a court support service that addresses the needs of families piloted at a regional Magistrates' Court in Victoria (Hastrich 2015). This service will be discussed in detail in 'Chapter Three: The Literature Review'. Furthermore, and reflecting the upcoming discussion, for such courts to be successful there needs to be strong links to services in the community (Richardson, Thom & Brian 2013).

2.3.3 Victorian sentencing practices

The ‘Victorian Sentencing Manual’ provides a practical sentencing guide for the judiciary operating within all Victorian jurisdictions (Judicial College of Victoria 2013). Similar to the VPM, the sentencing manual is written in gender-neutral language through the use of terms such as ‘offender’. This language may be a product of liberal feminist scholarship, discussed previously. Where gender specific terms are used, such as women and female, these typically relate to specific case examples. For example, ‘Section 10.6 – Gender’ (paragraph 1) states that the “the law does not treat females differently in the sentencing process”. However, this section of the manual also stipulates that individual characteristics cannot be ignored within sentencing decisions. For the judiciary, this seems to reflect factors closely associated to gender, such as pregnancy, early maternity, and children (See ‘Section 10.6.1 – Circumstances where gender relevant’) (Judicial College of Victoria 2013). Furthermore, ‘Section 11.7.4.1 – Separation from dependent family members’ highlights that dependent children can be taken into consideration by the judge when imposing a sentence on a parent (Judicial College of Victoria 2013). However, the manual acknowledges that being a single parent does not always lead to leniency unless a social welfare agency is unable to place the children, children have the potential to fall into ‘moral danger’ due to the parent’s absence, the child is a newborn, and if the offender has an intellectual or personality disorder (Judicial College of Victoria 2013). Therefore, the ‘Victorian Sentencing Manual’ suggests that gender-responsiveness is dependent on the circumstances of the offence, the circumstances of the offender, and the individual discretion of the presiding judge. This may lead to judicial inconsistency around sentencing of mothers.

As previously stated, gender-responsive practice is often related to responding to children of offenders. Therefore, a number of international responses to the issue of sentencing parents have been developed. For example, the US Washington State Department of Corrections (2015) introduced the Family and Offender Sentencing Alternative (FOSA) in 2010. This sentencing alternative allows judges to impose a community-based supervision and treatment order, or electronic monitoring, rather than a prison sentence for non-violent offenders who have dependent children (Department of Corrections Washington State 2015). More recently, consultation occurred regarding Scotland’s proposed *Support for Children (Impact of Parental Imprisonment) (Scotland)* bill. This bill required the court to consider the impact of parental custody on children when making sentencing decisions. However, there was not enough time between the consultation process, and for the bill to be introduced into a 2015

parliamentary session (Fee 2015). Such responses, while taking a gender-neutral approach, have important implications for female offenders, as they are more likely to have dependent children than their male counterparts.

The 'Victorian Sentencing Manual' also makes provisions relating to mental illness (Judicial College of Victoria 2013; Sentencing Advisory Council 2014). The manual stipulates that mental illness is part of an offender's personal circumstance, and thus may represent a mitigating factor that can be taken into account during sentencing ('Section 10.9 – Mental impairment'). In addition, this manual also outlines orders that are only available for offenders who have a mental illness, including the court assessment order, and temporary or secure treatment orders ('Section 18 – Orders for mentally ill offenders') (Judicial College of Victoria 2013; Sentencing Advisory Council 2014).

Given that policing and judicial policies and practice are typically framed in gender-neutral terms, it is unlikely that the distinctive needs of female offenders are seen, or met. Often the issue of gender is operationalised as responding to children, yet both Victorian police and judicial guidelines do not respond to children of offenders. In addition, while the police and judicially acknowledge the issue of mental illness in their associated practice, it remains unclear how co-occurring parenting responsibilities are addressed within these offender populations. Inroads made recently within international contexts provide important examples on how to respond to children of mothers navigating the prison system. Only time will tell if there will be a flow-on effect across other western jurisdictions such as Victoria.

2.4. Gender-responsive correctional policy

The introduction of Victoria's 'Better Pathways: An Integrated Response to Women's Offending and Reoffending' represented an opportunity to enhance the gender-responsiveness of the Victorian criminal justice system to female offending and re-offending (Corrections Victoria 2005). This strategy recognised that women represent a higher needs group, due to their distinctive needs, characteristics, life experiences, and family circumstances, but lower risk than their male counterparts (Corrections Victoria 2005). This strategy argued that correctional service delivery, including policies, programs, services, and interventions, must be holistically designed and delivered to meet these gender differences. Using 28 short-term and nine longer-term initiatives, this policy sought to break the cycle of offending, reduce the increasing number of women entering the prison system, and address recidivism and victimisation needs (Corrections Victoria 2005, 2007). Importantly, and with

relevance to this study, this strategy also included objectives relating to practical assistance for managing family ties, and supporting children as well as objectives relating to mental health (e.g. development of an intensive support unit, and specific counselling and support services) (Corrections Victoria 2005).

According to Sheehan (2013, p. 124) Corrections Victoria took a ‘social return on investment’ perspective in the ‘Better Pathways’ policy. This means they wanted to reduce intergenerational offending and exclusion, reduce harm and improve the outcomes for both women and their children. Indeed, the initial evaluation of this policy conducted by PricewaterhouseCoopers (2009) reported that women on community corrections orders and female prisoners identified that their highest priorities were accommodation and family reunification, with programs in these areas having the greatest impact; while secondary needs were health, education, and employment. This result is perhaps unsurprising given the importance of the motherhood role for female prisoners (Barnes & Stringer 2014), and stable accommodation is a critical component of women regaining custody of their children post-release (Sheehan 2013).

Fulfilling an objective of the ‘Better Pathways’ strategy, the Victorian government released the ‘Better Pathways in Practice: The Women’s Correctional Services Framework’ a model for the:

“delivery of correctional services that takes into account the distinct needs, characteristics, life experiences and family circumstances of female offenders within broader offender management practice” (Corrections Victoria 2007, p. 6).

This framework provides an overarching set of procedures for fulfilling the ‘Better Pathways’ strategy that includes a mission statement, seven guiding principles, and a number of operational objectives, encompassing the areas of correctional service delivery, workforce recruitment, training and development, and correction policy and planning. As an outcome, this framework set out 30 priority projects relating to the four key areas identified in the ‘Better Pathways’ strategy, with the timeline for completion being mid-2009 (Corrections Victoria 2007).

As an outcome of the ‘Better Pathways’ strategy and associated framework, priority appeared to be given to the areas associated with recidivism, such as appropriate infrastructure and programs (Corrections Victoria 2009a). At the infrastructure level, the Dame Phyllis Frost

Centre (Victoria's maximum-security prison for women) received a new multi-purpose programs building and a mental health unit called Marmak to improve access to mental health services within and outside of prison. The prison also received upgrades to the medical centre, the education centre, and to the industries building (Corrections Victoria 2008, 2009a). Importantly, with the goal to better support family ties, the visits centre was upgraded to include: a multi-purpose room for children's programs as well as toys and books; an outdoor sheltered seating area; a playground with a basketball ring; and a barbecue (Corrections Victoria 2008, 2009a). This upgrade addresses some of the problems identified in previous research: that prison procedures and policies around non-contact (e.g. use of glass or metal barriers between mothers and visitors, or procedures around touching/hugging) and inappropriate and intimidating visiting rooms hamper opportunities for intimacy between mothers and their children during visits (Flynn 2014; Snyder, Carlo & Mullins 2002; Tudball 2000).

At a program level, the 'Better Pathways' strategy and associated framework funded a range of gender-specific support programs to address issues pertaining to recidivism. A Women's Integrated Support Program (WISP) provided intensive case management, and support from 8-10 weeks pre-release up to 12 months post-release. This program supported women in a number of key areas: gaining secure housing, the management of legal and court issues, family reunification and parenting issues, employment and skills training, health and mental health including drug and alcohol services, and assistance with material aid and daily living skills. However, there have been changes to the non-government service provider since its inception due to the government tendering process (Corrections Victoria 2008; Sheehan 2013). This highlights the influence of the political and economic context on correctional policy and procedure as each new tender requires both the prison, and the women to adapt to changes in personnel and ways of working. Furthermore, WISP program has been replaced by the Reconnect program which offers transition support for up to 12 months for female prisoners who have a high risk of reoffending (Department of Justice and Regulation 2016; Victorian Association for the Care and Resettlement of Offenders [VACRO] 2015) . In addition, the Women4Work Program was implemented to provide employment support to women exiting prison to find work, provided in-prison employment 'expos', and individualised and comprehensive job training. However, this program ceased operation due to funding issues, and was replaced by programs that provide training and work opportunities in prison that reflect community employment (Corrections Victoria 2008; Sheehan 2013).

Other programs include: a CREDIT bail transitional housing program – public housing dedicated to women exiting prison; a Childcare and Transport Subsidy (CCaTs) program that provides childcare and transport subsidies for women to meet community-based orders; specific programs that address victimisation such as domestic violence and sexual assault services; a mentoring program; and dedicated women’s community corrections case managers, just to name a few (Corrections Victoria 2008; Sheehan 2013). The needs addressed by these programs are associated with a successful transition back into the community (Baldry et al. 2006; McIvor, Trotter & Sheehan 2009; Sheehan 2013; Trotter, McIvor & Sheehan 2012).

The ‘Better Pathways’ strategy and associated framework, while taking a specific prison-based focus, also worked within the courts to reduce women’s imprisonment (Corrections Victoria 2005, 2007). This addressed in part the criticism of gender-responsive practice that it is limited to the prison, and which fails to take a systemic view. Therefore, specialist training was provided to judges and magistrates on the effectiveness of sentencing orders for female offenders, sharing research with defence lawyers on the needs of female offenders, and lastly, and improving women’s access to legal information and advice (Corrections Victoria 2005, 2007). Whilst such initiatives were included, there is no evidence regarding implementation or impact, as this was difficult to measure (PricewaterhouseCoopers 2009).

The ‘Better Pathways’ policy was evaluated by PricewaterhouseCoopers (2009) using Corrections Victoria, service providers, female prisoners, and women on community corrections orders as key sources of data. The results indicate that the strategy and associated framework contributed to a reduction in the number of female prisoners, and to the overall imprisonment rate within Victoria (PricewaterhouseCoopers 2009). This reduction was attributed to the use of non-custodial prison options such as the transitional housing initiative and the CCaTs program, as well as improved transitional services (PricewaterhouseCoopers 2009). However, the results on which this claim is based are not presented in the publicly available executive summary. Therefore, it is difficult to know how such findings were calculated. In addition, and perhaps rather sadly, this finding has not stood the test of time, given the increasing female prison population since the publication of this study (ABS 2015). Such information suggests that this trend is likely to continue, and in many ways, calls into question the effectiveness of gender-responsive policies and practices without broader political support and guidance. Since the introduction of the ‘Better Pathways’ policy and associated framework, a conservative state government (2010-2014) prioritised law and

order. This has led to changes to parole requirements and to the sentencing laws, which have had a clear impact on prison numbers (Callinan 2013; Hedderman 2010; Sheehan 2013; Victorian Ombudsman 2014). The Labor government, who came into office in late 2014, has inherited this agenda (these issues are discussed further in the upcoming ‘Section 2.8 The wider political context’).

A further limitation of the PricewaterhouseCoopers’ (2009) evaluation is that insufficient time had passed between policy development and the resulting evaluation, therefore, the relationship between this policy and recidivism was unable to be measured (Corrections Victoria 2009a). Despite these interesting findings, the full report by PricewaterhouseCooper has not been released by the Victorian government (PricewaterhouseCoopers 2009), therefore the integrity of the results cannot be verified; there is no information on the research method used, sample size, or data analysis strategy. However, this evaluation did suggest that gender-responsive policy had enhanced the responsiveness of the correctional system. The quality of service provision was seen to improve with the use of specifically designed programs to meet the needs of female prisoners. This conclusion related to facility upgrades (e.g. Marmmak, Programs building, and the education centre) and to the implementation of specific programs such as the Vietnamese Liaison Officer (PricewaterhouseCoopers 2009). Lastly, the PricewaterhouseCoopers’ (2009) evaluation reported that the policy provided post-release services (e.g. WISP, CREDIT Bail Housing, and CCaTs) that kept women out of prison (Corrections Victoria 2009a; PricewaterhouseCoopers 2009). However, as previously reported, the direct relationship between these programs and recidivism was unable to be directly measured, with the authors further noting that there was little integration and coordination between the programs (PricewaterhouseCoopers 2009). Sheehan (2013) argues that post-release services must be supported by a ‘joined up policy’ between corrections and broader community services such as health and housing, as such integration and holistic approach better facilitates the transition from prison into the community (Sheehan 2013).

The need for ‘joined up’ services was echoed more recently by a Department of Justice funded study which evaluated the ‘Better Pathways’ strategy and the associated framework. The researcher was involved as an research assistant in this study, where women exiting Victoria’s two female prisons between October 2011 and May 2012 were invited to participate in an interview in prison, and then at three, six, and 12 months post-release. Ninety women undertook the initial interview, with an undisclosed number completing the remaining interviews (Department of Justice and Regulation [DOJR] 2016). Whilst only a

summary of the results are publicly available, this study found that the women perceived the prison programs as helpful, with assistance with children identified as a key factor related to helpfulness. Noted barriers of prison-based services included long waitlists, limited resources, combined with short prison sentences. Furthermore, the disconnection between prison-based and community services represented a significant challenge experienced by this group of women upon their release (DOJR 2016b). These findings suggests, that unless there are better connections between prison and community services, the longer term benefits of prison-based services will not be actualised. Instead, when the ‘Better Pathways’ policy and associated framework was developed and later evaluated, local practice models which aim to connect government, non-government, and community agencies, discussed in ‘Section 2.7 The intersection between the criminal justice system and the wider systemic context’ had yet to be conceptualised and developed (Department of Human Services 2013).

2.5 Current Victorian practice within prisons:

In line with practice at arrest and sentencing, and shaped by the ‘Better Pathways’ policy, a number of rights, laws, and correctional standards underpin the management of Victoria’s two prisons: the Dame Phyllis Frost centre (DPFC), and Tarrengower. The DPFC is the Victorian Government’s maximum security prison for women, located in an outer western Melbourne suburb, with an operational capacity of 344 beds (Department of Justice 2014a). This prison facility was originally known as the Deer Park Metropolitan Women’s Correctional Centre (MWCC), which opened in August 1996 and represented Victoria’s first privately built and operated prison. The MWCC replaced the Fairlea Women’s Prison, which has been operating since the mid-1950s (Corrections Victoria 2009b). In 2000, as the result of facility and services delivery issues, the Victorian Government took control of the MWCC under the *Corrections Act* 1986, recommissioning the prison as DPFC after a well-known advocate for female prisoners (Corrections Victoria 2009b; Department of Justice 2014a). Tarrengower is Victoria’s minimum-security prison for women. This prison was originally a farm and was opened by the state government after renovations in 1988. Tarrengower has an operational capacity of 72 beds and is located in a rural Victorian town (Department of Justice 2014b). Victoria does not have a medium security prison for female prisoners. Therefore, female prisoners with a medium security assessment are housed at DPFC (Corrections Victoria 2009b).

2.5.1 Legislation

The *Corrections Act* 1986 and the *Corrections Regulations* 2009 provide the legislative basis for the provision of adult correctional services within the Australian state of Victoria (Corrections Victoria 2014a). Importantly, Section 47 of the *Corrections Act* 1986 outlines the rights of prisoners, for example access to open-air exercise, adequate food and clothing, reasonable medical and dental care, and at least one visit per week. However, as Naylor (2014) reports, these rights are often expressed in general terms, which make it difficult to enforce in practice. Furthermore, under Section 21(1) such rights can be overridden for safety, security, and good order reasons (Naylor 2014).

As with any public authority in Victoria, the correctional service, under the Victorian *Charter of Human Rights and Responsibilities Act* 2006, is also required to act in accordance with human rights, and to consider these rights when developing and accessing policies and laws, delivering services, and making decisions. Of particular relevance to female offenders, the *Charter of Human Rights and Responsibilities Act* 2006 stipulates that everyone is entitled to equality before the law, with special consideration given to attributes – such as sex, parental status, and pregnancy – that can disproportionately impact individuals (‘Section 8’). Families and children are protected, including prisoner-family relationships and children who reside in prison with their mothers (‘Section 17’), and lastly prisoners are entitled to humane treatment and services (‘Section 22’) (Department of Justice Human Rights Unit 2008; Victorian Equal Opportunity and Human Rights Commission 2012). The Victorian *Charter of Human Rights and Responsibilities Act* 2006 incorporates rights from the ‘International Covenant on Civil and Political Rights’ 1996 (ICCPR), and the ‘International Covenant on Economic, Social, and Cultural Rights’ 1996 (ICESCR); with the ‘Universal Declaration of Human Rights’ 1949 forming the basis of these subsequent frameworks (Department of Justice Human Rights Unit 2008). Therefore, within the context of the Victorian *Charter of Human Rights and Responsibilities Act* 2006, the impact of gender, particularly the mothering role, must be acknowledged within correctional practice. However, this act only provides guidance. There is no mechanism for enforcement if parliament, courts, or public authorities such as the criminal justice system, do not comply with these rights (Naylor 2014). Aside from Victoria, the Australian Capital Territory is the only other Australian jurisdiction that takes a human rights approach within corrections (Easteal et al. 2015).

2.5.2 Correctional Standards

The ‘Standard Guidelines for Corrections in Australia’ (Corrective Services Ministers’ Conference 2012) provides principles and associated guidelines for correctional practice within Australia (Corrective Services Ministers’ Conference 2012) and reflects the United Nations ‘Standard Minimum Rules for the Treatment of Prisoners’³ (Corrections Victoria 2009b). This Australian correctional standard is a “statement of national intent” (Corrective Services Ministers’ Conference 2012, p. 3) and is thus not an enforceable law (Naylor 2014). This highlights the need for individual state and territory legislation to cover corrections (Easteal et al. 2015). Furthermore, this standard is gender-neutral, referring to prisoners as a whole rather than by their sex, referring to prisoners rather than male or female prisoner/s. However, the standard does acknowledge gender four times: in the ‘Classification and Placement’ of prisoners where classification of female prisoners should reflect their lower security and higher health and welfare needs (‘Section 1.43’), as well as the segregation of male and female prisoners (‘Section 1.44’); in the ‘Health Services’ section which stipulates access to health and welfare services, particularly pre-natal and post-natal treatment and accommodation (‘Section 2.45’); and lastly in the ‘Rehabilitation Programmes and Education’ section which outlines that programs and services provided to female prisoners should be developed following consultation with relevant stakeholders (‘Section 3.14’) (Corrective Services Ministers’ Conference 2012).

Reflecting the *Corrections Act* 1986 (s31) discussed previously, this standard also sets out guidelines for children who reside in prison with their ‘primary carer’. The use of the gender-neutral term could suggest that both male and female prisoners have equal access to such programs. However, at an operational level these programs are designed as a gender-responsive program therefore only female prisoners have access to units where children, up to the age of five years, can reside with their primary carer mother during her prison sentence (often referred to as Mother-Baby Units (MBU)) (Bartels & Gaffney 2011). This program only provides a limited number of beds for women and their children. It is open for women who are pregnant or have young dependent children upon imprisonment, who do not have a history of child abuse, and are convicted of a non-violent offence. Other factors that impact on consideration for the MBU is a mother’s behaviour while in prison, program participation, reason for request, and availability of alternative care arrangements (Burgess & Flynn 2013;

³ This standard was revised in 2015, and is now called ‘Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)’ (United Nations 2015).

Department of Human Services 2012). Despite being in operation for the last 30 years, an evaluation of this program has not occurred, however Corrections Victoria commission a review of Australian and international literature on MBU in order to inform future policy and program development (Shlonsky et al. 2016). Outside of this, the guidelines advocate for the maintenance of family ties between prisoners and their significant others through visits, letter writing, and phone calls (Corrective Services Ministers' Conference 2012). However, due to the use of gender-neutral language, these guidelines do not outline specific programs and/or services for mothers and their children.

In addition, the mental health needs of prisoners is also acknowledged in the 'Standard Guidelines for Corrections in Australia' (Corrective Services Ministers' Conference 2012). For example, this standard stipulates that prisoners should be screened in order to identify and provide appropriate mental health services; that segregation can be altered or terminated on mental health grounds; access to appropriate management and to prison-based mental health services as well as speciality forensic services; for prison discharge planning to include referral to community-based agencies for the continuation of treatment; and finally that expectation of work is dependent on physical and mental capacity (Corrective Services Ministers' Conference 2012). This is in accordance with the 'National Statement of Principles for Forensic Mental Health'. This is discussed in greater-depth in the upcoming 'Section 2.5 Current Victorian practice with forensic services', which stipulates that mental health services in prison must be equivalent to the services available in the general community (Mental Health Standing Committee 2006). Furthermore, the programs relating to both mental illness and parenting are referred to in very general terms, with details of specific programs available within the female prison system discussed in the upcoming discussion.

The Victorian correctional system does take into account the role of gender in service management and delivery through the use of different correctional standards for male (see: 'Correctional Management Standards for Men's Prisons in Victoria') and female offenders. The 'Standards for the Management of Women Prisoners in Victoria' (Corrections Victoria 2009b) guided the Victorian correctional system from 2009 to 2013. This standard was developed in response to the 2003 recommendation by the National Corrective Services Administrators Forum: Working with Female offenders for a set of 'Principles for Working with Female Prisoners' (Corrections Victoria 2009b) and replaced the 'Correctional Policy and Management Standards (for Women)' 1995. It is important to note, that the 2009 standard was revised in 2014 to reflect the Department of Justice's "commitment to the

provision of a safe, secure, and humane correctional system” (Corrections Victoria 2014b, p. 5), and incorporates the amendments made to the men’s correctional standards (Corrections Victoria 2014b). However, the 2009 version was the standard in operation when the present study was conducted. Therefore, the 2009 version has most relevance to this discussion.

In what Bartels and Gaffney (2011) call the most comprehensive set of standards for women prisoners in Australia, the ‘Standards for the Management of Women Prisoners in Victoria’ (Corrections Victoria 2009b) established the minimal requirements for correctional service delivery that takes into account the “needs, behaviour and experiences of women prisoners” (Corrections Victoria 2009b, p. 6). As such, this standard included both gender-neutral and gendered terms. The gender-neutral term of ‘prisoner’ was used when acknowledging standards that relate to both male and female prisoners, such as orientation, accommodation, food, access to religious services, recreational activities, release procedures, and administration. This highlights the criticism that correctional policies for female prisoners are merely adapted from what is considered appropriate for men (Easteal et al. 2015). In contrast, the gendered term of ‘women prisoner’ was used when acknowledging the perceived distinctive needs of female prisoners, including access to specific health and wellbeing services, domestic violence services, sexual assault counselling, mental health services, rehabilitation services, and children and family services (Corrections Victoria 2009b). This use of gender-neutral and gendered terms is also evident in the 2014 version (Corrections Victoria 2014b). Whilst such standards represent an important step forward for Victorian prison operations, it is not without limitations. For example, the Victorian Ombudsman (2014, p. 29) asks in her 2014 review of prison rehabilitation and transitional programs: “Do the ‘Standards for the Management of Women Prisoners in Victoria’ appropriately reflect the particular experience and needs of women offenders?”. In many respects, questioning the relevance of current responses to female prisoners, particularly in terms of appropriate offending, educational, transitional programs, and prison infrastructure (Victorian Ombudsman 2014).

The Victorian correctional standards recognise that “women prisoners generally present with a range of complex health and wellbeing needs” (Corrections Victoria 2009b, p. 37). Suggesting that issues pertaining to mental illness, self-harm and suicide, and grief and anxiety associated with the separation from children are recognised within the standards, particularly in the health and wellbeing section. Whilst this recognition is typically framed generally, it is explicitly specified that women identified as being at risk of self-harm or

suicide must be referred to a mental health professional within two hours of identification (refer to ‘Section 1. Reception, and Section 10. Management of Prisoners at Risk of Suicide or Self-harm’) (Corrections Victoria 2009b). The more recent version of the correctional standards reflects the 2009 version, however it goes a step further and explicitly mentions forensic mental health services, including the role of forensic services within the prison setting (Corrections Victoria 2014b).

In relation to motherhood, ‘Section 17. Children and Family Ties/Relationships’ of the Victorian correctional standards stipulates (Corrections Victoria 2009b, p. 54):

“Prison programs, services and procedures reflect the centrality of women’s roles as mothers and care givers, promote the maintenance and strengths of relationships with family and friends and recognise the grief and anxiety associated with separation from children”... “Women prisoners who are the primary carers of dependent children are permitted to care for their young children in prison where it is in the best interests of the child and where the management, good order and security of the prison is not threatened”.

As such, ‘Section 17’ incorporates a number of programs that recognise motherhood. Both female prisons in Victoria have a dedicated MBU, providing cottage-style units exclusively for mothers and their pre-school aged children, as well as a program where non-resident children can stay with their mothers during weekends and on school holidays (Bartels & Gaffney 2011; Department of Human Services 2012; Department of Justice 2010). In addition, a dedicated Mother and Child Support Worker administers the MBUs for both prisons, as well as supporting pregnant women in custody, families affected by imprisonment and providing associated programs. Furthermore, Tweddle Child and Family Services, a community-based organisation, provides parenting programs. A prison-based Family Support Service offers assistance for all mothers in custody to manage issues relating to their children and families. Both prisons also offer programs that support regular contact between mothers and their families through mail, telephone, and visits programs (Bartels & Gaffney 2011; Corrections Victoria 2009b). Motherhood is also acknowledged elsewhere. For example, Section 19 facilitates flexible working arrangements for pregnant women, and mothers who have children residing with them in prison (Corrections Victoria 2009b). Section 21 outlines a temporary absence from the prison program where mothers spend time with their children outside of prison grounds (Corrections Victoria 2009b). Lastly, Section 33 outlines that

visitation rights for children under 16 years, and that participation in the MBU cannot be withdrawn for disciplinary actions (Corrections Victoria 2009b). Such provisions are also located in the 2014 version of the Victorian correctional standards, albeit in different sections.

Importantly, both versions of the Victorian correctional standards recognise the distinctive needs of female prisoners, including issues relating to mental illness and motherhood. Such standards are supported by the gender-responsive strategy ‘Better Pathways’ policy and the associated framework discussed previously (Corrections Victoria 2005, 2007, 2009b, 2014b). These standards, alongside the gender-responsive policy and associated framework, aims to improve prison management practices and rehabilitation outcomes for female prisoners (Corrections Victoria 2014b). However, the ‘Better Pathways’ policy, while relevant to the criminal justice system, does not address the forensic system.

2.6 Current Victorian practice within forensic services

Forensic services bridge the gap between the criminal justice and the mental health systems, and because of the specific focus of the present study on the experiences of imprisoned mothers with a mental illness as they navigate these systems, practice within the forensic system is relevant to this discussion. The ‘National Statement of Principles for Forensic Mental Health’ provides principles and guidelines for both adult and juvenile forensic practice within Australia (Mental Health Standing Committee 2006). Reflecting the standards for correctional practice, there are not enforceable by law as the provision of forensic services is a state and territory responsibility (Mental Health Standing Committee 2006). Generally, this principle is written in gender-neutral terms using the terms ‘prisoner/young offender’, or ‘persons’. However, gender is acknowledged three times. First, in the rationale for the principles, stating “specific attention should ensure optimal outcomes for special groups such as women...” (p. 3), then in ensuring access and early intervention for minority groups such as women (‘Principle 4: Access and Early Intervention’), and finally, in providing individual care for populations where it has been historically difficult to respond, such as women (‘Principle 9: Individualised Care’) (Mental Health Standing Committee 2006). Parenting and children, aside from children who are juvenile offenders, are not acknowledged within these principles.

Forensic services within Victoria were established by the *Mental Health Act 1986*, and are governed by the more recent *Mental Health Act 2014*, as well as the *Crimes (Mental*

Impairment and Unfitness to be Tried) Act 1997, the *Corrections Act* 1986, and the *Sentencing Act* 1991 (Victorian Institute of Forensic Mental Health 2014a). Under the Victorian *Mental Health Act* 2014 a forensic patient is someone who is: not guilty by reason of mental illness; unfit for trial; received a term in a mental health facility; or lastly, has been transferred from prison due to a mental health condition. The Victorian Institute of Forensic Mental Health provides a range of services for these with a serious mental illness (Victorian Institute of Forensic Mental Health 2014a). These services include a 116 bed secure inpatient hospital called Thomas Embling Hospital located in an inner Melbourne suburb; the provision of inpatient and outpatient services at Melbourne Assessment Prison and DPFC; a consultant psychiatrist for state-managed prisons; and community based forensic mental health services that offers support upon release from prison, as well as services in court, and behaviour change programs (Victorian Institute of Forensic Mental Health 2014a). Therefore, the Victorian Institute of Forensic Mental Health provides previously discussed mental health services at DPFC. When looking exclusively at the female forensic population, Thomas Embling has a 10-bed acute unit for women, a mixed-gender rehabilitation unit, and a gender-responsive women's care program which is designed to meet the specific psychiatric care and treatment needs of women (Victorian Institute of Forensic Mental Health 2014b). Furthermore, the Victorian Institute of Forensic Mental Health (2014a) reported that work was underway to create a Women's Specialised Care Pathway position at Thomas Embling. This position aims to increase the responsiveness of the hospital's policies and programs to the needs and experiences of female forensic patients (Victorian Institute of Forensic Mental Health 2014a). Despite this, the researcher was unable to find any publicly available documents that specifically outline gender-responsive programs and practices at Thomas Embling.

Reflecting the experiences of children within the criminal justice system, children have only just begun to be 'seen' within the forensic services. For example, children were first mentioned in the Victorian Institute of Forensic Mental Health's (2012) 'Report of Operations' in regards to reviewing and revising policies and procedures around children visiting at Thomas Embling. However, the most recent report indicated that a child-friendly meeting room had been created to improve the visiting experiences for families (Victorian Institute of Forensic Mental Health 2014a). Indeed, previous reports acknowledged only the needs and services for families and carers (e.g. carer support groups, and annual family barbeques). This change may be related to the most recent *Mental Health Act* 2014, which as

previously mentioned, outlines that the needs of children must be recognised within adult mental health services.

2.7 The intersection between the criminal justice system and the wider systemic context

As highlighted in the previous discussion, there is a need for ‘joined up’ prison and community services. Yet, practice within community services, including government, and non-government agencies, is often limited to addressing single issues (e.g. mental illness, or substance use, or domestic violence) within a context of specialised, and fragmented services. Collaboration between services is hampered by the differences in eligibility thresholds and screening, levels of skills and expertise, service ideologies, policies and mandates, institutional cultures, funding contracts, and ethical and legal considerations (Canaway & Merkes 2010; Department of Human Services 2013; Hunter & Price-Robertson 2014; McDonald & Rosier 2011, 2013; Richardson, Thom & Brian 2013; Walsh, Tilbury & Osmond 2013; Department of Human Services 2011). Richardson et al. (2013) calls this fragmented service context ‘silos’, with the difficulties underpinning collaboration as the ‘silo mentality’. Within this context, the needs of parents and their children are also invisible, despite the acknowledgement that parental problems, such as mental illness, substance use, and domestic violence, can have negative implications for children (Cummins, Scott & Scales 2012; Hunter & Price-Robertson 2014). The Victorian 2011 ‘Protecting Vulnerable Children Inquiry’ highlighted that “services need to recognise and take action regarding the needs of their clients as parents and respond to the needs of their children” (Cummins, Scott & Scales 2012, p. xxxv). This was also echoed in the Victoria Governments’ 2011 review into the state’s human service system (Department of Human Services 2011) and within Australia’s ‘National Framework for Protecting Australia’s Children 2009-2020’ (Commonwealth of Australia 2009). Such criticisms has resulted in the development of the Victorian ‘Services Connect’ model and the Australian ‘Child Aware’ approaches. These recent developments mirror international practice and policy, for example, the UK’s ‘Think Family’ initiative (Diggins et al. 2011; Roscoe, Constant & Ewart-Boyle 2012; Social Exclusion Task Force 2008a, 2008b), which was developed as an outcome of the UK government’s crime prevention agenda (Scott 2009). Building the capacity of adult-focused services to respond to the parenting needs of clients is seen to protect and enhance the wellbeing of vulnerable children (Scott 2009).

The Victorian Government Department of Human Services' (2011) 'Services Connect'⁴ model recognises that multiple and complex problems faced by families cannot be adequately addressed by one service provider. As such, this model uses a case management response, whereby one key worker identifies and coordinates the service responses to families with multiple and complex needs. The goal of this model is for an integrated person-centred approach to welfare services that uses family sensitive practices (Department of Human Services 2013). With relevance to imprisoned mothers, 'Services Connect' model looks at offending within its assessment tool, with referral pathways into services from the courts and prisons (Department of Human Services 2013). This reflects Sheehan's (2013) proposition that 'joined up' prison and community services are a must for successful reintegration back into the community. It also reflects the concept of 'no wrong door' to accessing assistance. However, this model was implemented in a small-scale trial, with the evaluation completed but not released to the public.

Complementing the Victorian 'Services Connect' model, 'Child Aware' is a federally funded early intervention and protection approach (Hunter & Price-Robertson 2014). Its goal is to put children's needs at the centre of practice to improve child and family wellbeing. As such, this approach takes a systemic view, and provides information and resources for adult services to be family-sensitive, child-inclusive, strengths-based, collaborative and culturally competent when working with families (Hunter & Price-Robertson 2014). Interestingly, Extra Edge Community Services (2013) in Western Australia run a child-aware prison program that provides workshops for prison officers and incarcerated mothers. The goal of these workshops is to share knowledge and raise awareness of issues affecting prisoners and their children (Extra Edge Community Services 2013; Hunter & Price-Robertson 2014). However, the researcher was unable to locate any publicly available information regarding this program. Despite this, this program does show the applicability of this approach in the prison system, and may have the potential to address the criticisms of the police and the judiciary practice manuals and guidelines discussed previously.

2.7.1 The Victorian mental health system

One important example of taking a collaborative family perspective comes from the Victorian mental health system. The experiences of children of parents with a mental illness share similarities with children of imprisoned parents. Both groups experience shame, stigma, poor

⁴ As the result of the government change in late 2014 the 'Services Connect' model only received funding up to 2016 (Department of Treasury and Finance 2014, 2015).

mental health outcomes, antisocial behaviour, limited access to services, and abrupt separation from their parent due to institutionalisation (Moses 2010), yet the responses to these two vulnerable populations are vastly different. The mental health system in the last two decades has consistently drawn attention to the needs of both parents and their children, and in many respects models good practice. This is evident at the legislative level, as the Victorian mental health system, including the forensic system, is regulated by the *Mental Health Act 2014*, which as previously mentioned, explicitly acknowledges that: “children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing, and safety recognised and protected” (Mental Health Act 2014 (s.11(j))). A similar acknowledgement does not exist within criminal justice system legislation. At a policy level, the ‘Fourth National Mental Health Plan’ (Australian Government Department of Health and Ageing 2009), the ‘Families where a Parents has Mental Illness (FaPMI) strategy’ (Victorian Government Department of Human Services 2007), and the ‘Principles and Actions for Services and People Working with Children of Parents with a Mental illness’ (Australian Infant, Child, Adolescent and Family Mental Health Association 2004) all guide practice within the mental health system. These policies embed the needs of children of parents with a mental illness and advocate for collaboration between multiple service systems. These include the health and mental health, child protection, education, and justice systems, such collaboration seeks to reduce the impact of parental mental illness on the family unit (Australian Government Department of Health and Ageing 2009; Australian Infant, Child, Adolescent and Family Mental Health Association 2004; Victorian Government Department of Human Services 2007). Furthermore, research was recently undertaken to update the practice standards for adult mental health services to improve the visibility of families where a parent has a mental illness (Goodyear et al. 2015).

As an outcome, a number of positions, resources, and programs were developed within the mental health system. For example, specialist positions that respond to the needs of carers, children, and family members of people with a mental illness; worker lanyards with prompts; specific policies for children visiting; specialised resources and training for professionals; care-planning for hospitalisation; and forms that examine children’s needs at intake (COPMI 2014; Cuff & Morgan 2015; Maybery et al. 2012; Reupert, Green & Maybery 2008). At a program level, Victoria has implemented the ‘Let’s Talk About Children’, an intervention developed in Finland. This brief intervention involves a two to three session discussion between the professional and the parent with a mental illness to identify the needs of children,

family strengths, and link with support and resources (Cuff & Morgan 2015; Solantaus et al. 2009, 2010). This program is currently being trialled within Victoria's mental health system, with the potential to be adapted to other settings, such as prisons (Cuff & Morgan 2015). Furthermore, Finland is in the process of reviewing the implementation of this program within their corrections system. Initiatives that link adult mental health and child systems can also be seen in Netherlands, Norway, Sweden, and the US (Beardslee et al. 2012).

Whilst this discussion provides a snapshot of recent developments within Australia, it shows the incorporation of children into legislative, policy, and practice levels of adult systems, with the specific example coming from Victoria's mental health system. This is important as women within the prison system are more likely to be primary caregivers, and more likely to report a mental health issue, amongst other concerns. As seen in the aforementioned discussion on gender-responsive correctional practice, such practice is often operationalised as responding to the needs of mothers, with children 'seen' rather than specifically responded to. Thus, recent practice within the community service system may provide guidance for ensuring that the correctional system both sees and responds to the needs of children who have an imprisoned mother. This discussion also highlights examples of improving linkages between prison and community systems, and between adult and child systems. However, for such linkages to succeed, a supportive political context is necessary.

2.8 The wider political context

Government and political bodies also play an important role in how the criminal justice system responds to female offenders (Hedderman 2010; Sheehan 2013). Malloch and McIvor (2013) attribute the increase in women entering the prison system, evident in many western jurisdictions, to a range of complex social and political factors, rather than an overall increase in the seriousness of women's offending. These include legislative changes, and increasing punitive responses to male offenders, which in turn affect their female counterparts.

For example, Sheehan (2013) attributes the increase in the Victorian female prison population since the PricewaterhouseCoopers' (2009) evaluation on the 'Better Pathways' policy, to the change in the Victorian government in 2010. The shift from Labor to a conservative Liberal government, who had a clear 'law and order' agenda, resulted in significant budget reforms to all government systems, including the criminal justice system. Furthermore, there was an increase in the use of custody as the response to offending (Sheehan 2013) due to parole reforms (Callinan 2013), and changes to the sentencing laws which abolished suspended

sentences (Sentencing Advisory Council 2013; Victorian Ombudsman 2014). Such changes were tied to specific violent offending by a small number of male offenders, and the resulting community outcry; this had unintended consequences for the correctional system as there was an increase in the number of people held in police and court cells, as well as in prison (Victorian Ombudsman 2014). The government's response was to expand the capacity of the prison system, which included building 88 new prison beds at DPFC (Victorian Ombudsman 2014), rather than re-examining the principles and objectives under the 'Better Pathways' policy and associated framework. As the Victorian Ombudsman (2014) notes, a rise in the prison population puts strain on existing programs and services. Therefore, the procedures set out in the Victorian gender-responsive policy may not be met, or even appropriate within the current prison environment. In November 2014, the Victorian government shifted back to Labor however, this new government appears to be following somewhat in their predecessors footsteps; addressing the growing population rather than focus on prevention (Department of Justice and Regulation 2015a). The 2015-16 Victorian budget committed \$119 million to expansion of Victoria's female prison system. At DPFC, this expansion includes 114 new beds, of these new beds, 44 were allocated to the mental health unit Marmak. There will also be expansions to prison industries, the medical centre, and the kitchen. At Tarrengower, this expansion includes a 18-bed unit for the mainstream population as well as a multipurpose programs building (DOJR 2015b; Department of Treasury and Finance 2015; Noolan 2015). Promisingly, this budget also included increased funding to mental health, counselling, and rehabilitation programs within the female prison system (Department of Treasury and Finance 2015; Noolan 2015), addressing some of the Victorian Ombudsman's (2014) criticisms.

The influence of agenda of the government of the day is also evident in the UK. Hedderman (2010) notes that while Labour had made some progress in responding to the needs of female offenders since 'The Corston Report', such as developing and financially supporting community-based programs for female offenders (e.g. the Asha Women's Centre in England and Centre 218 in Scotland; see discussion in Gelsthorpe & Hedderman 2012), there were no outstanding legacy as it was a "matter of too little too late" (p.495). By the time Labour left office in 2010, after 13 years in power, the prison numbers had risen, with Hedderman (2010) concluding that it was unlikely that the Conservative-Liberal Coalition would have imprisoned women as a top priority. This conclusion is echoed by the later Justice Select Committee inquiry into the progress made on the recommendations set out in 'The Corston

Report' (House of Commons Justice Committee 2013). Player (2014) highlights that the systemic context prohibits the actualisation of gender-responsive initiatives. This is because the ideology underpinning gender-responsive policies and practices (e.g. distributive justice) conflicts with the ideology of the criminal justice system (e.g. retributive justice). This then influences how the concepts of equality, rehabilitation, and justice are interpreted and implemented (Player 2014). Furthermore, the willingness of governments to fund such programs is hindered by a lack of a solid evidence base around the impact and success of gender-responsive initiatives, given that government funding is often focused on meeting rather enumerative targets such as reducing crime and recidivism (Gelsthorpe & Hedderman 2012). Within this context, the concept of 'justice reinvestment' has just begun to gain traction in Western criminal justice jurisdictions. 'Justice reinvestment' advocates for a reinvestment of criminal justice funds into community-based services, such housing, health and mental health services, to prevent crime and offending (Brown, Schwartz & Boseley 2012), reflecting earlier calls for 'joined up' prison and community services. The high level of demand currently evident in the rising numbers in many western jurisdictions, differences in government ideologies, and the complexity that underpins women's needs, do not make for an easy response (Gelsthorpe & Hedderman 2012; Player 2014).

2.9 Summary and conclusion

This chapter sought to examine how the correctional system conceptualises the 'problem' of imprisoned women, and how this system responds to the needs of mothers and women with a mental illness. As such, this discussion included an examination of feminist criminology, as well as an examination of the operationalisation of gender within current correctional legislation, policies, standards, and practices. Examples include Australian, and international western correctional jurisdictions.

This discussion found that feminist perspectives moved the correctional system from gender-blind to a mixture of gender-neutral and gender-responsive practices. Whilst it is evident that gender-responsive practice often acknowledges women's mental health issues and parenting responsibilities at imprisonment, these issues are often addressed separately with little overlap. Furthermore, this chapter highlights the lack of unified practices at arrest and sentencing that addresses these issues, with the parenting responsibilities of forensic patients still relatively invisible within the forensic system. For example, the policies at arrest are typically gender-neutral, and fail to raise awareness of the increased needs of mothers. Therefore, in many respects, the needs of mothers with a mental illness are only visible at

imprisonment. This continues to reinforce the systemic bias that this system has towards women.

This discussion also highlighted that for the needs of imprisoned mothers with a mental illness and their children to be appropriately addressed, there needs to be a 'joined up', or whole of community approach. Outside of the prison system, the mental health system has made significant progress towards incorporating the parenting needs of clients into service provision. There has also been important shifts towards collaborative practices between welfare services, for example, the Victorian 'Services Connect' model and national 'Child Aware' approaches. However, the research on such collaboration within the Australian context is still new, with advances limited by the fragmented service system, and the vagaries of the socio-political cycle. Until such issues are addressed, criminal justice legislation, guidelines, policies, systems, and programs that fail to recognise gender will no doubt continue to yield vengeful equality. This is evident in the increasing number of women entering the Victorian prison system, despite a gender-responsive framework.

This chapter provided the necessary context to how the Victorian criminal justice system currently responds to the parenting needs of mothers with mental illness, and their children, as they navigate this system at the point of arrest, sentencing, and imprisonment. Complementing this, the upcoming chapter discusses current and past research into imprisoned women and their children, with a particular focus on how mothers with a mental illness navigate this system. Chapter Three shows the implications of such correctional laws, policies, and programs on the lives of those who traverse this system.

Chapter Three: The Literature Review

“There is no such thing as a single-issue struggle because we do not live single-issue lives”

Audre Lorde

Mothers with a mental illness represent a largely invisible criminal justice population. As evident in the previous chapter, some attention is paid at the legislative, policy and practice levels to the parenting responsibilities of imprisoned women, and to women who have a mental illness. Yet, responses to women who straddle this divide appear to be missing. This invisibility is also evident within research, with the issue of mental health typically not considered in research investigating the experiences of imprisoned mothers and their children (Laux et al. 2011; Loper 2006), and is often seen as a demographic characteristic (see: Glaze & Maruschak 2008; Mumola 2000). In addition, other research into imprisoned mothers has tended to overlook mental illness, typically focusing on substance use (see: Poehlmann et al. 2008; Sharp & Marcus-Mendoza 2001) despite the interlinked nature between mental illness and substance abuse (Johnson 2004a). In contrast, research into imprisoned women with a mental illness has focused on aggregating prisoner mental health data by gender, prisoner status (e.g. sentenced or on remand), or by the type of prison (see: Butler et al. 2005) as well as describing the associated programs and treatment needs (see: Faust & Magaletta 2010; James & Glaze 2006). In that research, children are typically only considered as a demographic characteristic of the mother (for an example see: Tye & Mullen 2006, p. 268), or an afterthought in the discussion. Whilst both streams of research are important for policy and practice, current approaches fail to consider the intersectionality and complexity that underpins the experiences of mothers and their children. Therefore, like the service system, policy, practice, and research is also rather siloed.

This literature review uncovered just six studies that examine the intersection between mental illness and parenting responsibilities of imprisoned women. These studies examine the broad theme of parenting responsibilities within the prison and forensic settings (see: Birmingham et al. 2006; Chao & Kuti 2009; Cormac et al. 2010; Gregoire et al. 2010; Laux et al. 2011; Parrott, Macinnes & Parrott 2015), with Laux et al. (2011) also examining vulnerabilities experienced by imprisoned mothers prior to imprisonment. In many respects, this latter study represents the only article that is directly related to this present study. The remaining studies

focus on gender-responsive practice such as contact maintenance programs (Cormac et al. 2010) and parenting programs (Birmingham et al. 2006; Gregoire et al. 2010), or the parenting status of forensic mothers (Chao & Kuti 2009; Parrott, Macinnes & Parrott 2015).

Due to this limited knowledge base, this review took a necessary broader focus and examined the distress associated with imprisonment, and the separation from children. Whilst distress does not always equate to a clinically diagnosable mental illness (Phillips 2009), these studies were included for review due to the dramatic shift in contact with children that primary carer mothers experience when imprisoned, from daily face-to-face contact, to relying on their children's carer for contact. This could have implications for mothers who already have a mental illness. Therefore, this review also uncovered eight articles that examined the link between distress and the separation from children (see: Fogel & Martin 1992; Houck & Loper 2002; Hurley & Dunne 1991; Lindquist & Lindquist 1997; Loper 2006; Loper et al. 2009; Roxburgh & Fitch 2014) or infrequent contact with children (see: Poehlmann 2005b) during the mother's prison sentence.

Given these two distinct research streams, this chapter incorporates the relevant literature to map and explore the current knowledge base surrounding mothers who have a mental illness as they navigate the criminal justice system. As such, a traditional narrative approach to the literature review is used (Jesson, Matheson & Lacey 2012), with literature sourced from journal articles, government and organisational reports, and academic books. This literature is drawn from a number of disciplines including criminology, law, psychology, social work, and nursing, and typically comes from Australia, the US, and the UK. The studies included in this review span the period from 1960 to 2016. This was a pragmatic decision as little attention has been paid to this group of imprisoned mothers. Therefore, to limit the study to the last decade would reduce the scope of this review, and overlook key pieces of literature.

To provide clear links to this present study and to the research questions, this chapter begins with a brief examination of the women's individual, social, and systemic context prior to imprisonment. This context could have implications for the mothers' parenting abilities, and to women's pathways into offending, and imprisonment. This chapter also includes an examination of how imprisoned mothers navigate the criminal justice system represented by the decision-making points of arrest, sentencing, and imprisonment, looking exclusively at

how this system responds to this group of mothers. This chapter concludes with a critique of the literature presented in this review.

3.1 Mothering in difficult contexts: Pathways into prison

Women who enter the criminal justice system arrive with a wide variety of interlinked individual, social, and systemic challenges (McIvor 2007). The prevailing themes within the literature suggest that incarcerated women are typically young, therefore of childbearing age (Glaze & Maruschak 2008; McIvor, Trotter & Sheehan 2009; Sheehan 2010), and often have experienced economic disadvantage and financial debt. This includes low educational attainment, unemployment or transient employment, and homelessness or inadequate or unstable housing (Baldry et al. 2006; Bloom et al. 2002; Corrections Victoria 2011; Holtfreter, Reisig & Morash 2004). In addition, imprisoned women also have a range of health issues, including communicable diseases and chronic illness (AIHW 2010), mental health issues, typically Affective Disorders and Anxiety Disorders (AIHW 2010; Butler et al. 2005, 2006; Fazel & Danesh 2002; Tye & Mullen 2006), have substance abuse issues. This latter issue is often reported as being a self-medicating behaviour (Greene, Haney & Hurtado 2000; Johnson 2004a, 2004b; Langan & Pelissier 2001; Laux et al. 2011). The research also shows that imprisoned women often report histories of victimisation and abuse in childhood and adulthood (DeHart 2008; Greene, Haney & Hurtado 2000; Johnson 2004a; Messina & Grella 2006; Messina et al. 2007), and have limited support networks (Enos 2001; Murray 2007; Salisbury & Van Voorhis 2009; Corrections Victoria 2005). These challenges affect not only themselves but also their children, and suggest that these women parent within challenging circumstances. Furthermore, the accumulation of disadvantage provide women with distinct pathways into prison (Medlicott 2007).

Pathways research argues that men and women have very different criminogenic risk factors and needs that underpin their offending (Brennan et al. 2012; Salisbury, Van Voorhis & Spiropoulos 2009; Salisbury & Van Voorhis 2009; Van Voorhis et al. 2010), whilst sharing some risk factors and service needs such as antisocial associates, criminal thinking, criminal history, substance abuse, education, employment, and housing (Brennan et al. 2012). A number of gendered risk factors and service needs have also been identified, such as victimisation, dysfunctional adult relationships, mental health issues, sense of self-efficacy, and parenting issues (Brennan et al. 2012). Indeed, the acknowledgement of these gendered pathways underpins gender-responsive practice discussed in the previous chapter. However,

the study of gendered pathways into prison is still at a relatively early stage of development. Although, both qualitative and quantitative research is spread across various disciplines, such as feminist criminology, criminal careers research, and developmental psychopathology, it remains poorly integrated (Brennan et al. 2012). This means that the evidence base surrounding gendered pathways is still relatively new, and requires further development and refinement. Despite this, evidence does suggest that women enter the criminal justice system as an outcome of both shared and gendered risk factors; this includes both mental illness and motherhood (Brennan et al. 2012).

3.1.1 Motherhood as a pathway to imprisonment

Research broadly indicates the influence of motherhood on women's pathways into prison (Berry et al. 2009; Ferraro & Moe 2003; Loper 2006). Loper (2006), in her study which compared the characteristics of 350 mothers and 166 women who had never had a child, highlighted that mothers and non-mothers differ in offending behaviours, with property and drug offences significantly associated with mothers, and violent offending such as homicide significantly associated with non-mothers. Loper (2006) concluded that different contexts dictate how mothers and non-mothers offend. Indeed, a small qualitative study by Ferraro and Moe (2003) supported this. Interviewing 30 women imprisoned within the US Arizona Pima County Adult Detention Facility, the authors found that the women with dependent children often described their offending as being linked to their economic circumstances, conceptualising "crime as an alternative to hunger and homelessness" for both themselves and their children (Ferraro & Moe 2003, p. 19). Several participating women saw non-violent crime as a reasonable avenue to meeting their children's needs as their economic situation was also burdened by debt and unemployment.

Berry et al. (2009) sought to further understand the link between women's illegal behaviour and their familial contexts, economic situation, and experiences of victimisation. They implemented a larger scale quantitative study using eight measures, surveying 285 women within an unspecified US Midwestern state. The participants were sourced from prison (n=157) and community samples who had a history of arrest and/or imprisonment (n=128). The authors found that motherhood was significantly associated with involvement with the criminal justice system. Women with children were significantly more likely to be arrested, and significantly more likely to be imprisoned, especially for economically based crimes, when compared to non-mothers. This finding echoes the results of Ferraro and Moe (2003). While there was no difference between these groups for violent or drug-related crimes, it was

found that larger numbers of children increased the arrest rates for drug related crime, and having younger children increased the arrest rates for economic based crime (Berry et al. 2009). Given the focus on the connection between economic based crime and parenting, it is unsurprising that the early research of Bonta, Pang and Wallace-Capretta (1995) found that being a sole parent was significantly associated with higher rates of recidivism compared to women who had partners (51.7% versus 22.2% respectively). This may indicate support for research which highlights that sole mothers are more likely to experience multi-layered individual, social, and systemic issues, such as mental health issues and economic marginalisation, compared to their partnered counterparts (Berkman et al. 2015; Burstrom et al. 2010; Crosier, Butterworth & Rodgers 2007).

Ferraro and Moe (2003) also reported that offending often followed the removal of children by statutory welfare agencies. The resulting ‘nothing to lose attitude’, linked with access to drugs and/or alcohol, typically resulted in a downward spiral to imprisonment. This finding is strengthened by Ross, Khashu and Wamsley’s (2004) large-scale analysis of foster care data from New York State’s Law and Administration for Children’s Services and criminal history data from New York State’s Division of the Criminal Justice Services for 973 children whose foster care placement overlapped with the incarceration of their mother during the years of 1997-1999. The authors found that foster care placement typically precedes maternal criminal activity and the resulting imprisonment, with the convictions related to non-violent crimes such as drug-offences or theft. This result contradicts the previous assumption that imprisonment results in foster care placement (Ross, Khashu & Wamsley 2004).

This research suggests that both the presence and absence of children can contribute to offending behaviours, therefore the direct link between parenting responsibilities and offending is not clear. Indeed, it may be the interplay between parenting and children alongside other vulnerabilities, such as distress, poor support networks, financial difficulties, or substance use, which all contributes to individualised offending pathways. This may explain the research that suggests that parenting is also a protective factor against offending (Giordano et al. 2011; Yule, Paré & Gartner 2015). This interplay is also emphasised in the research examining mental illness as a pathway into offending.

3.1.2 Mental illness as a pathway to imprisonment

When looking exclusively at pathways into offending for women who have a mental illness, research suggests that mental illness, including history and current symptoms, is interlinked

with histories of victimisation, dysfunctional adult relationships, substance abuse, and parenting (Brennan et al. 2012; Salisbury, Van Voorhis & Spiropoulos 2009; Salisbury & Van Voorhis 2009; Van Voorhis et al. 2010). With victimisation being one of the most notable risk factors, given the evidence linking experiences of victimisation and trauma to subsequent mental health issues in prison samples (DeHart et al. 2014; DeHart 2008; Messina et al. 2007; Messina & Grella 2006). For example, Lynch et al. (2012) used structural modelling to examine the links between victimisation, mental illness, and offending behaviours. The authors conducted 491 structured diagnostic interviews with imprisoned women in the US states of Colorado, Virginia, Maryland, Idaho, and South Carolina. The interview used a number of unstandardised and standardised measures to measure childhood and adulthood experiences of trauma (Lynch et al. 2012). The authors found that women who experienced victimisation during childhood (such as experiencing physical and sexual abuse, witnessing violence, child corruption, and caregiver substance use), were more likely to report adult victimisation (such as partner violence, witnessing violence, and sexual and physical abuse), and that adult victimisation predicted poor mental health. However, it was the presence of a mental illness, rather than experiences of victimisation, that predicted offending behaviours (Lynch et al. 2012). Based on this pathway, Lynch et al. (2012) concluded that women had more extensive criminal histories when they had complex mental health presentations. The factors significantly associated with complex mental health presentations included the number of co-occurring disorders, level of impairment in everyday life, and psychopathology. This suggests that serious mental illness results in impaired functioning, and contributes to offending behaviours. Interestingly, this study also found that mental illness was significantly associated with service utilisation; however, the use of services was not associated with the women's offending history. This suggests that while a large number of women with a mental illness accessed mental health services, service utilisation did not divert them from engaging in offending behaviours. This highlights the difficulties of services in seeing relevant intersections and complexity for imprisoned women, as discussed in the previous chapter. Particularly relevant is that Lynch et al. (2012) did not discuss motherhood or children, aside from offences against children. An associated study by Dehart et al. (2014) used mixed method interviews to measure mental illness, victimisation, and offending, as well as gaining a life history with 115 imprisoned women, randomly selected from the larger sample in Lynch et al.'s (2012) study. The authors reported that the experiences of pregnancy and parenting were included in the life course interviews, however such information was not examined in the published article. This suggests that while such

demographic information is collected it often represents a factor that is not examined in combination with mental illness.

A limitation of the aforementioned study is that it specifically examined serious mental illness (e.g. Major Depressive Disorder, Bipolar Disorder, and Psychotic Spectrum Disorders) alongside substance use and Post-Traumatic Stress Disorders. This is an important limitation as the prevalence of ‘less serious’ mental illnesses, such as Anxiety Disorders, is high in the criminal justice system, especially for female prisoners (Baksheev, Thomas & Ogloff 2010; Tye & Mullen 2006). Furthermore, the associated Dehart et al. (2014) study noted that a limitation of their study was that they did not explore the relationship between Personality Disorders, and the onset of offending.

Such findings are important as it suggests that a relationship between mental illness and offending exists within the context of other individual, social, and systemic challenges. This reflects the concept of intersectionality discussed in the previous chapter and as well as the issue of cumulative harm – that offending is an outcome of an accumulation of factors, rather than presence or absence of one factor alone. This intersection may also explain why previous research, which focused on mental illness as the sole predictor for offending and recidivism and included very small female samples, was inconclusive (see: Andrews & Bonta 2010; Bonta, Law & Hanson 1998). Alternatively, this finding could also relate to the gendered nature of mental illness first addressed in Chapter One. Women may enter the criminal justice system via the mental health system due to the pathologising of behaviour which is often absent in men. However, this finding does underscore the importance of community-based partnerships between the mental health and the criminal justice systems. While women with a mental illness typically access some kind of community-based mental health treatment, utilisation does not divert them away from the criminal justice system. This raises issues regarding the appropriateness of services accessed for this particular group of women.

This discussion examined, albeit briefly, the contribution of both motherhood and mental illness to offending. Prior to imprisonment, mothers parent within difficult contexts, with their pathways into prison influenced by their mental health, particularly when they have co-occurring disorders, substance use, and an impaired level of daily functioning. Motherhood and parenting responsibilities also influence pathways into prison as children may create an additional stressor, in already stressed lives. Both research streams examining these

intersections highlight that such experiences are often interlinked with economic stress, substance use, victimisation, and levels of appropriate formal and informal support. These work together to provide women with distinct, and often individualised, pathways into prison. This interplay may also affect their ability to navigate the criminal justice system, at the points of arrest, trial and sentencing, and imprisonment.

3.2 Navigating the criminal justice system

There is very little literature that specifically examines the experiences of mothers with a mental illness as they navigate the criminal justice system, particularly at the points of arrest and sentencing. Only Laux et al. (2011) examines the needs of imprisoned mothers prior to their imprisonment; the remaining studies only address the point of imprisonment (Birmingham et al. 2006; Chao & Kuti 2009; Cormac et al. 2010; Gregoire et al. 2010; Parrott, Macinnes & Parrott 2015). However, the woman's ability to navigate this system is also shaped by the interplay between the individual, social, and systemic challenges, highlighted previously.

3.2.1 Mothers with a mental illness in the criminal justice system

Laux et al. (2011) investigated the mental health service needs of 304 mothers imprisoned within a county gaol in a large US Midwestern city. These mothers were recruited for a larger study examining the impact and effectiveness of a local Drug Court (see: Piazza, Salters & Laux 2006), and the substance abuse counselling needs of incarcerated mothers (see: Laux et al. 2008). The data in these aforementioned studies is used to examine the mental health needs of incarcerated mothers, with the authors noting a scarcity of research that examines this area. The mothers participated in a series of monthly qualitative interviews over a one-year period, however only 56 mothers participated through to the final interview (Laux et al. 2011). This attrition reflects the transient nature of this population upon release, which had been documented in other research (O'Brien & Bates 2003), as well as their chaotic lifestyles (Laux et al. 2011). Only 425 interviews out of the total 1,161 interviews conducted were directly relevant to a mental health focus. These examined the mothers' experiences with formal systems, including mental health and criminal justice, their health risks, and experiences of victimisation. It is unclear how many participants these 425 interviews relate to. Laux et al. (2011) report that the vast majority of participating mothers described experiencing depression and anxiety (Laux et al. 2011). However, only one-half of their participants reported receiving a clinical diagnosis, while the remaining participants' poor mental health was based on self-report. This does introduce bias into the data, as it is

dependent on the subjective interpretation of what mental health and illness means to each participant. This chosen methodology also inflates numbers, and fails to provide an accurate picture of the mental health issues present in incarcerated mothers. The authors did not explain why they used such an open-ended methodology, but it may be the result of their aim to focus specifically on “women’s perceptions and opinions about their needs, issues, barriers, and experiences, as well as those of their children” (Laux et al. 2011, p. 292). Therefore, what mattered was the participants’ perceptions rather than clinical confirmation.

The research by Laux et al. (2011) shows that this group of imprisoned mothers negotiate multiple and often independent systems, for example the criminal justice, social welfare, and the mental health systems, with varying degrees of success. The majority of mothers had received some form of mental health treatment prior to imprisonment, including inpatient and outpatient services as well as medication. This result reflects previous as well as more recent research (see: Faust & Magaletta 2010; James & Glaze 2006; Lynch et al. 2012; Mundt et al. 2015; Sodhi-Berry et al. 2014), and suggests high levels of mental health treatment by female prisoners prior to imprisonment. However, a limitation of Laux et al. (2011) is that while it makes general comments on mental health service use, the study does not provide information regarding the specific services accessed by the participating mothers. The ABS (2008) notes in *The National Survey of Health and Wellbeing* a plethora of services accessed by Australian adults (aged 16-85 years) within the community for mental health support, including hospital admissions, visits to the general practitioner (GP), psychologist or mental health nurse, self-help, and internet support groups. Furthermore, Australian females are most likely to access their GPs over any other mental health service (ABS 2008). This service can prescribe medication, develop mental health care plans, and refer for counselling, or other clinical treatments (Britt et al. 2014). However, an Australian survey of GPs found that management of depression in general practice is hampered by the limited time available that GPs have for consultations, costs and long waitlists for specialists, practice workloads, and inadequate knowledge of mental illness (Richards et al. 2004). Therefore, understanding what services are accessed by imprisoned mothers represents an area for further research as such information has important implications for service and policy development. This is important as Lynch et al. (2012) found that mental health was a significant predictor of offending. Therefore, community-based mental health services have the potential to provide early intervention, and redirect women away from the criminal justice system.

However, the mothers in Laux et al.'s (2011) study did comment generally on the aspects of mental health treatment that were helpful, such as providing treatment to manage symptoms, providing support, and improving skills in communication. The participants also commented generally on unhelpful aspects, such as treatment being only for a short time, and difficulties finding the right treatment, or professional. This study did not examine whether such treatment responded to the participant's offending or parenting needs (Laux et al. 2011). This finding reflects the study by Lynch et al. (2012), and suggests that whilst the majority of participants received some type of formal support prior to imprisonment, they did not appear to access services or treatment that appropriately addressed their issues and diverted them away from offending. This may be an outcome of the previously noted fragmented services system. Indeed, Laux et al. (2011) advocated for mental health counselling services to take a multisystem perspective, given the complexity found within these participants. This result could also relate to barriers and issues within the mental health system.

Laux et al. (2011) also noted that the mothers identified a number of barriers to accessing community-based treatment. One important barrier included the inability to afford treatment and medication, especially relevant considering the reported difficulties with employment: only 12% of participants reported full-time employment prior to imprisonment (Laux et al. 2011). This barrier may be more applicable to the location of the study as the US health system varies considerably from other western jurisdictions, which typically have public health care. Laux et al. (2011) also identified addiction to and the side effects of medication, lack of awareness of treatment and medication, difficulties obtaining transport to treatment, difficulties obtaining childcare, and experiences of stigma with services as barriers to utilisation (Laux et al. 2011). The latter barrier may have particular relevance to this group of mothers, considering they navigate both the criminal justice and the mental health system, and the stigma attached to the use of both systems. Furthermore, the study noted that navigation through the criminal justice system, dealing with legal issues, their hearing, and their resulting imprisonment, were a source of stress for the women. This had further consequences for their mental health, showing the unanticipated consequences of participation.

Laux et al. (2011) also found that the mothers linked their poor mental health to a range of factors including compromised interpersonal relationships, substance use, and to experiences of victimisation. Substance use, such as alcohol and illicit substances, was a commonly reported method of managing mental health symptoms. Furthermore, these experiences

occurred within a context of grief and loss, stress and trauma associated particularly with experiences of childhood and/or adulthood victimisation, and unstable or transient lifestyles (Laux et al. 2011). According to the authors, these experiences had consequences for mothers sense of self-esteem and self-efficacy, which translated into other more practical difficulties such as maintaining employment or education.

These intersections, also added difficulties to their parenting experiences, as these participants had on average 2.9 children. The mothers identified issues associated with separation from their children, such as losing custody, leaving children unsupervised, and children staying away due to the symptoms associated with mental illness. They also reported that their children displayed emotional, psychological, and behavioural issues. The participants attributed these aforementioned issues to their mental health status (Laux et al. 2011), reflecting an unanticipated cost of cyclical issues, with poor mental health resulting in poorer ability to parent. However, this study interviewed mothers in prison as well as upon release into the community. It is therefore unclear whether their poor mental health related to their reception into prison, during their sentence, or release into the community. Each stage comes with its own difficulties, as noted elsewhere (AIHW 2010; Butler et al. 2005; McIvor, Trotter & Sheehan 2009; Sheehan et al. 2016).

What is important about the study by Laux et al. (2011) however is that it represents one of the few to deliberately connect and examine the commonly co-occurring issues of parenting and mental illness in imprisoned women, within a practice-based focus of examining the mental health and counselling needs of imprisoned mothers. This study shows that mothers with a mental illness commonly report depression and anxiety, and that many access some form of mental health treatment prior to imprisonment. For some, there are difficulties accessing treatment due to a lack of knowledge regarding services, and the cost associated with access. Furthermore, complex individual and systemic issues affect their mental health issues, offending behaviours, and parenting ability, showing in part the cyclical nature of such issues. Despite these vulnerabilities, there appears however no coordinated responses to this group of mothers who straddle both the criminal justice and mental health system. This review therefore turns to the small body of research, which examine the influence of parenting responsibilities on the navigation through the criminal justice system.

3.2.2 Mothers in the criminal justice system

A small South Australian study highlights that women's concern for their children's care and safety may also affect their ability to navigate the criminal justice system successfully (Lilburn 2000b, 2000a), in addition to their individual, social, and systemic challenges, such as mental illness (Laux et al. 2011). In a now rather dated study, Lilburn (2000a), examined the policies and procedures at arrest, and during trial and sentencing in order to gain an understanding of the experiences of mothers as they were arrested and sentenced in South Australia. This study included consultations with an undisclosed number of criminal justice and community-based agencies who offered support to justice-involved women, as well as interviews with 15 women who had a history of imprisonment. There was no recorded information regarding the inclusion of agencies who worked with women who had a mental illness. The author found that there was a lack of coordinated planning within and between the criminal justice and the social welfare systems, with little attention paid to circumstances of the women, such as their primary carer status (Lilburn 2000a). This is also reflected in the current Victorian policy and practice documents examined in the previous chapter. This result is troubling as Lilburn (2000a) also found that mothers whose children had secure care arrangements had an easier process at arrest, sentencing, and imprisonment. This result suggests that once women are able to fulfil necessary parenting tasks, they are able to attend more fully to their own needs, and to the legal issues they are facing (Lilburn 2000a). Therefore, this lack of planning and coordination may result in increased risks to mothers and their children. A noted limitation of this study is that it did not explore the role of mental illness on the care planning process. Instead, the author cautioned the criminal justice system about pathologising women's offending and argued that this system must take into account individual experiences and social circumstances.

A more recent Australian study mirrors and extends this finding. In the broader study with which this present study is associated, Flynn et al. (2015) drew on data from 124 professional stakeholders who had contact with prisoners and their families in either the criminal justice or social welfare systems across both the Australian states of Victoria and New South Wales (NSW). These professionals included those who worked in the mental health system. The aim was to describe and document the decision-making that occurs to meet the care needs of children when their primary carer enters the criminal justice system. The findings indicate that the needs of children are still largely invisible in services whose primary clients are adults. This is because of either a lack of formal guidelines or protocols within and between

agencies, or the limited understanding of the guidelines or protocols in existence. The limited information sharing between the criminal justice and statutory child welfare system is particularly noted (Flynn et al. 2015). A limitation of this study is that it did not examine the stakeholder data for gender differences between primary carer mothers or fathers, so the relevance to primary carer mothers is unclear. Anecdotally, however, when taking about parents, the stakeholders often defaulted to mothers. Furthermore, there is also no specific analysis of the stakeholder data from professionals who worked in the mental health system, so the relevance to primary carers who have a mental illness is also unclear.

The results by Lilburn (2000a) and the more recent study by Flynn et al. (2015) highlight systemic issues. Once a mother enters prison, she may have little opportunity to discuss the care arrangements for her children with family or significant others, therefore her ability to arrange care plans prior to imprisonment is paramount. Yet this ability is dependent on the interplay between the mother's individual, social, and systemic factors, with Laux et al. (2011) showing the impact of mental health issues on the mother's level of functioning. As Lilburn (2000a, p. 31) notes:

“The question is not whether these systems do or do not recognise the situation of women who have dependent children, it is more a question of how they recognise it and what procedures are in place to deal with the situation”.

3.2.3 Experiences at arrest: Interactions with the police

In one of the only studies to investigate law enforcement responses to arrested mothers and the resulting implications for children, Nieto (2002) conducted surveys with 350 local law enforcement agencies, 58 county sheriff's departments, and 58 county social welfare departments in the US state of California. In addition, interviews were conducted with community service providers who work with children, their carers, and incarcerated mothers. Nieto (2002) found that two-thirds of law enforcement agencies, including police departments and the county sheriff's departments, did not have formal policies on how police should respond to children when their mothers are arrested. This had consequences for practice, with only 13% of the officers reporting that they would always ask an arrestee if they had children, whether the children were present or not. In addition, the presence of children rather than physical evidence (e.g. toys and clothes) was more likely to increase inquiries about the children's care (42% versus 12%) (Nieto 2002). Such results suggest that negotiating parenting responsibilities and children of arrestees are not considered core to

everyday policing. Nieto (2002) also reported that the officers tended to rely on personal experiences, or ‘instinct’, on deciding how to respond to children. While over two-thirds reported that they would generally accept the mother’s suggested caretaker, only one-half of the agencies had procedures in place to check the suitability of these placements (Nieto 2002). This suggests that a number of placements are made by police officers at their discretion and without formal procedures or guidelines in place. Compounding this, Nieto (2002) also found that statutory child welfare agencies were not mandated to assume the care of children when their mother was arrested. Therefore, approximately one-half of the statutory child welfare agencies did not have formal policies with law enforcement agencies on how to respond in a situation when a parent is arrested, nor did they have consistent policies on where to place children (Nieto 2002). This highlights the general invisibility of this group of children. The law enforcement officers also made no mention of the mental health issues of arrestees.

While Nieto’s (2002) study represents a key piece of research in this area, it was not subject to any external review. It has however had some impact. These findings, alongside other projects, seminars, and conferences within the US (see Puddefoot & Foster 2007 for an discussion), are behind the amendments to the Californian Penal Code, as discussed in the previous chapter, to include guidelines, policies, and training for law enforcement agencies when they encounter children during an arrest of a parent or guardian (Puddefoot & Foster 2007). Interestingly, this ‘traction’ seems to be limited to the policy and practice level, as this study is rarely referenced in academic research. A smaller but a more recent study by Neville (2009) confirms the findings of Nieto’s (2002) within the US state of Michigan. This research however was part of a larger study, which has yet to be published.

A general lack of policies and procedures at arrest for responding to mothers was also established by the Victorian Association for the Care and Resettlement of Offenders (VACRO) and Flat Out (2006) in a Melbourne-based study which examined the experiences of 15 mothers, with 35 dependent children, as they navigated the criminal justice system. The authors also included matched data from police, judges, legal representatives, and carers, becoming one of the few studies to holistically examine the experiences of mothers at arrest, sentencing, imprisonment, and release. This study highlighted the gaps within the then policies and procedures of the Victorian Police and in the knowledge of police officers of how to respond to arrestee’s children. As these gaps were also evident at each stage of the criminal justice system, VACRO and Flat Out (2006) called for better coordination between

criminal justice, child welfare, and community-based systems to account for the needs of children at each of these stages (VACRO & Flat Out 2006)

Despite developments in policy in Victoria, including the 2012 ‘Protocol with Child Protection’ discussed in Chapter Two, this gap in police knowledge and procedures was highlighted again more recently by Flynn et al. (2015). That study found that whilst the Protocol provided some general guidelines which could assist in responding to children when their parent was arrested, the police had limited awareness of their formal responsibilities (Flynn et al. 2015). This may be why Flynn et al. (2015) found, similarly to Nieto (2002), that police often relied on informal expectations, as part of their overall duty of care to the community. This was dependent on personal experience and the culture of individual police stations (Flynn et al. 2015).

3.2.4 Experiences at sentencing

Similar to arrest, women’s parenting and childcare responsibilities also represent a specific challenge for sentencers when responding to women who come before the court (Gelsthorpe & Sharpe 2015), as the court must balance such responsibilities against the need to respond to the offence and impose a sentence. As Hedderman and Barnes (2015, p. 112), based on their analysis of recent sentencing trends in the UK and group interviews with nine magistrates, judges, and recorders, reported “sentencing of women takes place amid shifting and contradictory policy messages, legislation, and media representations”. The consequences of this is evident in the research of Flynn et al. (2015) and Minson and Condry (2015). These two studies represent some of the first to examine the invisibility of children and parenting responsibilities in the procedures at sentencing. Previous studies have focused more exclusively on the intersections between gender, familial factors, and ethnicity on sentencing decisions (see: Bontrager, Barrick & Stupi 2013; Daly 1987a, 1987b, 1989; Logue 2011; Spohn & Beichner 2000; Spohn 1999, 2009, 2015; Stacey & Spohn 2006).

The magistrates who were interviewed in both Australian states in Flynn et al.’s (2015) study reported that there were no clear protocols, policies, or guidelines directing them on how to respond to children. Indeed, the ‘Victorian Sentencing Manual’ (Judicial College of Victoria 2013), discussed in the previous chapter, acknowledges that dependent children can be taken into consideration when imposing a sentence, but there are no formal guidelines within this manual as to what constitutes hardship and how to apply this to parents’ situations given the focus is on ‘exceptional’ circumstances. Similar to the experiences of the police participants,

magistrates reported that they often relied on their personal experiences to guide their responses to children. As a result, mothers and their children, are completely dependent on the magistrate who may incorporate children into their sentencing considerations or instead, focus entirely on the crime and prior convictions (Flynn et al. 2015). This ensures that there is “no consistent or predictable outcomes” for primary carer mothers facing imprisonment when they are attempting to plan the care of their children (Flynn et al. 2015, p. 20).

This issue is by no way limited to Australia. Using a different methodology to Flynn et al. (2015) but finding similar results, Minson and Condry (2015) examined the casefiles of 43 defendant mothers who appeared before the Crown Court or the Court of Appeal in both England and Wales in order to gain an understanding of how ‘visible’ children are in sentencing. Similar to Flynn et al. (2015), the authors found that there was limited guidance for sentencers in how to apply mitigation to defendant mothers. Indeed, Crown Court judges used phrases such as “act of mercy” rather than case law or principles to explain why the defendant mother’s sentence was reduced (Minson & Condry 2015, p. 39). Furthermore, although pre-sentence reports which outline parenting responsibilities assisted with the visibility of children, they did not produce a consistent response to the mother’s primary carer status (Minson & Condry 2015). The authors also note the barriers to judicial discretion include legislation that outlines mandatory minimum sentences, as well as a lack of knowledge around the vulnerabilities that underpin the lives of justice-involved mothers and their children.

Both aforementioned studies highlight a need for clear and consistent guidelines for judges when sentencing primary carers, with the latter study focusing exclusively on mothers (Minson & Condry 2015). As an outcome of that research, Minson, Nadin, and Earle (2015), in conjunction with the Prison Reform Trust in the UK, presented a discussion paper to the Magistrates’ Association towards the end of 2015, outlining areas for reform. The areas of reform included: reviewing the sentencing guidelines to incorporate a framework for sentencing primary carers; increasing use of non-custodial sentences; and providing support, education, and research for judges, magistrates, and legal representatives on the impact of imprisonment on mothers and their children, amongst other areas (Minson, Nadin & Earle 2015). Such action suggests that the evidence regarding the lack of clear and consistent guidelines is strong enough for grounds for reform. The implications of this paper on sentencing practice have yet to be published.

Women's parenting and childcare responsibilities also present other issues for the court system. The UK Commission on Women and the Criminal Justice System (2009), first highlighted in the previous chapter, conducted a five year long review of the experiences of women in the criminal justice system. They gathered testimony from a large number of government departments, voluntary sector, and criminal justice organisations, as well as from an undisclosed number of women accused or convicted of crime, amongst other groups of women. This review highlighted three key needs: providing childcare facilities at court; ensuring legal representatives inform mothers about possible sentencing outcomes; as well as providing court based services that assist mothers in making appropriate care arrangements upon receiving a custodial sentence (Commission on Women and the Criminal Justice System 2009). Indeed, an evaluation of a family support service piloted at a Victoria regional Magistrates' Court, provides evidence that courts are suitable locations to offer support to families (Hastrich 2015). Such services can ease the transition into prison, and reduce distress, particularly important for women who typically have mental health issues. It would also reduce the siloed nature of the criminal justice system.

3.2.5 Experiences at imprisonment and the mothers' mental health

Although a large number of studies have documented the high proportion of women with a mental illness in the criminal justice system (AIHW 2010; Butler et al. 2005, 2006; Fazel & Danesh 2002; Fazel & Seewald 2012; Fries et al. 2013; Tye & Mullen 2006), a limited number have exclusively examined the role of family and children, and the associated separation, in the development, continuance, or exacerbation of such issues during imprisonment (see: Fogel 1993; Fogel & Martin 1992; Houck & Loper 2002; Hurley & Dunne 1991; Lindquist & Lindquist 1997; Loper 2006; Loper et al. 2009; Roxburgh & Fitch 2014). However, it is important to note that mental illness was not the specific focus of these studies, as the authors did not ask if the participants had a mental illness diagnosis nor did they examine prison medical records. Instead they typically relied on instruments to measure psychological distress (Houck & Loper 2002; Hurley & Dunne 1991; Lindquist & Lindquist 1997; Loper 2006), or current symptoms of depression or anxiety (Fogel 1993; Fogel & Martin 1992; Loper et al. 2009; Roxburgh & Fitch 2014). Phillips (2009, p. 92) notes that distress usually represents a "standalone symptom, as a qualifier of other symptoms and as a general measure of severity" in the diagnostic criteria for mental illness. Therefore, distress does not always equate to having a clinically diagnosable mental illness, and can be transient, subsiding with removal of the stressor. Therefore, these studies are examining distress as a

consequence of imprisonment and the associated separation from children, rather than as a pre-existing issue. The contribution of these studies is further complicated by the inconsistent use of scales to measure distress, for example, only three studies used the same scale (see: Houck & Loper 2002; Lindquist & Lindquist 1997; Loper 2006). This may also be an outcome of the advances in psychiatric understanding since the first article was published. These aforementioned limitations do reduce the ability to develop a consistent body of knowledge regarding the ongoing impact of family and separation on the mental health of imprisoned mothers. Despite this, it is important to acknowledge this body of research, considering that lack of evidence on the experiences of imprisoned mothers with a mental illness. When primary carer mothers enter prison, there is a dramatic shift in contact with their children, which could have mental health implications (Houck & Loper 2002).

In one of the first studies to examine the relationship between mental health and familial factors, Fogel and Martin (1992) compared mental health issues for imprisoned mothers and non-mothers across time. The authors used a semi-structured interview and two standardised instruments to examine the anxiety and depression levels of 35 mothers and 11 non-mothers imprisoned in the US North Carolina Correctional Center for Women. These instruments were administered during their first week of incarceration, and six months later, with the participants recruited via Catherine Fogel's study on the health of imprisoned women for her doctoral dissertation. Fogel and Martin (1992) found that while both groups experienced elevated mean anxiety scores at the initial interview, only non-mothers experienced a decrease in their anxiety scores at follow up. The authors hypothesised that this finding was associated with the mothers' ongoing separation from children. The results from the semi-structured interviews indicated that a higher proportion of mothers than non-mothers reported distress associated with the separation from family, as well as awareness of the difficulties experienced by their children. However, the differences between these two groups were not statistically significant, and may relate to the small sample size used in the comparison groups. Indeed, these were limitations acknowledged by the authors. In a methodologically similar but separate study, Fogel (1993, p. 374) concluded that a "lack of contact with and involvement in their children's lives constituted a severe psychological stress for mothers" which had repercussions for their health and wellbeing while in prison. Neither study commented on any pre-existing mental illness in the samples.

Other research conducted in Australia and the US has not found a link between distress and familial factors for imprisoned mothers (see: Hurley & Dunne 1991; Lindquist & Lindquist

1997). Conducted around a similar time as the previous study, Hurley and Dunne (1991) aimed to measure rates of psychiatric distress in an Australian female prison, as well as the relationship between psychiatric distress and characteristics and life experiences of this group. The authors conducted structured interviews that included four instruments that measured stressful life events, psychological distress, mental illness, and depression, with 92 women (of whom 61 were mothers) incarcerated within Brisbane's Women's Prison. Whilst not a key focus of the study, the analysis examined the association between psychiatric distress and parental status, along with the associated separation from children. The authors found that there was no significant difference in the distress scores between mothers and non-mothers. The authors did report however that separation from children was the most frequently reported stressful life event for their sample (Hurley & Dunne 1991). Interestingly this study did include a structured diagnostic interview designed to enable a diagnosis of mental illness. However, the results from this measure was not compared across parental status and distress (Hurley & Dunne 1991).

In addition, and taking a gendered approach, Lindquist and Lindquist (1997) examined the influence of environmental stress and gender on the mental health of 103 females and 95 males imprisoned within an medium-sized county gaol in a unspecified southern US city. Respondents participated in a structured interview that included a number of instruments, as well as open and closed questions. Given the focus on gender and mental health, parental status was used as a control variable, as the authors concluded based on Fogel's previous research (Fogel 1993; Fogel & Martin 1992) that parental status could increase the vulnerability of female participants. This study found that female prisoners experience higher rates of mental distress than male prisoners even accounting for parenting status. While parenting and the associated separation from children, was not associated with distress levels for either male and female participants (Lindquist & Lindquist 1997). The authors concluded that "the unexplained variation in mental health status for female inmates remains a mystery" (p.522) and advocated for future research to focus on other personal or social resources of incarcerated women (Lindquist & Lindquist 1997).

With the aim of building upon this rather limited, and conflicting evidence around the link between distress and familial factors, Houck and Loper (2002) hypothesised that the variability in the previous findings could be explained by the treatment of parents as a homogenous group (e.g. simply as mothers versus non-mothers). Therefore, the authors surveyed 362 mothers imprisoned within an unspecified US maximum-security prison,

examining parenting stress, attachment with children, mental health issues, and experiences of legal issues in regards to children, as well as prison records for misconduct. What is unique about this study is that it did not include a comparison ‘non-mother’ or ‘non-parent’ group, focusing instead on examining differences *within* the sample of mothers, specifically those who reported high or low levels of parenting stress. The results showed that elevated stress levels were associated with limited contact with children, visitation issues, and concern around parental skills and competence, as well as higher levels of anxiety, depression, somatisation, and institutional misconduct (Houck & Loper 2002). This result highlights a relationship between parental stress and the psychological and physical wellbeing of imprisoned mothers: as the mother’s parenting stress levels increased so did their symptoms. Therefore, the level of parenting stress, and the factors associated with the distress have greater relevance than simply the mother’s parental status alone (Houck & Loper 2002).

Building upon the work of Houck and Loper (2002), Loper (2006), whose research was first discussed in ‘Section 3.1.1 Motherhood as a pathway to imprisonment’, included a non-mother comparison group to contrast the prison adjustment difficulties. The participants, 350 mothers and 116 non-mothers, in an undisclosed US prison completed a number of self-report questionnaires that examined mental health, prison adjustment, and where relevant, parenting stress. The author found that there was little difference found between mothers and non-mothers in terms of their self-reported mental health symptoms, and levels of misconduct. When the mothers were grouped by their level of parenting stress there were significant differences, as mothers with low parenting stress had better mental health and prison adjustment, and less rule infractions than those with high parenting stress (Loper 2006). These results infer that the ways in which mothers are able to maintain their parenting roles during imprisonment has significant implications for their levels of stress, mental health, and adjustment during their sentence. Indeed, more recent research expanded the factors associated with distress and parenting stress for imprisoned mothers, to include a poor alliance with children’s caregivers (Loper et al. 2009) as well as children’s age, child care arrangements with grandparents or significant others, and the frequency of contact with children (Roxburgh & Fitch 2014).

This discussion, beginning with rather dated research, shows the progression of thinking from a dichotomous construct (e.g. mother versus non-mother or parent versus non-parent) (Fogel 1993; Fogel & Martin 1992; Hurley & Dunne 1991; Lindquist & Lindquist 1997) to one where the level of parenting stress and the interplay between factors such as contact with

children, the nature of the alliance with children's caretakers, children's care arrangements, the age of the children, and concern around parental skills and competence, can mediate the impact of the distress associated with the separation from children (Houck & Loper 2002; Loper 2006; Loper et al. 2009; Roxburgh & Fitch 2014). This interplay can be understood when taking into consideration the research that suggests that imprisoned mothers are not always confident that their children's care arrangements are safe (Cunningham & Baker 2003; Flynn 2008; Sharp & Marcus-Mendoza 2001). Therefore, the aforementioned research examining the link between distress and separation from children, provides evidence that a mother's ability to make care planning decisions, and her engagement in informal and formal support, mediates her levels of distress and mental health functioning as she navigates the criminal justice system, particularly at the point of imprisonment. This is important considering the high levels of mental health issues evident in this population prior to imprisonment (Laux et al. 2011). Therefore, the process whereby justice-involved mothers plan and arrange their children's care, as well as the gender-responsive practice of the prison system, such as contact maintenance, parenting, and health and wellbeing programs, becomes relevant to the discussion.

3.2.5.1 Planning and arranging children's care

When parents go to prison their children are usually cared for informally within their own nuclear or extended family networks without child welfare involvement (Hairston 2009). This trend holds true across a number of western jurisdictions, including Australia, the US, and the UK (Trotter et al. 2015). For children who have incarcerated fathers, their mother will most commonly continue to care for them, whether their father lived in the family home or not (Glaze & Maruschak 2008; Mumola 2000). When a mother goes to prison, she will rely on a wider network of people to care for her children, most typically grandparents. This is closely followed by the father of the children, extended family members, friends, and even statutory welfare agencies (Flynn 2012, 2013; Johnson 1995; Johnson & Waldfoegel 2002; Trotter et al. 2015).

The care arrangements for children of forensic mothers

Less is known however about care arrangements of children whose mothers who end up in forensic hospitals. This is because the parenting issues of this population have been largely overlooked (Chao & Kuti 2009; Parrott, Macinnes & Parrott 2015). This is most likely due the nature of the crimes committed, typically murder, attempted murder, and manslaughter,

and to their severe mental health issues, typically schizophrenia (Boyd-Caine & Chappell 2005; Ellis et al. 2010; Ogloff, Lemphers & Dwyer 2004; Ong et al. 2009). Chao and Kuti (2009) conducted a descriptive retrospective study, using 324 patient case files and interviews with relevant professionals, within two medium secure forensic inpatient units in London, UK. The purpose of this study was to gather initial information about the parenting experiences of forensic patients (Chao & Kuti 2009). The authors found that of case files reviewed, just under 10% related to female inpatients (n=32). Of these women, 38% (n=12) were mothers. Chao and Kuti (2009) reported that compared to forensic inpatient fathers whose children were cared for by their biological mother, inpatient mothers were more likely to have complex care arrangements for their children, such as the child living overseas or under the care of statutory welfare organisations (Chao & Kuti 2009). Seeking to address this research gap, Parrott, Macinnes, and Parrott (2015) conducted narrative interviews with 18 parents (10 fathers and eight mothers) located in a medium security English hospital. The authors only examined the care arrangements of children who the parents had direct contact via email, phone, or face-to-face visits, during their admission. Parents without direct contact were excluded as closed adoptions accounted for the loss of contact. Six mothers provided care information about eight children. Four were living with their fathers, three with relatives, and one was in statutory welfare care. In comparison, all children of the five-inpatient fathers lived with their other parent (Parrott, Macinnes & Parrott 2015). These two studies show that there was a level of similarity with correctional research. Imprisoned mothers with a mental illness also depend on a larger range of people to care for her children (Chao & Kuti 2009; Parrott, Macinnes & Parrott 2015). Furthermore, Parrott, Macinnes, and Parrott (2015) reported that two mothers and one-half of the fathers lost custody of their children, but they provide no timeline regarding whether this occurred prior to or upon their admission. There was also no mention of the primary carer status of the parents prior to their offending and/or admission. Chao and Kuti (2009) did however report that the majority of their participants were primary carers.

These two studies specifically examined the parenting experiences of mothers with a mental illness. Their forensic status however complicates the examination of their children's care arrangements. Due to their severe mental health issues and to their offending, it is likely women's involvement in the care planning process was limited. Indeed, Parrott, Macinnes, and Parrott (2015) narrative interviews with the mothers highlights that prior to their admission, this group of mothers experienced periods where they could not look after

themselves, and had difficulties communicating and responding to their children's needs. Furthermore, these two aforementioned studies are exploratory; there has been no research conducted to examine how, or even if, forensic mothers arrange their children's care. Given the level of similarity in the care arrangements between imprisoned and forensic mothers, this discussion moves to a broader examination of the care planning experiences of imprisoned mothers.

The care planning experiences of imprisoned mothers

The placement options available to incarcerated mothers is dependent on the resources of the mother, her crime and sentence length, the age of the children, and the quality of the mother-carer relationship (Baker et al. 2010; Cecil et al. 2008; Enos 2001; Flynn 2008, 2013; Strozier et al. 2011). This may explain why research into care planning for female prisoners children has consistently shown that this process is typically unplanned, informal, and unassisted (Healy, Foley & Walsh 2000, 2001; Hounslow et al. 1982; Zalba 1964). As a result, children of incarcerated mothers are more likely to experience instability, with multiple care arrangements over the course of their mother's imprisonment, and separation from siblings (Johnson 1995; Poehlmann et al. 2008; Stanton 1980; Zalba 1964).

In one of the first large scale studies to examine care planning, Zalba (1964) conducted a multi-stage study at the California Institution for Women, which at the time was that state's only female prison. As part of this study, Zalba (1964) examined the experiences of 124 imprisoned mothers who had minor children (n=303), and investigated the level of inter-agency communication, cooperation and coordination between professionals who were actively involved with these families. Zalba (1964, p. 63) found that "haphazard planning and placement for children" was often the result of family stress and confusion regarding the possible outcomes of the court case in the pre-imprisonment period. As a result, mothers often made only temporary placements for their children. When practical care arrangements were made, they had the potential to become untenable over time (Zalba 1964). Such placements were made in a context of low social resources, a lack of trust or limited knowledge of services, and very limited formal agency involvement. In this study, mental illness only represented a demographic characteristic of the mother and was not examined. Zalba (1964) concluded that there was a need for interagency communication and collaboration between the criminal justice system, including prison and community corrections, as well as child and social welfare services, to ensure a family-orientated pre-

and post-release planning process, in order to improve the effectiveness of the services provided. Given the author discussed public welfare services in general terms, it is unclear whether this includes the mental health system. Zalba's (1964) call for interagency and cross-sector collaboration to respond to prisoners and their families has been echoed again more recently in Australia (see: Saunders & McArthur 2013; Trotter et al. 2015). However, an 18-month project conducted in the US state of Missouri examined interagency and cross-sector collaborative planning process for prisoners and their families, highlighting the difficulties of adult and child focused services in determining whose needs should be the main focus; the prisoner parent or their children (Abram & Linhorst 2007). Such difficulties in regards to inter-agency collaboration have been noted elsewhere (McDonald & Rosier 2011, 2013).

Whilst the impact of parental imprisonment was first acknowledged in the US in the 1960s, the uptake has been slower in Australia, with Hounslow et al. (1982) representing the first Australian study to examine this issue. This mixed methods study included data from 244 questionnaires completed by prisoners in NSW who had children aged 16 years and under, interviews with prisoner parents (55 mothers and 50 fathers), and interviews with 33 adults and children who had direct experience with the criminal justice system. When looking exclusively at the results obtained from imprisoned mothers, the authors found that, similar to Zalba (1964), informal care arrangements between mothers and carers of their children were often ad hoc and lacked ground rules around contact and communication. These care arrangements were also similarly underscored by a lack of information made available to mothers from their legal counsel about the possible sentence outcomes, as well as the parent's mistrust of support services (Hounslow et al. 1982). A subsequent Australian study by Healy, Foley and Walsh (2000) conducted in Queensland, strengthens Hounslow et al.'s (1982) findings, as they are replicated almost two decades later in a different state. This smaller-scale study included interviews with imprisoned parents (19 fathers and 11 mothers), a focus group conducted with relevant family members and other close supports (n=8), and a combination of interviews and focus groups with professionals who work with prisoners and their families (n=14). It is unclear whether any of these professionals worked in the mental health system. Although this study included both imprisoned mothers and fathers and did not delineate results by gender, the findings reiterate that poor care planning preparation was linked to confusing communication between the legal counsel and the parent, and was associated with overly optimistic attitudes of either party about the likelihood of the sentencing outcomes. The chaotic lifestyles of the family, particularly in regards to substance

use, also played a role in poor care planning. Furthermore, engagement with formal support networks was often hampered by distrust and fear that children would be removed and placed into foster care (Healy, Foley & Walsh 2000, 2001). This suggests that systemic responses from both the criminal justice and welfare systems influence the care planning process, and outcomes for children.

A small body of research also examines the individual maternal and contextual factors, rather than the systemic factors, associated with these care decisions. Enos (2001) examined the experiences of mothering within a US female prison using a mixed methods approach which combined observations made during a weekly parenting program and interviews conducted with 25 imprisoned mothers (Enos 2001). The author found that mothers considered a number of factors when determining their children's care, including the quality of the mother-caregiver relationship, the quality of the child-caregiver relationship, and the resources available to the caregiver in order to provide safe and stable care (Enos 2001). Therefore, mothers, when confronted with the need to plan the care of their children during their imprisonment, weigh up the value and feasibility of different placement options. Factors such as the sentence length, age and gender of children are considered when making care decisions (Enos 2001). Whilst Enos (2001) acknowledged that the care arrangements differed across race and ethnicity, her examination did not include other individual characteristics of the mothers such as substance use or mental illness. She did recognise that placement options were dependent on the resources of the mother, particularly in reference to support networks. In addition, Enos (2001) did not examine the association between the mother's preference and the stability of care arrangements.

With the aim of extending the work of Enos (2001) to a larger sample, as well as examining the interaction between maternal preferences and the stability of care arrangements, Poehlmann et al. (2008) interviewed 96 incarcerated mothers recruited from a US Midwest medium-minimum security female prison (Poehlmann et al. 2008). These women were part of a larger study conducted between 1999-2002 which examined the effects of maternal incarceration on families and children (see: Poehlmann 2005a, 2005b), with this data set being used for multiple studies. The inclusion criteria for this study included primary carer mothers (defined as the main caregiver prior to incarceration) whose child/ren aged between two and seven years resided in informal care arrangements, such as with relatives (Poehlmann et al. 2008). The participating mothers reported that they weighed up a number of factors when determining their children's care, where the preference was for quality, safe,

and stable care where the caregiver had an established relationship with the children (Poehlmann et al. 2008). The authors identified continuous care arrangements were more likely to occur when the mother's placement preferences were honoured and where there was a positive mother-caregiver relationship (Poehlmann et al. 2008). Therefore, the social resources of the mother play a role in the care planning process, a particularly problematic result for imprisoned mothers who have limited resources or options on which to base their choices. For example, the study by Sharp and Marcus-Mendoza (2001) which examined the issues associated with placements, highlights that low social resources result in placements with caregivers, typically maternal grandparents, who have a history of substance use, and abusive or violent behaviour.

The study by Poehlmann et al. (2008) also included an analysis of the maternal and family variables, such as race and ethnicity, mother's age, child's age, number of children, length of sentence, socio-demographic factors, and substance use, finding that none of these characteristics are significantly associated with stability of children's care arrangements. It is important to note however, that Poehlmann et al. (2008) did not examine mental illness. This characteristic could also represent a potential issue that may also affect their ability to negotiate with potential caregivers and ensure that their preference is one that is honoured.

Building on Australian knowledge, specifically on the impact of maternal imprisonment on adolescent children in Australia, Flynn (2008, and related publications: 2012, 2013, 2014) examined how 15 mothers who had been in prison engaged in decision-making and planning for the care of their children. These participants were drawn from a sample of 139 women who were involved in a larger study that examined the use of criminal justice, and social welfare services after imprisonment (see: McIvor, Trotter & Sheehan 2009). Flynn (2008) used interviews with the participant mothers and their adolescent children (n=14) to develop a hierarchical care planning typology: 'secure care arrangements', 'care by default arrangements', and 'no care arrangements'. This typology aimed to capture the range of care outcomes for children. 'Secure care arrangements' represented a clear care planning process, while in comparison 'no care arrangements' had no clear planning process and imprisonment resulted in a family crisis (Flynn 2008, 2013). Maslow's (1970) hierarchy of needs was the theoretical basis for the analysis and resultant typology. The results showed that only a small minority of the adolescents (n=6) experienced secure care arrangements (Flynn 2008).

Flynn's (2008) interviews with the 15 mothers also identified a number of individual, social and systemic factors that influenced the care planning process prior to prison, and expanded the factors discussed previously (see: Enos 2001; Healy, Foley & Walsh 2000, 2001; Hounslow et al. 1982; Poehlmann et al. 2008; Zalba 1964). The personal factors included experiences of mental illness and substance use as well as poor social resources. The systemic factors included: unrealistic ideas regarding the criminal justice process; time constraints, particularly when women are arrested and denied bail or when sentencing unexpectedly resulted in imprisonment; the lack of police policies regarding children; as well as a lack of acknowledgement of children in the court proceedings (Flynn 2008). This once again highlights the role of systemic responses from both the criminal justice and welfare systems on the care planning process, and outcomes for children. Indeed, Flynn (2008) found that knowledge or experience of the criminal justice system process, acceptance of the prison sentence as a likely outcome of the court proceedings, access to social resources, and open dialogue with children was associated with all secure care plans.

Importantly, the study by Flynn (2008) extends the discussion to experiences of substance abuse and mental illness typically those that are unresolved or untreated, in this process. Echoing in part the earlier assumption, that mental illness adds difficulty to the care planning process (see: Chao & Kuti 2009; Parrott, Macinnes & Parrott 2015). Indeed, Flynn (2008) found that maternal substance abuse or mental illness did not appear to hinder the care planning process as long as these issues were acknowledged by the mothers and were being addressed, with assistance from their wider support system. This may explain in part why Poehlmann et al. (2008) did not find a relationship between substance use and the stability of care plans.

This body of research examining care plans highlights the role of the mother's individual, social, and systemic factors, and the interplay between these factors are relevant to the care planning process. With Flynn (2008) representing the only study to report on the impact of mental illness in the care planning process. Outside of planning and arranging children's care, the gender-responsive practice of the criminal justice system, first identified in the previous chapter, may also play a role in maintaining the parenting role and managing distress.

3.2.5.2 Gender-responsive prison practice

Laux et al. (2011) highlights that mental illness is one important issue that mothers bring into prison, with the separation from children having the potential to exacerbate distress

associated with their mental health issues (Fogel 1993; Fogel & Martin 1992; Houck & Loper 2002; Hurley & Dunne 1991; Lindquist & Lindquist 1997; Loper 2006; Loper et al. 2009; Roxburgh & Fitch 2014). Engagement with gender-responsive prison programs, first identified in Chapter Two, may mediate this level of distress. Therefore, the following discussion briefly examines the research relating to gender-responsive practice in terms of contact maintenance programs, parenting programs, and health and welfare programs. In-depth examination of such practice is beyond the scope of this study given its specific focus; included in this discussion are the remaining three articles that are directly relevant to the specific focus of this study. Cormac et al. (2010) examines contact maintenance programs in forensic hospitals, while the remaining two articles examine the mental health needs of imprisoned mothers housed within a Mother-Baby Unit (MBU) (Birmingham et al. 2006; Gregoire et al. 2010).

Contact maintenance programs

Contact maintenance programs, such as letter writing, telephone calls, and visits with children provide an avenue for imprisoned women to maintain their mothering role, as well as the parent-child relationship (Shlafer, Loper & Schillmoeller 2015). Using two surveys conducted by the US Bureau of Justice Statistics which examined prisoners and their children (see: Glaze & Maruschak 2008; Mumola 2000), Maruschak, Glaze and Mumola (2010) reveal that three-quarters of prisoners in state prisons have some contact with their adult and/or minor children. Of these, the vast majority exchange letters with their children, just over one-half talk with their children over the telephone, but only 42% receive at least one face-to-face visit during their prison sentence (Maruschak, Glaze & Mumola 2010). There are also gender differences in contact, with mothers more likely than fathers to have at least one form of contact with their children during their sentence, and more frequent contact (Maruschak, Glaze & Mumola 2010). Whilst the authors also reported that mothers were more likely than fathers to have mental health issues, and access mental health treatment or services prior to or during their imprisonment, this issue was examined as a contextual factor effecting the families' lives prior to imprisonment (Maruschak, Glaze & Mumola 2010). There was no analysis examining differences between mothers with and without mental illness, and contact with children during their sentence.

Research indicates that contact between mothers and their children is mediated by a number of factors, such as the children's age, financial considerations, the geographical distance to

the prison, time constraints of the carers, and mother or caregiver opinions around contact (Burgess & Flynn 2013; Flynn 2014; Poehlmann et al. 2008, 2010; Snyder 2009). According to Enos (2001), having supportive and competent caretakers for their children increases the likelihood that mothers are able to maintain their parenting role during their prison sentence. For example, the study by Poehlmann et al. (2008), described earlier, found that positive mother-caregiver relationships, alongside more stable care arrangements, is related to frequent visits and increased telephone contact between mothers and their children. Furthermore, other research indicates that supportive caretakers are also associated with mother satisfaction with the care arrangement (Butler 1994; Flynn 2008). However, not all mother-caretaker relationships are positive. Hostile relationships between mothers in prison and ex-partner caretakers have been reported in a number of studies, where ex-partners have restricted contact between mothers and their children (see: Arditti & Few 2006; Cunningham & Baker 2003; Flynn 2013; Martin 1997). The prison environment (e.g. no contact visits, visits behind a barrier, being searched, use of drug dogs, and high levels of surveillance), prison policies and procedures (e.g. prison rules around days and time for visiting, and clothing guidelines), and custodial staff attitudes also play a role in facilitating or hindering contact (de Hann 2010; Flynn 2014). As an outcome of these factors, imprisoned mothers and their children often experience a lack of dependable and good quality contact (Murray, Farrington & Sekol 2012).

The existing evidence, however, highlights the benefits for mothers of maintaining meaningful parent-child contact (Burgess & Flynn 2013). A range of international studies have indicated that maintaining family relationships helps to facilitate positive post-release plans. It reduces the likelihood of reoffending (see: Bales & Mears 2008; Healy, Foley & Walsh 2000, 2001; Mignon & Ransford 2012); provides a concrete motivation for behavioural change (see: Casey-Acevedo & Bakken 2002; Ferraro & Moe 2003); facilitates better adjustment during the prison sentence (see: Houck & Loper 2002; Loper et al. 2009); and reduces stress related to the mother-child bond and parental competence (see: Tuerk & Loper 2006). Indeed, the work of Poehlmann (2005b) highlights the importance of contact with children on the depression symptomology of imprisoned mothers. Although this was the same sample as that referred to in Poehlmann's (2008) study described previously, this analysis (Poehlmann 2005b) had a different focus, therefore the final sample size reported differs. This study included a widely used instrument that measured current experiences of depression, as well as other instruments that examine contact with children, relationships with

children and carers, experiences of past trauma, as well as open-ended questions regarding their thoughts regarding their separation from children. The results indicate that infrequent face-to-face contact with children is significantly associated with current symptoms of depression at interview (Poehlmann 2005b). This shows the importance of face-to-face contact on the wellbeing of imprisoned women who have a mental health issue, and highlights the role prison-based support services must play in supporting women who have infrequent contact. As Poehlmann (2005b) reports, the participating mothers described their initial separation from children at imprisonment as distressing, with a small number of women describing suicidal thoughts and actions. As with the previous discussion examining distress and the associated separation from children due to imprisonment, this result is limited by the fact it focused on current symptoms, rather than on whether the mothers had a clinically diagnosed mental illness. However, this study represents one of the few to connect maternal distress with contact with their children during imprisonment.

Contact with children has also been found to have negative implications for imprisoned mothers. Houck and Loper (2002) called attention to that fact that the majority of imprisoned women and their children experience a dramatic shift in the amount of contact, going from daily face to face contact prior to incarceration, to in many cases less than once a month. The implications of this dramatic shift may explain why Casey-Acevedo et al. (2004) and Benning and Lahm (2014) whose examination of contact and the resulting behavioural outcomes for women (e.g. rule infractions), highlighted the emotional and behavioural consequences of contact, frequent or otherwise. In their work, the authors argue that contact provides reinforcement of the guilt associated with being imprisoned, and grief over the loss of influence over their children's lives, and missing major family events (Benning & Lahm 2014; Casey-Acevedo, Bakken & Karle 2004). Whilst not the focus of this study, it is worthwhile noting that contact with imprisoned parents also has mixed implications for their children (Flynn 2014; Poehlmann 2005c; Shlafer & Poehlmann 2010; Trice & Brewster 2004). When examining children's attitudes around visiting, Flynn (2014) report that children typically expressed negative views regarding visiting their mother in prison due to the prison environment (i.e. visiting and surveillance processes, lack of privacy, and staff attitudes). Despite these experiences, children still wanted to visit their mother. Such research again highlights the importance of prison services and programs that both facilitate meaningful contact, and provide mental health support for mothers. This research also shows the importance of acknowledging and responding to the complexity inherent in imprisoned

mothers and their children, and the interplay between factors that have the potential to continue or exacerbate mental health issues during imprisonment.

In the forensic setting, the existence of contact maintenance programs is complicated by both the nature of the offence for which people are being detained, which is often against family members, as well as the severity of the mental disorder (Chao & Kuti 2009). As a result, Chao and Kuti (2009) argue that the literature often restricts itself to examining the safety issues surrounding family contact within this setting. Cormac et al. (2010) also highlights this in her postal survey with 68 professionals from a range of medium and low secure forensic psychiatric services in England and Wales. The aim of that study was to examine the level of service provision to children and families. The authors found that while family visiting rooms were available in 75% of services, fewer services provided child-friendly facilities such as toys suitable for pre-school (63%) and school-aged (50%) children, and only approximately 15% provided facilities for adolescent children (Cormac et al. 2010). While forensic patients, especially mothers, are able to maintain some form of contact with their children (Chao & Kuti 2009; Parrott, Macinnes & Parrott 2015), the quality of this contact is hampered by the lack of attention to children within this system. As discussed in the previous chapter, gender-responsive practice typically limits itself to the prison setting, rather than the community or forensic setting. In addition, outside of contact maintenance programs, parenting programs are also another aspect of gender-responsive practice.

Participating in parenting programs

Participating in parenting programs represents another avenue to improve parenting capabilities, and in many respects, parent in prison. As such, a large body of evidence has indicated that imprisoned mothers are at risk of maladaptive parenting (Green et al. 2005); this is unsurprising given the research that highlights that this group often parent within difficult environments. When looking exclusively at the parenting environments of imprisoned mothers with a mental illness, only two pieces of directly relevant research exist. Conducted over the past decade by the same group of researchers, examining the mental health needs of imprisoned mothers housed within a Mother-Baby Unit (MBU) (Birmingham et al. 2006), and compared these needs to mothers imprisoned without their children (Gregoire et al. 2010).

In order to address the gap within the literature regarding the prevalence of mental illness in the population of imprisoned mothers with young children in the MBU, Birmingham et al.

(2006) examined the social and demographic status, prevalence of mental illness and treatment needs of 55 mothers participating in all MBUs in English prisons. Using semi-structured interviews, the authors found 60% (n=33) of the mothers described a history of one or more of the five categories of mental illness, including Personality Disorder, Psychotic Disorder, Neurotic Disorder, self-harm, and post-traumatic stress. These interviews also uncovered that 51% (n=28) of mothers within the MBU showed evidence of a mental disorder at the time of the survey, particularly Neurotic Disorder, Personality Disorder and substance abuse (Birmingham et al. 2006). These disorders represent the mild to moderate end of the mental illness spectrum, which differs from the previous research which examined severe mental illness only (see: Lynch et al. 2012).

Despite the extent of mental illness within this unit, only 24% (n=13) of the mothers reported that they had been under the care of a psychiatrist prior to imprisonment and had been prescribed antidepressant medication. Two of the mothers also reported that they been admitted into hospital for psychiatric treatment (Birmingham et al. 2006). The authors did not elaborate on any other mental health treatment received, particularly why all 13 mothers were under the care of psychiatrist as opposed on any other mental health professional or service. This level of formal intervention is lower than the rate for mothers located in the general prison population (Glaze & Maruschak 2008; James & Glaze 2006; Lynch et al. 2012; Mundt et al. 2015), and lower than the rate found in the general community (Harris et al. 2015; Whiteford et al. 2014). In addition, the authors also examined the prison medical records of 47 of these mothers (eight medical records were not available). Of the 28 mothers who showed evidence of a mental health issue at the interview, less than one-half of their prison medical records (n=10) mentioned mental health issues, with only three mothers receiving treatment: all however, were prescribed antidepressant medication. The majority of the 47 records did not mention current or past history of mental health issues or treatment needs (Birmingham et al. 2006). Such results suggest that mental illness and the associated treatment needs of imprisoned mothers within MBUs often go unidentified and untreated (Birmingham et al. 2006). This has implications for children as maternal mental illness is associated with, amongst other issues, mothers who are less emotionally available, with difficulties communicating and responding to children (Reupert & Maybery 2007).

Comparing their findings with the 1997 Office for National Statistics survey 'Psychiatric Morbidity among Prisoners in England and Wales' (Singleton et al. 1998), the authors concluded that the criteria and admission process for these units appear to exclude women

who have a mental illness, aside from mild-to-moderate mental illness (Birmingham et al. 2006). Despite this important finding, the direct relationship between the presence of mental illness and admission to prison based MBUs is not clear. In contrast, the examination of the medical records suggests that mental health issues within such units often goes unidentified, therefore this ‘selecting out’ cannot be tied to the presence of mental illness alone (Birmingham et al. 2006). Rather, as Birmingham et al. (2006) noted, the low incidence of women experiencing mental illness within the MBU maybe an outcome of women with mental health issues being unlikely to apply, the associated behavioural issues may lead to rejection, or these women may be on longer sentences and thus do not fit the selection criteria. This indicates the nature of the criminal justice system where the focus is on security. In this setting, MBUs are constructed as a privilege not a right for imprisoned mothers or their young children, despite the documented consequences of separating mothers and their children (Goshin, Byrne & Blanchard-Lewis 2014).

The results by Birmingham et al. (2006) also highlight the general invisibility of mental illness within these units, where the focus is on responding to the parenting needs of imprisoned mothers rather than their mental health needs. This reflects the discussion in the previous chapter, regarding siloed systems, that are often limited to addressing single issues, and highlights the challenges of responding holistically to families. However, the findings by Birmingham et al. (2006) are limited by time. The authors conducted this study in 2003, four years before the publication of ‘The Corston report’ (2007) which, as discussed in Chapter two, shaped gender-responsive developments in the UK criminal justice system, including ‘seeing’ and responding to women’s specific mental health and parenting needs. Since then, the number of MBUs in UK has increased from four to six (UK Government 2015), and a number of parenting and attachment programs have been introduced into these units (Baradon et al. 2008; Slead, Baradon & Fonagy 2013). It is unclear whether anything that specifically targets mental health issues has been introduced.

Building upon Birmingham et al.’s (2006) study, Gregorie et al. (2010) hypothesised that the risk of mental illness was higher for mothers who had recently given birth and were separated from their infants due to imprisonment. To explore this, Gregorie et al. (2010) compared the MBU sample to 112 imprisoned mothers who had a child aged under 18 months, who were residing with carers in the community. Gregorie et al. (2010) found that the non-MBU mothers had more in common with the general UK female prison population than with the

MBU population. The former showed higher rates of mental illness (90%, n=101, N=112) and less stable backgrounds, such as more likely to be single and unemployed.

Similar to the previous study (Birmingham et al. 2006), mental disorder was based on the five categories of mental disorder as outlined in the 1997 Office for National Statistics prison survey (Singleton et al. 1998). Expanding upon this finding, Gregorie et al. (2010) also compared the mothers who applied to participate in the MBU to those who did not; of the 112 mothers, less than one-third applied for a place. The reasons given from those who did not apply included child under the care of statutory child protection services, and the prison environment. In contrast, for the mothers who applied but were refused, their refusal was based on their sentence length, nature of their offence, behavioural issues, age of the child, and childcare history. In addition, mothers in the general prison population who applied for a bed within the MBU but were rejected had slightly lower rates of mental illness compared to those who did not apply. The article was unclear however regarding whether these comparisons were statistically significant or not.

The results of Gregorie et al.'s (2010) study provides further evidence that women with mental health issues may have a reduced access to participating in certain prison programs that may help to enhance their parenting skills (Birmingham et al. 2006). The impact of such results on care planning is profound as it suggests that mothers who have a mental illness, especially when symptoms are on the moderate-to-severe end, may be unable to obtain a place within a MBU (Birmingham et al. 2006; Gregoire et al. 2010). This may be an outcome of the aims of these units, and the risk-averse nature of prisons. This result is problematic, as the exclusion of mothers with a mental illness has implications for developing and maintaining the mother-child bond at such a crucial age, as well as improving the mothering skills of already vulnerable women. Therefore, it appears that those who need it the most do not have access. Indeed, research shows that disrupted attachment, alongside the context of the family has implications for children's health and wellbeing over the lifespan (Felitti & Anda 2010; Grella, Stein & Greenwell 2005; Schüssler-Fiorenza Rose, Xie & Stineman 2014).

The authors also conducted a follow-up study which examined the experience of this population of mothers following their release from prison (Dolan et al. 2013). The authors interviewed 112 women who participated in the previous two studies (Birmingham et al. 2006; Gregoire et al. 2010). Whilst an examination of Dolan et al. (2013) is beyond the scope

of this study as it focuses on the post-release period, it is worth mentioning that mothers with a mental illness who participated in the MBU were significantly more likely to have resumed the care of their children post release. Whilst this result does have methodological issues, as the MBU mothers may have been more stable and thus easier to locate, this result does show the importance of participating in such programs for returning to the mothering role, particularly for those who have a mental illness. Therefore, access to prison-based health and welfare programs may also assist imprisoned mothers with a mental illness.

Participating in health and welfare programs

Whilst not actively about parenting, access to mental health and welfare programs can have direct benefits for mothers, given the high levels of mental health issues prior to (Laux et al. 2011), and during imprisonment. The study by Laux et al. (2011) indicated that imprisoned mothers commonly accessed mental health services prior to imprisonment. This high level of mental health service involvement is also seen in the general female prison population (Faust & Magaletta 2010; James & Glaze 2006; Lynch et al. 2012; Mundt et al. 2015), undoubtedly linked to the fact that such services are an important part of gender-responsive practice. However, an in-depth examination of the literature base behind such services is beyond the scope of this study. That said, access to such services might explain why a small body of research controversially suggests that imprisonment is associated with good mental health.

Bonta and Gendreau (1990), in their review of the research literature, attributed good levels of health found in prison studies to access to health and mental health services, as well as regular accommodation, food, and exercise (Bonta & Gendreau 1990). While that finding may relate more to male prisoners than females, recent research specifically about women indicates that prison can represent a safe place for some. This is because it can be an escape from risky lifestyles such as prostitution, homelessness, substance abuse, as well as from male violence that characterises the lives of many imprisoned women (Bradley & Davino 2002; Ferraro & Moe 2003). In addition, prison can be a respite from the demands of mothering within these risky live styles (Ferraro & Moe 2003). Bradley and Davino (2002) also comment that prison provides an opportunity to recover and reflect, while being separated from the individual, social, and systemic challenges of everyday life. However, prison does have the potential to make mental health worse, with research highlighting a number of contributing factors such as, isolation and lack of mental stimulation, poor relationships with staff and bullying from other prisoners, safety and security issues, limited

access to mental health services, and, reflecting the previous discussion, a lack of family contact (Bradley & Davino 2002; Douglas, Plugge & Fitzpatrick 2009; Nurse, Woodcock & Ormsby 2003).

The data from these aforementioned studies (see: Bradley & Davino 2002; Douglas, Plugge & Fitzpatrick 2009; Ferraro & Moe 2003; Nurse, Woodcock & Ormsby 2003) are based on small-scale qualitative methodologies, therefore Harner and Riley (2013) sought to extend these results, to examine the impact of imprisonment on women's mental health. The authors conducted a two-stage study, whereby stage one was a prison health survey with 445 women respondents and the second stage of this study included twelve focus groups consisting of 65 women in total. The participants were imprisoned within a minimum-maximum security prison in an undisclosed location in the US (Harner & Riley 2013). These results mirror the previous research, with the authors finding that mental health can variably improve, become worse, or remain the same during imprisonment. The authors conclude that the idea that prison can be either good or bad creates a false dichotomy, with the impact of imprisonment likely to be fluid in nature, mediated by a range of individual, social, and systemic factors such as access to mental health programs (Harner & Riley 2013). Such results call attention again to the problematic nature of treating imprisoned women as a homogenous group, and the need to examine the intersections and complexity within mothers who have a mental illness.

3.3 The critique of current research literature

The previous sections reviewed the research examining the experiences of mothers with a mental illness as they navigate the criminal justice setting, with a particular focus on examining the intersections between their experiences. In order to understand the usefulness of this research to the current study, there is also a need to evaluate the methodologies and associated methods underpinning these studies. Four key issues emerge from this evaluation: the lack of attention to the intersections, definitional issues, limited Australian research, and design issues.

3.3.1 Lack of intersectionality: Finding imprisoned mothers with a mental illness

This review was challenged by working with two literature streams: imprisoned mothers and imprisoned women with a mental illness. Merging these was not feasible due to difficulty comparing and contrasting across the streams, in part due to the qualitative and quantitative divide, as well as the general invisibility of these intersections. For example, and as

previously mentioned, research examining the parenting experiences of imprisoned mothers is typically qualitative, where mental illness is one demographic factor that is acknowledged amongst many, if it is acknowledged at all. In comparison, the research examining the prevalence of, and treatment needs of imprisoned women is largely quantitative, where children are typically ‘sidelined’ as a demographic variable of the mother. The siloed nature of these research streams reflects in many ways what occurs at the legislative, policy, and practice levels of the criminal justice system and the wider community services, as discussed in the previous chapter. It also highlights the difficulty capturing the complexity underpinning the lives of imprisoned women, where the distinct and disjointed epistemological positions underpinning these streams make it difficult to draw them together in a cohesive manner.

This issue was compounded by the fact that only six studies, conducted over the past decade, deliberately connect this intersection. These articles are completely different in terms of their geographical location, place setting (prison or forensic facility), and methodology and associated methods. Indeed, all but one comes from the UK, with the other study set in the US. There is no Australian research. In terms of place, three studies were located in forensic facilities, two in prison, and one in prison-based MBUs. The methodologies are similar, in the sense that they are exploratory studies, however four were interview-based, one was a case file analysis, and one was postal survey. There are also differences in the sample size used, and the overarching aims of each study. The comparison between the six articles is presented below in Table 3.1. Whilst such differences reflect the exploratory nature of this research, the disconnected nature of this research make it difficult to incorporate, and draw strong conclusions.

Table 3. 1. The six articles that examine the intersection between motherhood and mental illness in the criminal justice system.

Study:	Place:	Location:	Aim:	Methodology:
Birmingham, L, Coulson, D, Mullee, M, Kamal, M & Gregoire, A 2006, 'The mental health of women in prison mother and baby units', <i>Journal of Forensic Psychiatry & Psychology</i>, vol. 17, no. 3, pp. 393–404.	England, UK.	Four Mother-Baby Units	"To determine the social and demographic context, prevalence of mental disorder, and psychiatric treatment needs of women in prison mother and baby units" (p.393).	Exploratory, semi-structured interviews with 55 mothers, 33 had a mental illness.
Chao, O & Kuti, G 2009, 'Supporting children of forensic in-patients: Whose role is it?', <i>Psychiatric Bulletin</i>, vol. 33, no. 2, pp. 55–57.	London, UK.	Two medium secure forensic units.	"Find out the proportion of patients who had children in this age group [18 years and younger], whether or not they were in contact with them and the extent to which services treating the patient had offered any support to the children" (p.55).	Exploratory, case file analysis of 12 mothers and 57 fathers, used professionals to fill in any missing data rather than asking the parent.
Cormac, I, Lindon, D, Jones, H, Gedeon, T & Ferriter, M 2010, 'Facilities for carers of in-patients in forensic psychiatric services in England and Wales', <i>The Psychiatrist</i>, vol. 34, no. 9, pp. 381–384.	England and Wales, UK.	Forensic units.	"To access the facilities and care arrangements for carers of inpatients in forensic psychiatric units in England and Wales" (p.381)	Exploratory, postal survey of forensic facilities.
Gregoire, A, Dolan, R, Birmingham, L, Mullee, M & Coulson, D 2010, 'The mental health and treatment needs of imprisoned mothers of young children', <i>Journal of Forensic Psychiatry & Psychology</i>, vol. 21, no. 3, pp. 378–392.	England and Wales, UK	Seven female prisons.	"Determine the nature and prevalence of mental disorders and mental health treatment needs, the extent to which these needs are identified by prison health services, and the care provided to women in prison who had children under the age of 18 months" (p.378)	Exploratory, semi-structured interviews with 112 mothers of young children, contrasted with the findings from Birmingham et al. 2006.
Laux, JM, Calmes, S, Moe, JL, Dupuy, PJ, Cox, JA, Ventura, LA, Williamson, C, Benjamin, BJ & Lambert, E 2011, 'The clinical mental health counseling needs of mothers in the criminal justice system', <i>The Family Journal</i>, vol. 19, no. 3, pp. 291–298.	Midwestern city, US.	County gaol.	"Conduct an exploratory investigation of the mental health status and counselling needs of mothers who are in the criminal justice system through the use of qualitative means" (p.292).	Exploratory, year-long monthly interviews, 304 participants (this number reduced over the year), motherhood not the sole focus as part of a larger study on substance abuse counselling needs.
Parrott, FR, Macinnes, D I. & Parrott, J 2015, 'Mental illness and parenthood: being a parent in secure psychiatric care', <i>Criminal Behaviour and Mental Health</i>, DOI:10.1002/cbm.1948	Unspecified location, UK.	One forensic unit.	"Given the knowledge gap about forensic mental health service users, our aim was to examine in depth their experiences of parenting" (p.2)	Exploratory, narrative interviews with eight mothers and 10 fathers.

3.3.2 Definitional issues

It is difficult to compare and apply the findings of the research used in this review, as there is also lack of consistency in defining and examining mental illness as well as what defines a mother.

3.3.2.1 *Defining and examining mental illness*

In the six most relevant studies to this review, there is a lack of consistency regarding how mental illness was defined. For example, Laux et al. (2011) relied on self-report, with only one-half of their participants reporting having a clinically diagnosed mental illness. The three studies located in the forensic setting did not discuss the mental health issues of their participants. The research by Birmingham et al. (2006) and Gregoire et al. (2010) used multiple instruments to examine the presence of each mental disorder in focus, with the studies using the same instruments to examine Personality and Neurotic Disorders, and substance use, but using different instruments to examine Psychotic Disorders and alcohol use. Furthermore, these instruments used were either the World Health Organisation (ICD-10) or the American Psychiatric Association (DSM-IV) diagnosis criteria, with the latter being revised in 2013 and is now in its 5th version (American Psychiatric Association 2013). This shows that the impact of using rather dated results, and the ways in which mental illness is conceptualised and diagnosed, has changed over time.

As discussed previously in ‘Section 3.2.5 Experiences at imprisonment and the mothers’ mental health’, such definitional issues are also compounded by the research which uses instruments to measure psychological distress (e.g. Houck & Loper 2002; Hurley & Dunne 1991; Lindquist & Lindquist 1997; Loper 2006), or current symptoms of depression or anxiety (e.g. Fogel 1993; Fogel & Martin 1992; Loper et al. 2009; Poehlmann 2005b; Roxburgh & Fitch 2014), rather than mental illness. The participants in these studies were not asked if they had a clinical diagnosis nor were the prison records examined. Furthermore, only three of the eight studies used the same scale (e.g. Houck & Loper 2002; Lindquist & Lindquist 1997; Loper 2006). This again makes it difficult to draw strong conclusions. In addition, other research examined only serious mental illness (e.g. DeHart et al. 2014; Lynch et al. 2012). It is not then unreasonable to extend the results to all mothers who have a mental illness, especially the ‘less serious’ mental health issues.

3.3.2.2 Defining mothers

There is also lack of consistency in how a mother is defined for research purposes. For example, some studies have taken a narrow focus, limiting their participants to those who have children in their care or custody prior to their arrest or imprisonment (Fogel & Martin 1992; Lindquist & Lindquist 1997), or participants who are the sole caretaker (e.g. Nieto 2002). Other studies have taken a broader view, and include mothers who have children irrespective of where the child is living prior to imprisonment (e.g. Berry et al. 2009; Laux et al. 2011; Zalba 1964). This broader definition is often used in studies where the focus is more generally on the experiences of imprisoned women (e.g. Ferraro & Moe 2003; Laux et al. 2011), as well as in studies that examine the experiences of imprisoned parents (e.g. Chao & Kuti 2009; Glaze & Maruschak 2008; Parrott, Macinnes & Parrott 2015). Indeed, Hounslow et al. (1982) included parents who had any form of contact with their children prior to incarceration. Laux et al. (2011) defined mother to mean a biological parent or someone who acted in the role of mother. Including those who are not the primary carer of their children, hides the crisis that occurs within families when the carer enters the criminal justice system as children who are living in kinship care, or with child protection, will most likely continue to live in these arrangements.

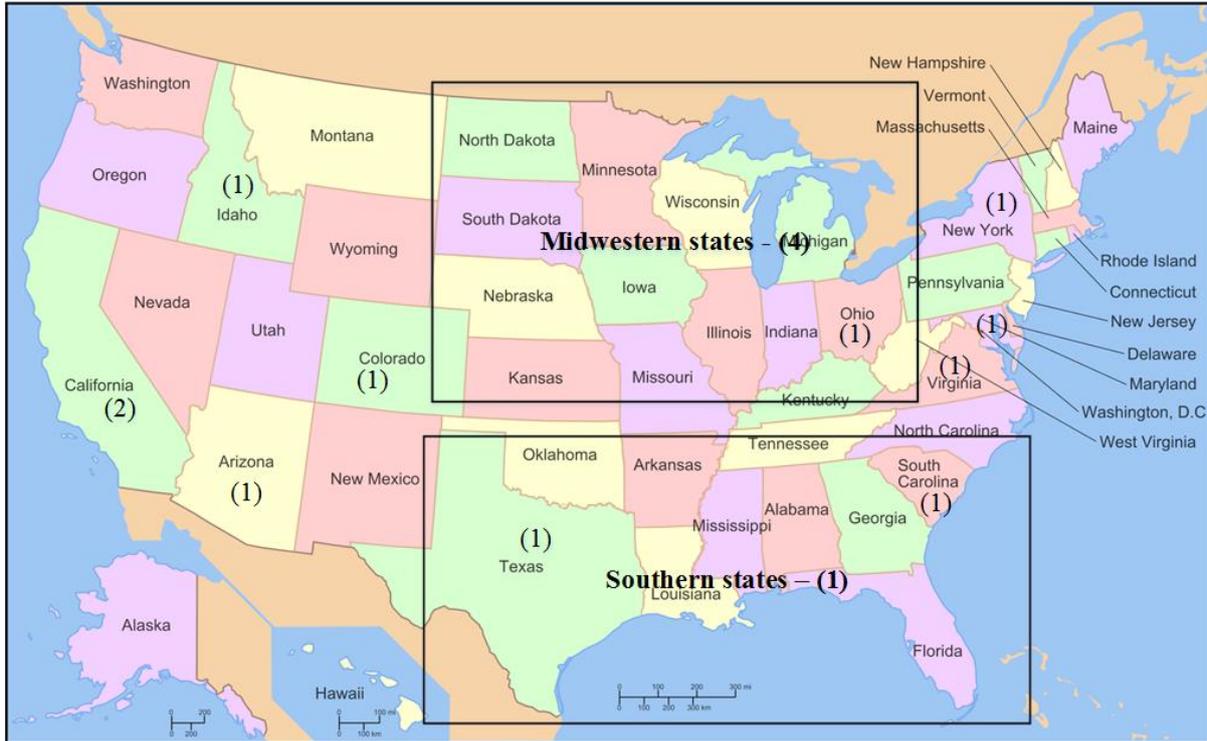
Furthermore, some studies included a specific age range for the participating mothers' children (e.g. Flynn 2008; Gregoire et al. 2010; Poehlmann et al. 2008; Poehlmann 2005b). Others took it more broadly, including mothers with children under the age of 18 years (e.g. Berry et al. 2009; Enos 2001; Nieto 2002; Roxburgh & Fitch 2014), or mothers with children under the age of 21 (Houck & Loper 2002; Loper 2006; Loper et al. 2009). Whilst this focus is important as research has shown that the age of children mediates the impact of parental incarceration (Eddy & Poehlmann 2010), it does not reflect the current status of families, where children can be dependent on their parents well into adulthood (ABS 2015; Qu & Weston 2013). Indeed, it may mean the experiences of older children still dependent on the imprisoned mothers are missed.

3.3.3 Limited Australian research

The majority of the research examining the experiences of imprisoned mothers as they navigate the criminal justice system, particularly how this system responds to this group of mothers, comes from the US, with a small number coming from Australia and the UK. Whilst this research provides important insights, it has limited generalisability to the Australian context due to the diverse range of people, practices, policies, and laws that underpin these

different criminal justice jurisdictions. Indeed, in Australia, management of crime and offenders is a state or territory based responsibility resulting in subtle differences between each setting. Furthermore, the research examined within this review comes from four out the seven states and territories: Victoria (e.g. Flynn 2008; VACRO & Flat Out 2006), NSW (Hounslow et al. 1982), South Australia (e.g. Lilburn 2000a), and Queensland (e.g. Healy, Foley & Walsh 2000, 2001; Hurley & Dunne 1991). Whilst this review does not examine all available Australian literature on prisoners and their children, given the specific focus of this present study, this does suggest that the Australian body of knowledge is rather limited, especially when it is taken into consideration that this inquiry spans the past three decades.

Given the US prison population represents one-fifth of the total world prison population (Fazel & Seewald 2012; Walmsley 2012), it is hardly surprising that the majority of the research discussed in this review is generated in that environment. However, as shown below in Figure 3.1, this research is typically disconnected, spread throughout the different states, with a number of studies failing to disclose location (e.g. Enos 2001; Harner & Riley 2013; Houck & Loper 2002; Loper 2006); three recruiting from multiple states (e.g. DeHart et al. 2014; Loper et al. 2009; Lynch et al. 2012); and just two using nation-wide prison survey data (e.g. Maruschak, Glaze & Mumola 2010; Roxburgh & Fitch 2014).



Note: This work, 'Map of USA with state names' is a derivative of the original license under Creative Commons Attribution-Share Alike 3.0 Unported.

Figure 3. 1. The location of the research from the US.

This scattered and disjointed approach makes it hard to develop a body of knowledge considering the differences in the criminal justice jurisdictions between each state. For example, the US has a complex criminal justice system that involves jails, as well as state, federal, and private prisons (Patterson 2012, p. 78–93); with each facility responding to different offender populations, and managed by different correctional jurisdictions (Patterson 2012). In comparison, Australia, and the UK uses the terms gaol and prison interchangeably. Other examples of the variation between the US and other western criminal justice jurisdictions include sentencing options. Whilst Australia and the UK abolished the death penalty, it is currently in operation in 31 out of the 50 US states (Death Penalty Information Center 2016). In addition, the US has 'three-strikes' laws for imprisonment after three offences, and mandatory minimum sentences (Belknap 2007). In contrast, Australian criminal just laws generally only provide guidelines for the maximum sentence, allowing for judiciary discretion (Law Council of Australia 2014). Such differences call into question the generalisability of research findings across western criminal justice jurisdictions.

3.3.4 Study design

Research has relied heavily on retrospective, single reporter, and single method designs. This is most likely related to difficulties recruiting in the prison environment, and retaining

participants over a period. For example, in the study by Laux et al. (2011), the participant numbers decreased due to difficulties contacting women in the post release period; with only 56 women participating in the final interview at 12 months. As previously mentioned, such difficulties were related to the transient nature of this population upon release as well as their chaotic lifestyles (Laux et al. 2011). This difficulty has been highlighted elsewhere (Davis, Francis & Jupp 2011; DOJR 2016; Liebling 1999; e.g. O'Brien & Bates 2003; Quina et al. 2007).

This review highlights four key issues within the current knowledge base surrounding imprisoned mothers with a mental illness. These key issues include the lack of attention to the intersections, definitional issues regarding mental illness and motherhood, limited Australian research, and design issues. Such issues make it challenging to draw the research together in a cohesive manor, and develop strong conclusions.

3.4 Significance of the literature: Seeing and responding to complexity

This reviews shows that imprisoned women with dependent children negotiate multiple and often independent systems, for example the criminal justice, child protection, and mental health systems. These systems are underpinned by a wide variety of legislation, policies, and practices. Women's ability to navigate these systems however, particularly the criminal justice system, is dependent on the interplay between individual, social, and systemic challenges. Mental illness represents one specific challenge, given the high rates of mental illness within the criminal justice system, and the association that mental health issues have with victimisation, substance use, and parenting issues. Despite this, mothers with a mental illness represent a largely invisible criminal justice population. Research typically examines mental illness with children as a demographic factor, or examines mothers and their children with mental illness representing a demographic factor, if this issue is acknowledged at all. Indeed, this discussion has shown that only six studies exist that deliberately connect mental illness and motherhood in imprisoned women. Laux et al. (2011) represents the study most central as it highlights the mother's difficult contexts prior to prison, particularly their high rates of mental health issues, service use, and difficulties with children. The remaining articles limit their focus to the point of imprisonment, and examine gender-responsive practice, such as contact maintenance programs (Cormac et al. 2010) and parenting programs (Birmingham et al. 2006; Gregoire et al. 2010), as well as the parenting status of forensic mothers (Chao & Kuti 2009; Parrott, Macinnes & Parrott 2015). The invisibility of this specific group of women within this system is troubling, given the nine studies that highlight the high

levels of distress associated with the separation from children at the point of imprisonment. Such experiences have the ability to exacerbate the symptoms and issues associated with mental illness. Taken together, such research highlights the need to examine the complexity and intersectionality that underpin the lives of imprisoned mothers, rather than viewing and responding to them as a homogenous group.

This literature review has provided evidence that imprisoned mothers parent within difficult and challenging contexts, with these contexts also playing a role in their offending behaviours and their entry into prison. However, at the point of arrest and sentencing, the criminal justice system is challenged in its responses to the parenting needs of women, often as a result of difficulties with current guidelines and policies. This has the potential to compound the problems experienced by mothers with a mental illness. In many respects, the criminal justice system does not respond to the parenting responsibilities or the mental health issues of imprisoned mothers until the point of her imprisonment; by then it is arguably too late. These interventions are an outcome of gender-responsive practice, which as discussed in the previous chapter, typically limits itself to prisons. This also has consequences for mothers who are admitted into forensic facilities.

The research examined in this review suggests a need for interagency and cross-sector collaboration to respond to the needs of women who have a mental illness, giving weight to the argument for 'joined up' criminal justice and community based services, discussed in the previous chapter. The review consistently suggests that imprisoned women, including mothers, engage with mental health services prior to imprisonment. However, these services do not divert these women away from the criminal justice system. Therefore, in many respects both systems have trouble seeing beyond single issues. Such difficulties may explain why the care arrangements for children are typically unplanned, informal, and unassisted, with stable and secure care plans dependent on the resources of the mothers.

This critique of the literature has revealed a number of limitations to the body of knowledge that examines the experiences of imprisoned mothers, and those with a mental illness, as they navigate the criminal justice system. First, and foremost, there is a lack of intersectionality in the research, with the experiences of imprisoned mothers with a mental illness invisible. Within available research, there are inconsistencies with defining mental illness and who or what constitutes a mother. Research is largely disconnected, and exploratory in nature. There is almost no research from an Australian context. The review was also broadened to include

articles that examined distress. However, there are also inconsistencies with the tools used in these studies, and these studies typically coming from the US or the UK, rather than Australia. Such issues make the drawing of cohesive and strong conclusion difficult. Therefore, the knowledge included in this review is tentative.

However, the review of the literature, as well as the policy and practice context discussed in the previous chapter, indicates that entry into the criminal justice system, and the navigation through it, should be seen as important decision-making points for addressing the needs of both mothers and their children. Incarcerated mothers are usually the primary and often sole caretakers of their children, therefore the points of arrest, sentencing, and imprisonment represent crisis points, where the immediate and longer-term care needs of children become paramount, particularly given the high rates of mental illness within this population. There is however limited available research that deliberately examines this intersection, with limited Australian context. This lends itself to the following core research question:

What are the experiences of mothers with a mental illness as they navigate the criminal justice system?

This research question is answered by attending to the following subsidiary questions:

1. What are the similarities and differences in the experiences of mothers with or without a mental illness as they navigate the criminal justice system?
2. What is the relationship between mental illness and motherhood as women intersect with the criminal justice system?
3. What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system?
4. How does the criminal justice system respond to this group of imprisoned mothers with a mental illness?

Chapter Two and Chapter Three have established the legislative, policy, practice, and research context of how mothers with a mental illness navigate the prison system, Chapter Four presents the methodology and associated methods that underpin this study, addressing the concerns evident in this chapter.

Chapter Four: The Methodology and Associated Methods

“Research is formalized curiosity. It is poking and prying with a purpose”

Zara Neale Hurston, in *Dust Tracks on a Road*, 1996, p. 143

This exploratory study uses a mixed methods approach to examine the experiences of and responses to mothers with a mental illness as they navigate the criminal justice system to plan the care of their children. Figure 4.1 below presents the framework for the design and implementation of this study.

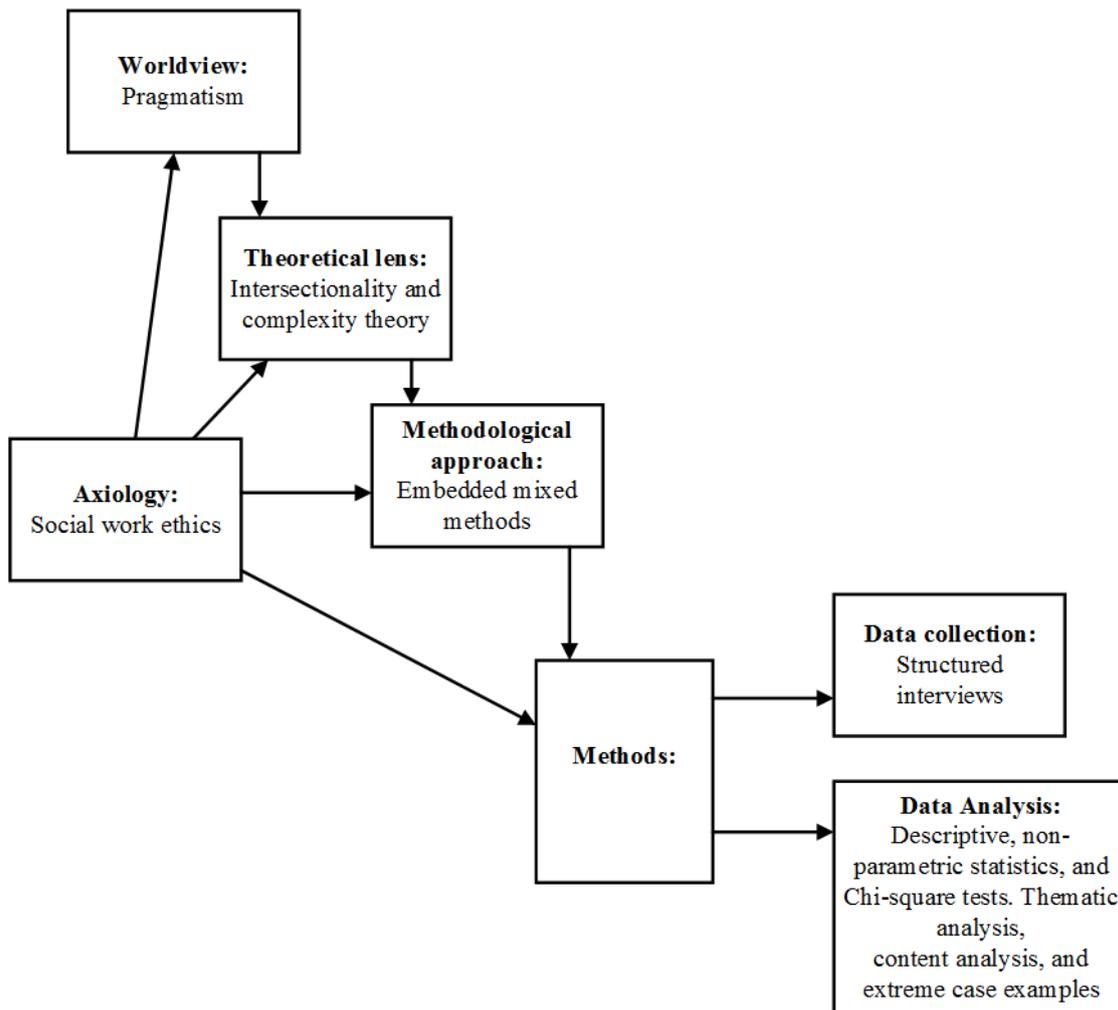


Figure 4. 1. The underpinning frameworks for developing this study (Creswell & Plano Clark 2011, p. 39).

This chapter describes the underpinning frameworks of this study: the worldview, theoretical lens, methodological approach and methods for data collection and analysis, within the

context of social work ethics (the axiology) (Creswell & Plano Clark 2011; Crotty 1998). As such, this chapter begins with a discussion on the research worldview and the theoretical lens that shaped the methodology and the associated methods of data collection and analysis. The chapter then builds on this to describe the methodology and associated methods used within this study. A discussion of the ethical and practical issues of conducting prison-based research is also included within this chapter. The discussion concludes with an examination of the strengths and limitations of the research design, particularly how this design addressed the methodological gaps previously identified within the research literature on imprisoned mothers with a mental illness.

4.1 The pragmatic worldview

In order to understand how this study was designed and implemented, it is important to understand the worldviews of the researcher. Worldviews are the set of values and beliefs that underpin and guide the research process: the assumptions made about reality, the different ways of knowing the social world, and the ways in which methods can represent knowledge gained from the social world (ontology, epistemology, and methodology respectively) (Grix 2002; Greene 2007). When researching social issues, worldviews also incorporate disciplinary understandings, practice wisdom, and past experiences (Greene 2007).

As a legacy of the quantitative-qualitative debate, tension still exists regarding the nature and role of worldviews within mixed method research (Greene 2007). This is because the worldviews underpinning quantitative and qualitative research present a largely dichotomous way of understanding the design and implementation of a given study. For example, quantitative research typically uses a post-positive/empiricist worldview, directing quantitative researchers to view research as a largely objective, value free endeavour, that focuses on empirically verifiable knowledge. Knowledge and theory development is seen as a deductive process. This worldview typically directs researchers to collect numerical data. In comparison, qualitative research uses a constructivist/interpretive worldview, which focuses attention to the social construction of knowledge, that is, how people interpret and ascribe meaning to reality. This position has an inductive view of the relationship between theory and knowledge, and acknowledges the role of values, bias, and experiences within the research process. This worldview typically directs researchers to collect non-numerical data from people, places, and texts (Bryman 2012; Crotty 1998). Subsequently, this debate centred on whether these worldviews are fixed or fluid positions, where a choice is made between either

quantitative or qualitative research methods, or whether worldviews and their associated methods can be mixed (Greene 2007; Tashakkori & Teddlie 1998). Indeed, advocates for mixed methods research highlight the need for methodological pluralism (Greene 2007).

A number of alternative and mutually exclusive positions have been developed to underpin mixed method research. The a-paradigmatic position allows researchers to see worldviews as peripheral to good research, and advocates instead, for the use of methods ‘best suited’ to answering the issue at hand (Tashakkori & Teddlie 2003). The substantive theory position, originating in the field of evaluation, places emphasis on theory to bridge the worldview divide (Greene 2007). A complementary strengths perspective mixes worldviews in a way that ensures the strengths of each worldview can be actualised (Greene 2007; Tashakkori & Teddlie 2003). The dialectic stance advocates that mixing worldviews and associated methods yields a better understanding of the issue (Greene 2007); while lastly, the alternative paradigm position uses a new worldview to underpin mixed methods, such as pragmatism, scientific realism, and transformative-emancipatory worldviews (Greene 2007; Howe 1988; Tashakkori & Teddlie 1998, 2003, 2010). Whilst this is an overly simplistic discussion, it highlights that worldviews can be used to combine methods typically thought of as quantitative or qualitative, highlighting the compatibility of these positions. Aside from the a-paradigmatic position, each position recognises the importance of worldviews in framing and guiding research, and determining research quality (Greene 2007).

The position underpinning this present study is the alternative paradigm position, specifically the pragmatic worldview. Pragmatism is a historically American worldview that has its roots in the writings of three philosophers: Charles Sanders Peirce (1839-1914), William James (1842-1910), and John Dewey (1859-1952). Important contributions to this philosophy have also been made by George Herbert Mead (1863-1931), Clarence Irving Lewis (1883-1964) and more recently, Richard Rorty (1931-2007) (Greene 2007). Tashakkori and Teddlie (2003, p. 713) define pragmatism as a:

“deconstructive [worldview] that debunks concepts such as ‘truth’ and ‘reality’ and focuses on ‘what works’ as the truth regarding the research questions under investigation. Pragmatism rejects the either/or choices associated with the paradigm wars, advocates for the use of mixed methods in research, and acknowledges that the values of the researcher play a larger role in interpretation of results”.

Therefore, a pragmatic worldview is positioned towards ‘what works’ when conducting research. The research questions are at the heart of the research design, a pluralistic stance to gathering data is adopted as both objective and subjective knowledge is valued, and emphasis is placed on the practicality, contextual responsiveness, and the consequences of a study (Biesta 2010; Creswell & Plano Clark 2011; Datta 1997; Goldkuhl 2008, 2012; Johnson & Onwuegbuzie 2004; Tashakkori & Teddlie 1998, 2003, 2010).

Despite the focus on the empirical and practical consequences of research, pragmatism is neither an atheoretical or anti-theoretical worldview (Greene 2007). This is because pragmatism honours both realism, as an ontological position, and constructionism as an epistemological position, in its view of the transactional relationship between human behaviour and the social world (Greene 2008; Johnson & Onwuegbuzie 2004). According to Crotty (1998) realism views reality as independent of the mind, whereas constructionism views meaning as constructed through the intersection with the social world, based on interpretation, and transmitted via the social context. Crotty (1998) also highlights the compatibility of these two positions, arguing that whilst the world can exist independently of the mind, understanding of the world and the associated meaning cannot. Pragmatism then becomes the bridge that links realism and constructionism together. This worldview values subjective knowledge of the external world as well as, the practical consequences of knowledge, amongst other things (Creswell & Plano Clark 2011; Greene & Hall 2010).

Currently, the pragmatic worldview is the most popular philosophical contender for mixed methods research (Greene 2008; Christ 2013; Tashakkori & Teddlie 1998, 2003, 2010). Nevertheless, Johnson and Onwuegbuzie (2004) remind us that it is not without its shortcomings. Mixed methods research is still a relatively new movement, compared to the more traditional divisions of qualitative and quantitative research, and as such, there is considerable debate within the mixed method community as to whether it requires an underpinning worldview, and if so, which worldview (e.g. pragmatism, scientific realism, or transformative-emancipatory) (Tashakkori & Teddlie 2003, 2010). Biesta (2010) asserts that there needs to be a more precise understanding of what pragmatism entails and its relevancy before it becomes *the* worldview for mixed methods research (as proposed by Johnson & Onwuegbuzie 2004; Tashakkori & Teddlie 1998, 2003).

Shaw (1999) advocated for a distinction to be made between methodological and philosophical pragmatism. Methodological pragmatism places emphasis on the research

context, the credibility of the methods used, and the practical applications of the research. In contrast, philosophical pragmatism places emphasis on the works of the aforementioned American philosophers and the abstract notions of truth and reality (Shaw 1999). In practice, methodological pragmatism would be similar to an atheoretical position discussed previously. Indeed, both methodological and philosophical components of pragmatism are needed for insightful inquiries into practice (Greene 2007), yet more often than not, methodological pragmatism is favoured (Shaw 1999). This may be related to researcher difficulty understanding the philosophical pragmatism, as Cherryhomes (1992) highlighted, pragmatism can be difficult to conceptualise as there are many different versions, due to differences in emphasis, interpretations, and reinterpretations. This is because the particular role of pragmatism within research is framed by the pragmatic perspectives of the researcher (Greene & Hall 2010). As Rylander (2012, p. 22) notes, pragmatism is a “continuously evolving conversation” rather than a static perspective. Biesta (2010) argues that pragmatism may provide a set of tools to determine the strengths and weaknesses of a mixed method approach, rather than an underlying justification. Furthermore, it is argued that the philosophical component of pragmatism needs “further conceptual and practical development” (Greene 2007, p. 85). In addition, the notion of practicality (or what works) that underpins pragmatism often fails to address “for whom is a pragmatic solution useful?” (Johnson & Onwuegbuzie 2004, p. 19; Mertens 2003).

Despite these shortcomings, the use of pragmatism as the underlying worldview is appropriate for this study. Pragmatism focuses attention to the interaction between the real world (action) and knowledge (Crotty 1998; Goldkuhl 2012), and provides an important “basis for research approaches intervening into the world [of imprisoned mothers with a mental illness, for example] and not merely observing the world” (Goldkuhl 2012, p. 136). Pragmatism, with its attention to what works, does not advocate for the use of one method over another, but rather for the method best suited to answering the research question (Yvonne Feilzer 2009; Greene & Hall 2010). For example, an alternative research methodology could have been a qualitative semi-structured approach. However, as will be discussed further in ‘Section 4.4 The methods’, this was not feasible within the Victorian prison environment, where audio recording devices are prohibited. Therefore, the research context, including the interpersonal, social, and political context, plays a significant role in determining which methodology and associated methods are appropriate. The researcher

simply does not have the luxury of methodological freedom. In this sense, this study leans towards methodological pragmatism (Shaw 1999).

This position is supported by Patton (2002, p. 72) who advocates that taking a pragmatic position permits the researcher to “eschew methodological orthodoxy in favour of methodological appropriateness as the primary criteria for judging methodological quality, recognising that different methods are appropriate for different situations”. The idea of methodological appropriateness is evident in the choice of pragmatism over the transformative-emancipatory worldview, which would arguable have aligned better with the feminist theoretical perspectives discussed below in ‘Section 4.2 The theoretical perspectives’ and the social work value base discussed in ‘Section 4.5 The axiology: Ethical research and procedural ethics’. However, the transformative-emancipatory perspective with its focus on issues of oppression and domination, is an umbrella term that includes emancipatory, anti-discriminatory, and participatory approaches (Mertens 2003). While these perspectives are relevant to marginalised women, it is difficult to extrapolate to the highly controlled prison setting, where there is a clear power differential. For example, advocacy is a central concept of this worldview, and of social work practice, yet as Mazza (2008) notes, advocacy within the prison setting is simply associated with gaining access to the prisoner. However, Borden (2013) argues that a pragmatic worldview is aligned with social work principles and practice. This is due to the pluralistic nature of this worldview, with its focus on experience, and the interaction between the person and their environment (Borden 2013; Rylander 2012). The use of the pragmatic perspective allowed for the development of a research design that attended to these power issues within the underlying theoretical perspectives of feminist intersectionality theory and complexity theory (discussed in the upcoming section), and the use of the social work axiology. This design draws attention to the interconnectedness of people and their environments.

4.2 The theoretical perspectives: Intersectionality and complexity theory

This study is scaffolded by an understanding of both feminist intersectionality theory introduced in ‘Chapter Two: Theoretical, Political, and Social Context’, and complexity theory. These two theories inform the design of the study rather than provide a specific tool for analysis, or for the generation of a new theory. Patton (2002) describes this as theory-oriented research where theory drives the focus and design of the study, rather than theory generating research where the goal is to construct theory, or evaluate an existing theoretical perspective. The use of theory to guide design is beneficial for social work research which

prioritises the applied application of research on lived experiences and practice wisdom (Shaw 2007; Thyer 2001). This use of theory is also supported by the underlying pragmatic worldview as both draws attention to the interplay between people and their environments (Crotty 1998; Goldkuhl 2012).

Within this worldview, the use of feminist intersectionality theory and complexity theory provides a link between mental illness and motherhood as women navigate the prison system. Both theoretical perspectives highlight the importance of examining more than one domain, due to the transactional relationship between human experiences and the social world. As Pycroft (2014, p. 15) notes:

“A whole range of physical, biological, psychological, and social systems constitute our lives, largely influencing how, when, and where we are born, what the quality of our lives and lived experiences will be”.

However, binary thinking is evident within many western philosophies and science, such as the qualitative versus quantitative debate (Davis 2008). Indeed, the literature review showed that research into the experiences of mental health issues for female prisoners is often conducted independently of their mothering role and vice versa (Laux et al. 2011; Loper 2006; Moses 2010). Yet the interlinked nature of motherhood and mental illness is evident within the literature. For example, pregnancy and childbirth represent vulnerable periods for women: those who have a previous history of mental illness face a higher risk of relapse following childbirth (McCauley-Elsom & Kulkarni 2007; Munk-Olsen et al. 2006; Oates 2003). Such thinking is problematic as people are more than just ‘single issues’ (Pycroft 2014). Therefore, research that can identify and respond to complexity within human experiences can improve the responses to vulnerable families at the individual, social, and systemic levels (Cummins, Scott & Scales 2012; Department of Human Services 2013; Hunter & Price-Robertson 2014).

Feminist intersectionality and complexity theory both recognise the ‘messiness’ of social research (Bryman 2012). Intersectionality theory acknowledges the systems of power that underpin gender, race, class, and other categories of difference (e.g. age, (dis)ability, and sexual orientation) (Burgess-Proctor 2006; Davis 2008). This theory assumes that individuals are located on a social matrix, operating at the micro (individual), meso (neighbourhoods), and macro (systems) level, where context determines the saliency of identities, social relationships, and the impact of important social systems (Daly 2010). Whilst this theory

highlights the ways in which difference can intersect to produce material and social disadvantage, intersectionality struggles to describe disadvantage within a larger web of complex and adaptive social systems (McGibbon & McPherson 2011). For example, women in the prison system are often involved with the mental health, health, and child welfare systems. Service provision within these systems is often siloed, with difficulties working across professional and organisational boundaries, as well as with families of clients (Department of Human Services 2013; Hunter & Price-Robertson 2014). Indeed, the qualitative motherhood research and the quantitative mental illness research discussed in the literature review highlight these silos at a research level. Complexity theory thus complements intersectionality; it provides a different way of seeing the actions and consequences of social systems (Biesta 2010). Particularly, in identifying disadvantage at the macro level, the intersection between the individual experience and the broader social systems (Green & McDermott 2010; McPherson & McGibbon 2014; Wolf-Branigin 2009). Simply put, intersectionality theory highlights the consequences of disadvantage on imprisoned mothers with a mental illness, whilst complexity theory highlights how social systems interact with these families, providing important tools for highlighting the need to investigate complexity at multiple levels.

The use of these two theoretical perspectives allow for issues relating to “power, space, place and time-context” that shape the lives of both the researched and researcher (Shaw 2007, p. 667) to be attended to within a pragmatic worldview. Mixed methods research then becomes the way to capture complexity of social issues (Greene, Benjamin & Goodyear 2001; Wolf-Branigin 2009). As Green et al. (2001, p. 26) highlights, research must “marshal all of our multiple ways of knowing, and their associated ways of valuing, in the service of credible and useful understanding”.

4.3 The methodology

The research methodology is the design behind the study: the “procedures of collecting, analysing, interpreting, and reporting data” (Creswell & Plano Clark 2011, p. 53; Crotty 1998). According to Crotty (1998, p. 14) “every piece of research is unique and calls for a unique methodology. We, as the researcher, have to develop it”. Therefore, the methodology of this present study is exploratory, concurrent embedded mixed methods (Creswell 2013; Creswell & Plano Clark 2011). An important part of the methodology underpinning this study also relates to rigour, the strategies used to ensure that the data collection, data analysis, and

data interpretation stages of research are valid and trustworthy (Creswell & Plano Clark 2011).

4.3.1 Exploratory research

An exploratory approach is used within this study as little is known about how mothers with a mental illness interact with and negotiate the criminal justice system in order to plan the care of their children, as evidenced by the literature review examined in the previous chapter. This approach provides a starting point for the generation of new ideas (Bryman 2012) about children of prisoners. Indeed, Rubin and Babbie (2013) suggest that an exploratory approach is appropriate when examining a topic or issue that is new and/or understudied. Qualitative, quantitative, or mixed methods can all be employed to identify the general terrain of the topic, including important themes and issues, becoming the building blocks for further research, for example descriptive or explanatory research (Alston & Bowles 2012; Rubin & Babbie 2013). In this sense, exploratory research is inductive rather than deductive (Bryman 2012).

There are however, a number of shortcomings associated with an exploratory approach. Rubin and Babbie (2013, p. 51) remind us that exploratory studies “seldom provide conclusive answers to research questions. They can only hint at answers and give insights into the research methods that could provide definitive answers”. Indeed, Smith (2012) proposes that researchers must sometimes sit with the fact that research will raise more questions than provide definitive answers. One reason for this is representativeness, as exploratory studies rarely use large sample sizes and more typically use small but information-rich samples, gathered using non-probability methods. Therefore, the results drawn from small samples are rarely definitive (Rubin & Babbie 2013). Neuman (2012) further acknowledges that there is a degree of difficulty underpinning exploratory research because the literature, from which ideas are drawn, is limited. In light of this, exploratory researchers should adopt an investigative stance, explore all sources of information, and be creative, open minded and flexible within their research (Neuman 2012). This is where mixed methods research, and the underlying pragmatic worldview, is appropriate.

4.3.2 Mixed methods research

There are many typologies that can be used to categorise mixed method research (See: Creswell & Plano Clark 2011; Tashakkori & Teddlie 1998, 2003, 2010), therefore this study chose a concurrent embedded mixed methods design (Creswell 2013; Creswell & Plano Clark

2011). Morse (2003, p. 190) defines mixed methods research as: "...the incorporation of various qualitative or quantitative strategies within a single project". This 'mixing' can occur at the levels of design, implementation, analysis, and interpretation. It provides the researcher with a comprehensive account of the issue that cannot be obtained using one type of research strand, and improves the credibility of the study (Creswell & Plano Clark 2011). The use of mixed methods research aligns with the social work background of the researcher as it provides a way to respond to the ethical and practical considerations that underpin social research within the prison setting. For example, the collection of two types of data in one data collection episode limited the burden on both the mother and the research environment. This study collected both quantitative and qualitative data concurrently within a single structured interview, where the interview was analysed in accordance with its stream, and the results merged together during the interpretation (Creswell 2013; Creswell & Plano Clark 2011). This approach is illustrated below in Figure 4.2.

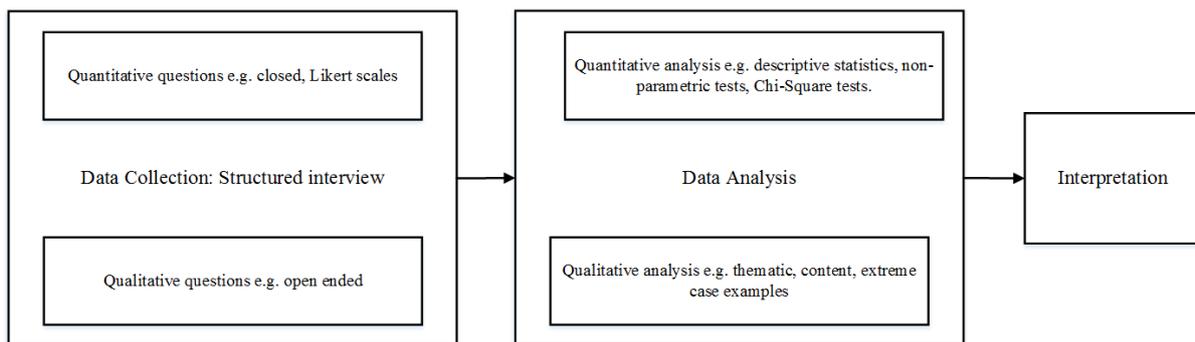


Figure 4. 2. The concurrent embedded mixed methods design.

In this structured interview schedule, quantitative questions typically dominated (this is discussed in the upcoming Section 4.4.3 Data collection strategy), however this study gives equal importance to the quantitative and qualitative strands in data analysis (this is further discussed in the upcoming Section 4.4.4 The data analysis method). Both strands play an important role in answering the research question as each provides a unique way to analyse and interpret the data that could not be obtained using one stand.

4.3.3 Methodological rigour

An important component of research is to ensure that the data, the results and the subsequent interpretation are valid and of good quality (Creswell & Plano Clark 2011). As Onwuegbuzie

and Johnson (2006, p. 48) acknowledge “research needs to be defensible to the research and practice communities for whom research is produced and used”. This means that research must be “credible, trustworthy, dependable, transferable, and/or confirmable” (Onwuegbuzie & Johnson 2006, p. 52), terms first proposed by Lincoln and Guba (1985). The concepts or criteria by which quality is judged differs between quantitative, qualitative and mixed methods research, but the underlying purpose, to ensure quality research remains the same (Creswell & Plano Clark 2011).

The fundamental principle of mixed methods research stipulates that “methods should be mixed in a way that has complementary strengths and nonoverlapping weaknesses” (Johnson & Turner 2003, p. 299). This principle recognises that all methods have strengths and limitations, and when viewed broadly, implies that research designs must creatively address these differences (Johnson & Turner 2003; Onwuegbuzie & Johnson 2006). Despite this principle, there is continued debate around the criteria for establishing quality within mixed methods research (Creswell & Plano Clark 2011; D’Cruz & Jones 2004; O’Cathain 2010; Onwuegbuzie & Johnson 2006; Tashakkori & Teddlie 2008). This debate is perhaps unsurprising considering the relative ‘newness’ of mixed method research as a distinctive methodological movement. Recently, a number frameworks and/or typologies have been developed to address the issue of quality within mixed method research (See: Dellinger & Leech 2007; O’Cathain 2010; Onwuegbuzie & Johnson 2006; Tashakkori & Teddlie 2008). However, these frameworks and typologies typically provide criteria on which to evaluate research rather than providing specific tools to build rigor into research. Furthermore, such frameworks are still relatively new, with the authors cautioning that they need further discussion and refinement. There is also little consensus within the literature regarding which frameworks should prevail.

In light of this, the present study took on the recommendations of Creswell and Plano Clark (2011) who suggested that when research involves both quantitative and qualitative strands of data, validity checks must correspond with the strand, rather than the development of an entirely new framework. As O’Cathain (2010, p. 535) suggests “quality assessments of the qualitative and quantitative components of a study is essential because each contributes to the study as a whole”. This approach is in line with the fundamental principle of mixed methods research, and has also been used within previous research (e.g. Johnson & Turner 2003). In light of this recommendation, the following discussion examines the most prominent quantitative and qualitative criteria for establishing quality (Creswell & Plano Clark 2011).

4.3.3.1 Internal validity and credibility

The quantitative criteria of internal validity parallels the qualitative criteria of credibility as both examine the integrity and accuracy of the information gathered and the associated conclusions, or inferences (Bryman 2012). One of the main methods of ensuring validity within quantitative methods is to control the variables being measured, and to ensure that the instrument used is validated (Bryman 2012). In many respects this criteria is inappropriate for this present study, due in part to the exploratory nature of this study, and to the prison environment. However, this study did attend to the issue of face validity and construct validity (Bryman 2012) as the interview schedule used in the present study mirrored the schedule used within the broader project, and was developed after an intensive literature review. It is also important to note, that the schedule used within the broader study was developed in consultation with the partner organisations, and thus, reflects both research and practice knowledge. Such steps improve the fidelity of the schedule used.

In addition, a number of qualitative strategies were used to improve the credibility of this present study: peer debriefing, triangulation, and reflective memos. According to Spillett (2003) peer debriefing occurs when researchers meet with others to review the design, and implementation of the a study. For this present study, this strategy included input from impartial graduate students and department colleagues twice a year, conversations with colleagues attached to the broader study, and regular formal supervision; all allowing for a comprehensive discussion of research ideas, findings, and values. This strategy also included consultations with a statistical consultant to ensure correct data analysis procedures. Triangulation is a fundamental approach in this study and involves using multiple methods to examine an issue in order to capture the diverse ways in which an issue can be viewed (Patton 2002). For this present study, it means using both quantitative and qualitative approaches to data collection, and analysis, as well as using a number of data sources. Whilst discussed in detail in the forthcoming ‘Section 4.4 The methods’, this study used a variety of data sources: mothers with and without a mental illness located in the community, prison, or forensic setting. The goal of this was to gain multiple perspectives, to provide comparison, and test for consistencies, as well as the inconsistencies (Patton 2002). As Patton (2002, p. 248) argues “...inconsistencies ought not be viewed as weakening the credibility of the results, but rather as offering opportunities for deeper insights”. The last strategy used to strength credibility was reflective memos. Reflective memos were kept during the data

analysis process to provide an audit trail. The purpose of these strategies was to ensure that the conclusions gathered are relevant, and useful for both practice and policy.

4.3.3.2 External validity and transferability

The quantitative criteria of external validity parallels the qualitative criteria of transferability as both examine the level in which the results can apply to other contexts or populations (Bryman 2012). Typically, large sample sizes and random sampling procedures are indicative of good external validity (Bryman 2012). However, this criterion was unsuitable due to the exploratory design, and impractical due to the prison research environment. As such, a number of qualitative strategies were used to strengthen the transferability of the findings. Whilst these sampling strategies are defined and discussed in ‘Section 4.4.1 Sampling’, the purposive sampling strategy of criterion sampling ensured that only primary carer mothers with dependent children were sampled, with extreme case sampling working in tandem to ensure that divergent, rather than typical, experiences were also captured. This ensures that cases are information rich (Patton 2002). However, it is important to note here that despite the use of the latter sampling strategy, this study was unable to recruit from the forensic setting. This is further discussed in ‘Section 4.4.2.4 Prison and forensic recruitment challenges’. Furthermore, the structured interview tool provided an in-depth description of the participant’s experience as they navigated the criminal justice system, with particular attention paid to the points of arrest, sentencing, and imprisonment. These data collection tools are further discussed in ‘Section 4.4.3 Data collection strategy’. This study acknowledges however that it is exploratory, therefore the goal was to highlight areas of concern and interest for future research, rather than aim for the transferability of results to the wider Australian and international female prison populations. This is one of the few studies to examine the experiences of imprisoned mothers with a mental illness.

4.3.3.3 Reliability and dependability

The quantitative criteria of reliability parallels the qualitative criteria of dependability as both examine the replicability and transparency of the research process (Bryman 2012). Therefore, a clear and concise outline of the research design, including the underlying worldviews, theoretical perspectives, and the methodology and associated methods supports this criteria (Bryman 2012). The reliability and dependability of this present study is also supported by the use of standardised and structured data collection tools. As previously stated, reflective memos and project documentation provide an audit trail.

4.3.3.4 Objectivity and conformability

This present study recognises that social research cannot be truly objective (Bryman 2012). As demonstrated in the upcoming ‘Section 4.5 The axiology: Ethical research and procedural ethics’, clear reflection, and attention to ethical issues within the research process are a paramount component of social work research. However, the standardised and structured interview schedule (discussed in the upcoming ‘Section 4.4.3 Data collection strategy’), and peer supervision ensures that the views being captured are the participants’ rather than the researcher’s.

Given the continued debate around validity and trustworthiness within mixed methods research, this present study uses the recommendations of Creswell and Plano Clark (2011) and has considered validity in relation to the quantitative and qualitative criteria. As discussed, this study uses a range of strategies to ensure the data, the results, and the subsequent interpretations are valid and of good quality (Creswell & Plano Clark 2011). In this sense, the methods chosen also have important implications for quality research.

4.4 The methods

Methods reflect the ways in which the data is gathered and analysed (Crotty 1998; Grix 2002). Both Crotty (1998) and Grix (2002) advocate for methods to be directly related to the research question. Indeed, good research is the result of how the data is collected, cross-checked, analysed, and presented, rather than the use of one specific method (Grix 2002). Thus, explicit description, and justification, of the methods is important. This section begins with a description of the sampling procedures, including the inclusion and exclusion criteria, recruitment of the participants, and concludes with strategies for data collection and analysis (as shown in Figure 4.1 at the beginning of this chapter).

4.4.1 Sampling

Sampling, a process of selecting out a subgroup representative of the whole, is an important component of the research process, the basis on which all inferences are made (Onwuegbuzie & Collins 2007). As such, this study used purposive sampling to recruit mothers in prison, or recently released, and those hospitalised in a forensic facility. According to Bryman (2012) purposive sampling, a form of non-probability sampling, is used when participants are recruited in a strategic way in order to answer the research question. Onwuegbuzie and Collins (2007) further noted that the appropriateness of the sampling strategy is also dependent on the research goal, objective, purpose, and the exploratory research design. Two

forms of purposive sampling were used, criterion, and extreme case sampling. Criterion sampling occurs when participants are recruited using specified criteria (Bryman 2012), whereby extreme case sampling occurs when the “far end(s) of a particular dimension of interest” are sampled (Bryman 2012, p. 419). The logic behind this is that extreme cases are information-rich. This means they can provide information relevant to improving conditions for people across the spectrum of interest, especially if sampling is done at both ends of the spectrum. In this sense, extreme cases sampling is useful for time and resource limited research (Patton 2005). According to Bryman (2012) purposive sampling often involves one or more sampling methods, where the aim is not representativeness. In addition, Teddlie and Yu (2007) acknowledge that multiple samples often underlie mixed methods research. This is why each recruitment setting required its own sampling strategy.

4.4.1.1 Criterion sampling

Primary carer mothers were eligible to participate in this study if at the time of their arrest/remand/imprisonment they had children (aged 0-18 years), and where subsequently the child/ren’s residence changed, and/or a new carer was introduced, and/or the child/ren were left with no carer. These inclusion criteria were developed by the broader study in consultation with the partner organisations, and defined primary carer status based on the practical outcomes for children.

These criteria were extended to the present study, with two additional criteria used for those who had a mental illness: (1) self-report of a clinically diagnosed mental illness, and (2) organisational assessment of the women’s ability to provide consent. Additional criteria were also used for participants recruited within the community: (1) released from prison within the previous 18 months, and (2) no longer subject to Department of Justice (DOJ) intervention. Recruitment of these participant groups is discussed in ‘Section 4.4.2.1 Recruiting imprisoned mothers with and without a mental illness’, and ‘Section 4.4.2.2 Recruiting mothers in the community’, with further discussion on the recruitment issues pertaining to these two groups discussed in ‘Section 4.4.2.4 Prison and forensic recruitment challenges’. Potential participants were excluded if they were non-English speaking, on remand for less than three months, assessed as being unable to provide consent, or lastly, still under DOJ intervention.

Non-English speaking. Participants were excluded if they could not speak English. This was a practical decision based on significant service gaps experienced when organising an

interpreter to come into the prison. The researcher actively decided not to pursue the avenue of phone interpreters due to the sensitive personal issues being discussed within the interview, and previous professional experience in direct practice where phone interpreters had refused to disclose information that was seen as stigmatising. Given that there is a large population of Vietnamese women imprisoned within Victoria (Corrections Victoria 2011), this decision rendered some, but not all, of their experiences invisible, contradicting in some small part, the theoretical perspective (intersectionality) and social work value base that underpins this study. This issue is further discussed in ‘Section 4.4.3 Data collection strategy’.

On remand for less than three months. Participants were excluded from the study if they had been in prison for less than three months. This period does not provide sufficient time to capture the full care planning decision-making process due to the uncertainty inherent in this period. This was a pragmatic decision made by the broader study that is in line with previous research (See: McIvor, Trotter & Sheehan 2009; Trotter, McIvor & Sheehan 2012).

Assessed as unable to provide consent. Participants were excluded from this study if they were deemed by the institution in which they were being held as being medically and/or psychiatrically unwell, and thus unable to give informed consent. As such, this project worked with relevant professionals in the community, prison, and forensic settings to determine who was able to participate and give consent. As an additional safeguard, the participant was monitored throughout the interview and ‘fitness for interview’ was based on participant behaviour, speech patterns and ability to reiterate the research in their own words. This exclusion criteria was in place, as a sampling strategy must be ethical, and participants ability to give informed consent is paramount (Kemper, Stringfield & Teddlie 2003). However, such criteria can also lead to disempowerment, as the women do not make the decision regarding participation. The issue of gatekeeping and informed consent, amongst other ethical concerns, is discussed in the upcoming ‘Section 4.5 The axiology: Ethical research and procedural ethics’.

Women released from prison within the previous 18 months who were still subject to DOJ intervention. Participants were excluded from the study if they were still subject to DOJ intervention, such as parole, at the time of the interview. This was a pragmatic decision as ethical approval for this study took six months (late 2012 to early 2013) due to the issues associated with recruitment within a prison setting and the need for approval from multiple

ethical and operational committees and partner organisations (for explanation of the ethical process see ‘Section 4.5.1 Multi-centred ethics’). Therefore, time became a factor because recruiting participants subject to DOJ intervention would have required further ethical approval processes.

4.4.1.2 Extreme case sampling

For this study, extreme case sampling sought to recruit primary carer mothers from Victoria’s forensic mental health hospital (please note that the aforementioned definition of primary carer mother outlined in ‘Section 4.4.1.1 Criterion sampling’ was used for both imprisoned and the forensic samples). This strategy sought to ensure that the voices of mothers at the ‘extreme end’ of the mental health spectrum were included. The voices of this group are generally hidden, as Chao and Kuti (2009, p. 55) report, “little attention has been paid to relations between detained forensic in-patients and their children”. Therefore, seeking out such participants was important. Despite this sampling procedure, the present study was unable to recruit forensic mothers. The recruitment strategy pertaining to this participant group is discussed in ‘Section 4.4.2.3 Recruiting forensic mothers’ with further discussion on the recruitment issues pertaining to forensic mothers discussed in ‘Section 4.4.2.4 Prison and forensic recruitment challenges’.

4.4.1.3 Implications of the sampling method

The use of purposive sampling within this study, does however, limit the generalisability to the wider population (Bryman 2012); with small sample sizes generally attributed to this sampling method as well as exploratory studies (Onwuegbuzie & Collins 2007). However, there is still little consensus around what constitutes an adequate sample size (Guest, Bunce & Johnson 2006; Mason 2010; Onwuegbuzie & Collins 2007). In studies using random (probability) sampling, procedures that typically underpin traditional quantitative studies, the sample size is easy to determine using a statistical power analysis (Onwuegbuzie & Collins 2007). However, as Guest, Bunce and Johnson (2006) notes, probabilistic sampling is virtually impossible with vulnerable populations, particularly those in closed settings.

The issue of sample sizes then becomes ‘murky’ with qualitative research. Guest, Bunce and Johnson (2006) suggested that when a study is narrow in its objectives, with a sample that is fairly homogeneous, then a sample size of 12 is sufficient for an interview-method study. However, if the goal is to compare groups on more than one dimension, then there must be at least 12 participants per group of interest (Guest, Bunce & Johnson 2006). Onwuegbuzie and

Collins (2007) suggest, rather cryptically, that in qualitative studies, sample sizes should be based on the number that achieves data saturation, but at the same time not large enough to obscure a deep, case-orientated analysis. Patton (2002) similarly advocates for qualitative sampling designs to state the minimum sample needed for adequate coverage of the social issue. In this sense, the sample size is influenced by researcher judgement and negotiation (Patton 2002).

Greater complexity is associated with mixed method research, as sample sizes may vary from small to large dependent on the strand and the research questions asked (Teddlie & Yu 2007). Reflecting Patton (2002), Onwuegbuzie and Collins (2007) provide recommendations for the minimum sample size needed for mixed methods research: six to 12 participants for interview studies. However, the debate spanning the quantitative and qualitative continuum suggests that sample size is a balance between methodology and practicality (Kemper, Stringfield & Teddlie 2003). It may be a rather pragmatic case of what is simply achievable. As Patton (2002) notes, the validity, meaningfulness and insights generated from research has more to do with the information collected, and how information rich the data is, than the sample size. Therefore, “it really depends on how you want to use your data and what you want to achieve from your analysis” (Guest, Bunce & Johnson 2006, p. 76).

In light of this discussion, the researcher aimed to recruit at least 12 mothers with a mental illness and at least 12 mothers without a mental illness (justification for the inclusion of participants without a mental illness is included in the upcoming section). This reflects the recommendation of Guest, Bunce and Johnson (2006). Given the exploratory nature of this study, the goal was not to be representative of the female prison population but rather acknowledge and explore the experiences of mothers with a mental illness as they navigate the criminal justice system.

4.4.2 Recruitment

This study sought to recruit mothers with a mental illness from three sites: (1) prison, (2) the community, and lastly (3) Victoria’s forensic mental health hospital between the months of March and December 2013. Participant mothers without a mental illness were also recruited from the two prison sites between May and December 2013. The purpose of this participant group was to provide a comparison and examine any differences in the experiences of these two groups as per the subsidiary questions. This allowed for an examination of the impact of

mental illness on the mothers' experiences. The ethical issues pertaining to these groups are discussed in 'Section 4.5 The axiology: Ethical research and procedural ethics'.

4.4.2.1 Recruiting imprisoned mothers with and without a mental illness

This study recruited imprisoned mothers with and without a mental illness from Victoria's two female prisons: the Dame Phyllis Frost Centre (DPFC) and Tarrengower prison. As previously mentioned, the participants without a mental illness were recruited for comparison. Within the prison setting, participant mothers were recruited from the general population using a number of strategies: information sessions, flyers, fortnightly bulletins, assistance from staff to identify potential participants, and a unit-by-unit 'walk around'. The most successful strategy employed was staff identification of potential participants, with identification based on program use, and knowledge of the individual prisoner's circumstances. However, this is not without its limitations as there was a potential for coercion (refer to 'Section 4.5 The axiology: Ethical research and procedural ethics' for a discussion on coercion within the prison setting). Furthermore, this study did not have access to participants housed in the management unit or the mental health unit (Marrmak) at DPFC as the women in the former unit were deemed a risk to the safety of the researcher, and the women in the latter unit 'too unwell' to participate. Therefore, the prison staff acted as gatekeepers to these prison populations, with this issue explored in greater depth in 'Section 4.5.1 Multi-centred ethics'.

When potential participants were identified, they were called via loud-speaker to the programs building, where they were introduced to the study by the researcher and if agreeable, would answer three selection criteria questions to see if they were eligible for participation. From there, information about the study was provided to the women in a plain English information form which they could keep (see Appendix 1 for the Participant Information for women with a mental illness and Appendix 2 for the Participant Information for women without a mental illness) and a consent form to sign (see Appendix 3 for the consent form for women with a mental illness and Appendix 4 for women without a mental illness). In line with DOJ policies, participants recruited in the prison setting did not receive reimbursement for their time (Department of Justice 2011).

4.4.2.2 Recruiting mothers in the community

This study recruited recently released mothers with a mental illness. 'Recently released' was defined as mothers who had exited the prison system between June 2011 and January 2013.

This time frame of 18 months was a pragmatic decision based on previous research which reported that mothers typically resumed the care of their children in the 12 months post-release (See: McIvor, Trotter & Sheehan 2009). As the initial purpose of recruiting from the community was to gain a perspective on the experiences of mothers with a mental illness reunifying with their children post-release, this extended time frame was important. However, this present study was only able to recruit two mothers in the community between March and December 2013. This sample size was therefore too small to include their post-release experiences in the data analysis. However, their experiences of entering the prison system were included. The difficulty recruiting in the community could be related to the transient nature and chaotic lifestyles of this participant population as documented in previous research (See: Laux et al. 2011; O'Brien & Bates 2003).

Recruitment of the community participants occurred via three partner organisations from the broader study who had direct contact with prisoners and their families: Victorian Association of the Care and Resettlement of Offenders (VACRO), SHINE for Kids, and Prison Fellowship Victoria. Flyers were placed in each organisation's main lobby and mailed to potential participants for self-referral (see Appendix 5 for the recruitment flyer used). The first round of mail-outs was sent to a total of 49 mothers which yielded only one reply. The second round of mail-outs to a different group yielded no responses. This further highlights the difficulty engaging with this population post-release. In addition, staff approached potential participants and discussed the project, and supplied to the researcher the contact details of those mothers who met the selection criteria and had agreed to be contacted. It is acknowledged that this strategy has a potential for coercion as the service provider, on whom they are dependent for assistance, approached the mothers. Therefore, when contact was made, the researcher advised potential participants that participation was confidential and voluntary, and that there were no consequences if they chose not to participate. This was again, reiterated at interview. Only one participant was obtained via staff identification. Ethical issues pertaining to the community participants, such as the issue of gatekeeping, is discussed in 'Section 4.5 The axiology: Ethical research and procedural ethics'.

Interviews with the mothers occurred in public settings, such as a café, at a time and place convenient to the participant. Food and/or drink were also provided. As with the imprisoned mother group, prior to the interview, the community-based mothers received information about the study in a plain English information form (see Appendix 6 for the Participant Information for community women) and a consent form to sign (refer to Appendix 3 for the

consent form). Upon completion of the interview, the participant mothers received a \$30 Coles-Myer gift card as a form of reimbursement. The purpose of the gift card was to recognise the women's time and minimise any costs associated with participating in the research, such as travel to get to the interview venue (Carlen & Worrall 2004).

4.4.2.3 Recruiting forensic mothers

This study sought to recruit mothers from the Thomas Embling Hospital (TEH). Given the closed nature of this setting, the researcher worked with the social work department at TEH to identify and recruit mothers. The social work department was provided with the study's participant information (refer to Appendix 1) and consent form (refer to Appendix 3) to pass along to interested women, with the social worker to contact researcher when someone expressed interest in participating. In line with Department of Justice policies, participants recruited in the forensic setting did not receive reimbursement for their time (Department of Justice 2011). Despite this process, this study was unable to recruit mothers from TEH, with specific recruitment challenges discussed in 'Section 4.4.2.4 Prison and forensic recruitment Challenges'. Ethical issues relating to forensic mothers, such as the issue of gatekeeping, are discussed in 'Section 4.5 The axiology: Ethical research and procedural ethics'.

4.4.2.4 Prison and forensic recruitment challenges

This study experienced a number of challenges while recruiting in the prison setting, not unlike those encountered in previous research (See: Davies 2011; Liebling 1999; O'Brien & Bates 2003; Quina et al. 2007). These challenges related to: (1) difficulty engaging women through the information sessions, fortnightly bulletins, and flyers; (2) mothers reporting fear that their information would be disclosed to statutory child protection services, despite assurances to the contrary; (3) a large number of mothers losing custody of their children prior to imprisonment, therefore being ineligible for participation; (4) prison staff's difficulty identifying women who fit the selection criteria; (5) personnel changes at DPFC (the study's key contact changed twice during the six month data collection phase); and lastly (6) practical challenges such as recruiting and interviewing during winter (staff advised that the women may be reluctant to come out in wet weather when called for an interview), as well as challenges relating to the prison environment (e.g. lockdowns and security requirements). Another challenge may relate to the security levels between the two prisons. Recruitment at DPFC occurred between the months of May to October 2013, and at Tarrengower prison between late-November and early-December 2013. Given the time spent recruiting, there is a higher proportional representation from Tarrengower. This could be related to differences

between the security levels, as Tarrengower being a regional minimum-security prison, was smaller, and the environment and recruiting process more relaxed. Prison-based research therefore requires a great deal of patience, flexibility, and resilience.

Recruitment at the forensic hospital also experienced a number of challenges. As reported by the social work department, these challenges related to: (1) a large number of forensic mothers losing custody of their children prior to their admission into TEH or at the time of their offence; (2) poor mental health at the time of recruitment; and lastly (3) the offence for which they were being held was committed against one of their children. Staff therefore advised that it would be difficult to discuss their children. These challenges resulted in this study being unable to recruit mothers within the forensic setting.

These aforementioned recruitment difficulties in the prison, forensic, and community (discussed in ‘Section 4.4.2.2 Recruiting mothers in the community’) settings highlight the impact of competing interests and problems relating to research within closed settings with vulnerable participants, as well as the narrow focus of this study. Despite these difficulties, the present study was able to recruit 40 mothers in total, 38 from the prison setting (19 mothers with mental illness and 19 without), and two from community setting. The breakdown across the participant groups is shown below in Table 4.1.

Table 4. 1. The participant breakdown by recruitment setting.

Setting	Mothers with a mental illness (N=21)	Mothers without a mental illness (N=19)
Community	2	N/A
Dame Phyllis Frost Centre	13	12
Tarrengower	6	7
Thomas Embling Hospital	-	N/A

This sample size shown in the table above reflects the recommendations provided by Guest, Bunce and Johnson (2006) who suggested that for an interview study the minimum number of participants required was 12 per group. However, the present study does acknowledge that this sample size, while appropriate for the qualitative stream of this mixed methods study,

does limit statistical power of the quantitative results. This issue is addressed in ‘Section 4.4.4 The data analysis method’.

4.4.3 Data collection strategy

The collection method used within this embedded mixed methods study was structured interviews with participant mothers. Structured interviews are typically conducted using an interview schedule that contains a range of opened-ended and closed questions, where closed, fixed, or pre-coded questions are usually dominant. The purpose of structured interviews is to provide standardisation in the application of and recording of the answers (Bryman 2012). The structured interview schedule used within the broader study were developed in consultation with the Monash University CJRC and the partner organisations (see Appendix 7 for an example of the broader study interview schedule). This present study amended the broader study’s schedule to include a range of mostly closed but some open-ended questions relating to mental illness. This amended schedule was only given to participants who self-identified as having a mental illness at the interview (see Appendix 8 for an example of the amended interview schedule for the prison and forensic setting). The main purpose behind this amended schedule was to reduce research burden on both the participant and the prison, as it allowed data collection for this study and the broader study to be conducted during one interview. In order to ensure consistency across participant groups, mothers interviewed within the community setting were also administered the amended structured interview, adapted to reflect their release status (see Appendix 9 for an example of the community based interview schedule).

Structured interviews are an important research method within Victorian prison and forensic settings where electronic devices, such as audio recorders, are prohibited (Department of Justice 2011). Thus, a structured interview provides the most appropriate way to ensure consistency of asking questions and recording answers. This not only assists data analysis, but importantly, ensures the credibility and trustworthiness of the information collected (Bryman 2012). In addition, this structured approach is both methodologically and environmentally responsive as it acknowledges the needs and characteristics of the target population. For example, Taylor (2004) recommends structure and guidance within interviews with female prisoners, as this makes the women feel more comfortable, and less threatened. She also highlights that many imprisoned women have low levels of educational attainment, and therefore can have issues with their language skills and confidence, all affecting their ability to adequately express themselves (Taylor 2004). This is important for

the interviewer-participant dynamics, which has the potential to be exploitative (Bryman 2012). Furthermore, Goulding (2004) notes in her interviews with female prisoners in Western Australia, the safe environment created by a researcher can lead to the women oversharing their personal information. Therefore, structured interviews can minimise this by putting clear boundaries around the conversation (Goulding 2004).

Structured interviews, however, are subject to a number of limitations (Bryman 2012), including poorly worded questions, interviewer inconsistency (especially when multiple interviewers are used), and poor understanding or misunderstanding of questions. In addition, there can be errors when the interviewer records the participant's responses by hand, given the time it takes to write (Bryman 2012). In order to reduce these limitations, the amended structured interview was member-checked by supervisors, as well as with other professionals working on the broader study. The goal of this was to ensure that the questions were worded correctly and to identify any gaps. All but seven interviews were conducted by the researcher; with an experienced research assistant, who interviewed approximately 50 imprisoned fathers for the broader study, conducting the remaining interviews. This ensured a consistent approach, as both interviewers knew the schedule, therefore bias in the researcher interpretation of the questions was controlled (Bryman 2012). Furthermore, when participants expressed poor understanding and/or misunderstanding of questions asked during the interview, the questions were reframed until participant comprehension and prompts were provided in the interview schedule. The interview schedules were re-checked at completion of each interview by the researcher to ensure all the information provided during the interview was captured, and that the notes made sense.

Similar to the study by Laux et al. (2011) discussed in the previous chapter, this study also relies on participant self-report, and is therefore dependent on the subjective responses of the participants. As such, there is the potential for an undiagnosed mental illness in mothers who did not report a mental illness. While Laux et al. (2011) included both participants who self-reported a clinically diagnosed mental illness or poor mental health at the time of the interview, only the former participant group was recruited in this present study. With the goal to provide extra safe-guards against bias, the interview schedule also asked the participants about the professional who first diagnosed their mental illness, age in which they were diagnosed, and medication used (refer to Appendix 8 for more detail). In addition, previous research comparing self-report with medical records (e.g. Bai et al. 2014; Schofield et al. 2011), and police data (e.g. Trotter, McIvor & Sheehan 2012) has found that prisoners are

reliable respondents. This is contrary to the idea that prisoners are dishonest (Schofield et al. 2011).

As well as the general limitations of structured interviews noted above, previous research also notes specific challenges in their use within the prison setting. This is evident in the work of Healy et al. (2000), who examined the impact of imprisonment on prisoners and their families using structured interviews with imprisoned parents. Healy et al. (2000) identified a number of issues with this strategy; notably prisoner dissatisfaction with the use of a highly structured interview format, and their inability to raise issues not addressed in the questions. The latter is also an issue raised by Liebling (1999) in her structured interviews with prisoners, and in some respects raises validity issues as it reduces the comprehensiveness of the data collected and the subsequent results. To counteract this, the interview schedule used in this present study did provide the women with an opportunity to explore issues outside of the standardised questions, with final questions asking for further comments. Furthermore, a number of questions asked in the present study were opened-ended questions, with the closed questions often including space for the women to further elaborate on their experiences.

Also noted by Healy et al. (2000), a limitation of the present study is that CALD and indigenous populations were not actively sought in the methodology and associated methods. This ensures that the distinctive experiences of these groups were not captured, further reducing the representativeness of this study to the wider prison population. The challenges of recruiting these populations are well documented within the literature. For example, Yildiz and Bartlett (2011) reviewed research undertaken in a women's prison in the UK, finding that prison studies frequently excluded foreign nations and people with limited English. Furthermore, researchers often fail to employ strategies (e.g. translated documents and use of interpreters) to identify and include these populations (Yildiz & Bartlett 2011). While Healy et al. (2000) acknowledge this issue in their interviews with imprisoned parents, they do not provide any suggestions for recruiting CALD prison populations, aside from advocating for further research. This limitation appears to be a reflection of broader systemic issues such as prison policies and procedures which make the process of obtaining an in-person or telephone interpreter difficult, rather than the cultural competence of the researcher (Centre for the Human Rights of Imprisoned People 2010).

As discussed above, structured interviews attended to the needs and characteristics of both imprisoned mothers and the prison setting, despite the aforementioned limitations. In line

with the pragmatic worldview, the methods used within a study must be appropriate for the setting.

4.4.4 The data analysis method

As an outcome of the concurrent embedded mixed methods approach, the data from the structured interviews was analysed using both quantitative statistical procedures (e.g. descriptive statistics, and non-parametric tests) and qualitative thematic and content analysis. As outlined below in Figure 4.3, the analysis of each stream was conducted independently and the results were merged during interpretation. The data from the structured interview schedules are directly comparable, as they were obtained using the same data collection strategy (Creswell & Plano Clark 2011).

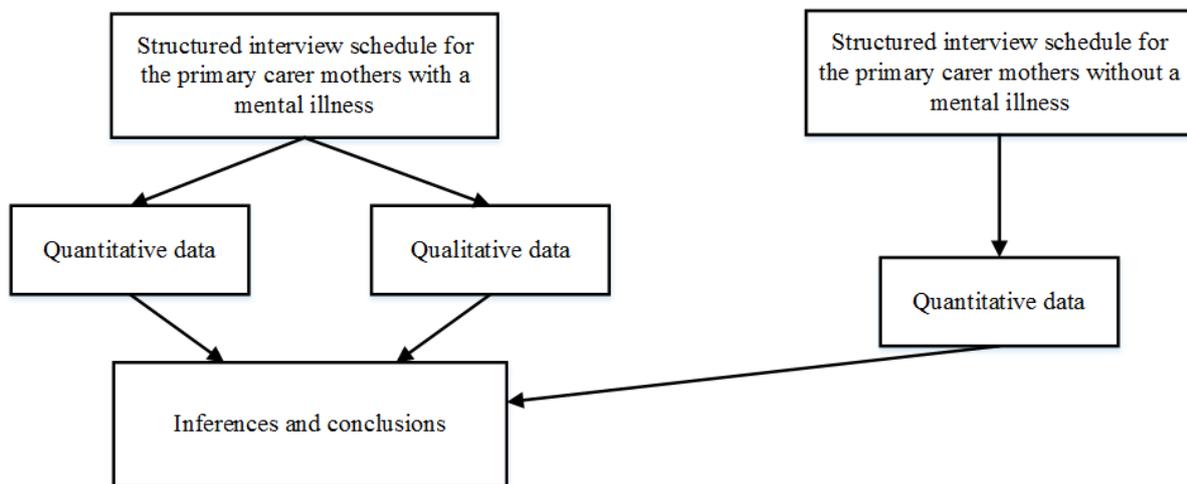


Figure 4. 3. Data analysis approach to this embedded mixed methods study.

Within this approach, the quantitative and qualitative strands have equal priority, meaning they both play an equal role in answering the research question (Creswell & Plano Clark 2011). This is because the quantitative data provides an enumerative way to examine the experiences for mothers with a mental illness (within-group analysis), as well as compare their experiences to the mothers without a mental illness (between-group analysis). The qualitative data allows for the ‘fleshing out’ of experiences of the mothers with a mental illness, in many respects providing a voice to the numbers, as seen in Figure 4.3. This supports Patton’s (2002, p. 193) contention that “qualitative data can put flesh on the bones of quantitative results, bringing the results to life through in-depth case elaboration”. This

approach was the result of the focus of the study: to document and describe the experiences of mothers with a mental illness as they navigate the prison system to plan the care of their children. Therefore, this approach takes the view that the importance of experiences is signified by the repetition of words and/or themes within and between data (Bryman 2012). The following discussion outlines how the quantitative and qualitative data were analysed.

4.4.4.1 Quantitative data

This present study transformed the raw data from the interview schedules into numerical values for statistical analysis (e.g. 0=no, 1=yes, and 2=maybe) (Onwuegbuzie & Teddlie 2003; Sandelowski, Voils & Knafl 2009; Tashakkori & Teddlie 1998). As such, a code book was developed to aid the data transformation process, and provide an audit trail (Creswell & Plano Clark 2011). The Statistical Program for Social Sciences (SPSS) version 23 (<http://www.spss.com>) assisted with data analysis, and was used to characterise the sample with descriptive and frequency statistics. The Chi-square test for independence, the associated Fisher's Exact Test, and a number of non-parametric tests (e.g. the Wilcoxon Signed Rank Test, and the Mann-Whitney U Test) were used to test for group differences and relationships between variables. The choice of these tests was related to the small non-representative sample, which did not meet the assumptions underpinning parametric tests (Field 2013; Pallant 2010).

The Chi-square test for independence examines two or more categorical variables so see if there is a presence of a relationship (Field 2013). This test measures the frequency of answers that fall into each category, and sees if these answers differ from what would be expected if there was no association, or the answers occurred by chance (Corder & Foreman 2009; Field 2013; Reid 2013). Given the small sample size of the present study, the use of this test was typically limited to 2 x 2 categories. Any questions that contained more than two categories were generally transformed into a dichotomous variable for analysis. In addition, this test needs expected cell frequencies to be greater than five. As an outcome, the Fisher's Exact Test was used to determine the probability that the Chi-square test is accurate when cell frequencies are less than five (Corder & Foreman 2009; Field 2013). For these two tests, the effect size, or the magnitude of difference between the two groups, is represented by the phi coefficient (ϕ) (Field 2013; Pallant 2010).

Two non-parametric tests were used: the Mann-Whitney U Test and the Wilcoxon Signed-Rank Test. The Mann-Whitney U Test is the non-parametric alternative to the Independent-

samples t-test and was used to test the differences between two groups on continuous measures (e.g. age, number of children, years of imprisonment). In addition, the Wilcoxon Signed-Rank Test is the non-parametric alternative to the Paired samples t-test, and is used to compare two scores from the same participant across different time points (Field 2013; Pallant 2010). For these two tests, their effect sizes are represented by r and were calculated manually using the procedures outlined by Pallant (2010).

For the aforementioned tests, significance was set at $p < .05$ or $p < .01$ (two-tailed). To understand the magnitude of the reported effect sizes, the values of less than .3 represented a small effect, .3 to .5 represented a moderate effect, and .5 and above represented a large effect size (Field 2013; Pallant 2010; Reid 2013). These tests were performed following the procedures described by Field (2013), Pallant (2010), and Reid (2013). As previously mentioned in 'Section 4.3.3. Methodological rigour', the choice of these statistical tests was approved by a qualified statistician.

Both McCall (2005) and Spierings (2012) advocate that quantitative analysis can be used to examine intersectionality, or the complexity and diversity, that exists within and between participant groups. In this sense, the quantitative analysis for this present study was guided by feminist intersectionality theory in two ways: (1) facilitate a between-groups analysis of the mothers with and without a mental illness, to examine if their experiences differed as they intersected with and navigated the criminal justice system; and (2) a within-groups analysis of the mothers with a mental illness to examine if diversity within this group lead to differing experiences as they intersected with and navigated the criminal justice system (McCall 2005; Spierings 2012). In order to carry out the latter analysis, the mothers with a mental illness were divided into three sub-groups, those who reported: comorbid mental illness; high/low prevalence disorders; and substance use. The ABS (2008) highlighted that the co-occurrence of mental disorders and/or substance use can indicate severe and chronic psychological, health, and social issues. In addition, Lynch et al. (2012) found that severe mental health issues, such as those classed as low prevalence disorders (e.g. Schizophrenia), were associated with offending. Therefore, the rationale behind these sub-groups was to examine whether comorbid mental illness, high/low prevalence disorders, and substance use, increased the complexity, and vulnerability associated with the mothers' navigation though the criminal justice system to plan the care of their children.

Sub-group one consisted of mothers who self-reported either multiple or only one mental health condition, whereby Sub-group three consisted of mothers who self-reported or did not report problematic substance use. Lastly, Sub-group two consisted of mothers' self-reported mental health conditions that could be categorised by high and low prevalence disorders using the fifth edition of the American Psychiatric Association's (2013) Diagnostic and Statistical Manual for Mental Disorders (DSM-5). For example, high prevalence was defined as disorders that had a community prevalence rate of 5% and over (e.g. Affective, Anxiety, Trauma and Personality Disorders). In comparison, low prevalence disorders were defined as disorders which had a community prevalence rate of less than 5% (e.g. Schizophrenia, Bipolar, and Eating Disorders). Therefore, the low prevalence disorders represent serious mental health issues (American Psychiatric Association 2013). However, it must be acknowledged that comorbidity makes classification difficult. Therefore, where this occurred, classification and labelling of high and low prevalence disorders was determined by which disorder was the primary disorder reported by the women. This was a practical decision by the researcher, and reflects Spierings (2012, p. 340) comment that "creating sub-groups does indeed mean deciding where to draw the line".

Whilst this present study uses quantitative analysis methods, it also acknowledges that statistical significance should not be used as the only marker for variance (Ziliak & McCloskey 2008) due to the limitations of the non-parametric tests used and the small sample sizes. Therefore, the analysis notes any visible differences in the participant groups, as well as tests that fall just outside of statistical significance. This highlights the importance of qualitative data, and explains why this present study gave equal priority to the quantitative and qualitative strands.

4.4.4.2 Qualitative data

This present study transcribed the interview schedule into Microsoft Word 2010 (www.microsoft.com), and uploaded these documents into QSR International NVivo version 10 (<http://www.qsrinternational.com/>) to assist with the thematic data analysis.

Braun and Clarke (2006, p. 79) define thematic analysis as a "method for identifying, analysing, and reporting patterns (themes) within data". Thematic analysis is a widely used form of qualitative analysis, however it is poorly demarcated within the literature. It has no clearly identifiable heritage and little to no clear agreement on how to conduct a thematic analysis, in comparison to grounded theory or analytic induction (Braun & Clarke 2006;

Bryman 2012). Given this context, this present study drew from Miles, Huberman, and Saldana (2014) in developing the thematic analysis plan, with Table 4.2 providing an illustrative example of the thematic analysis undertaken when analysing the responses to the question: Can you tell me about the circumstances of your arrest? The choice of using Miles, Huberman, and Saldana (2014) to guide the qualitative analysis was a pragmatic one, as these authors took a pragmatic realist approach in their description of data analysis. This approach is an appropriate fit with the worldview underpinning this present study.

Table 4. 2. The stages of thematic analysis (Miles, Huberman & Saldana 2014).

Stage:	Description of the process:	Example from data:	Example of main theme^a:	Example of sub theme^b:
First cycle coding:	A descriptive code summarises and labels a word or phrase.	“Really quite tragic as my daughter started her first day of prep. Dropped kids off at school, got home and there	^a Arrested at home	^b Children not present
	A process code labels conceptual or observable action.	was a knock on the door, the detectives came. I was emotional over my last child heading off to school and it	^a Police responses to motherhood	^b Positive
	An emotion code labels reactions.	made it worse. The police were nice enough to let me go and pick her up. I’ll never forget that day.” – Imprisoned mother with a mental illness	^a Mothers reaction to arrest	^b Distressed

The thematic analysis was conducted at two cycles: (1) identifying themes within each question; and (2) identifying overarching themes of the interview schedule sections (background, prior to prison, arrest, sentencing, and imprisonment sections). As seen in the example in Table 4.2, first cycle coding involved coding by interview schedule question, looking for main themes, and the associated sub themes with the purpose to summarise the data (Miles, Huberman & Saldana 2014). For example, the descriptive code ‘Arrested at home’ also included the sub code ‘Children not present’. The example in Table 4.2 also

highlights the use of process and emotion coding. Where applicable, this study also coded for participant values (e.g. values, attitudes, and beliefs) and evaluations (regarding correctional policies, and programs). Miles, Huberman, and Saldana (2014) sees first cycle coding as a deeply reflective process of analysing and interpreting the underlying meaning of a section of information. This process is guided by the research questions. Second cycle coding involves pattern coding where, as Miles, Huberman, and Saldana (2014) outline, the codes from first cycle coding are pulled together into more meaningful units of analysis. The goal of this cycle is to develop a sense of the interrelated categories/themes, causes and explanation, relationships, and theoretical constructs underpinning the first cycle coding. For this study, the example listed in Figure 4.2 above became part of the umbrella theme of Participation, and included both the individual factors that affected experiences at arrest (e.g. distress) as well as the systemic responses (e.g. how the police responded to motherhood).

Content analysis was also used within this study to determine the trends and patterns evident within the themes, in order to uncover and quantify these patterns (Bryman 2012; Vaismoradi, Turunen & Bondas 2013). For example, when examining the lives of the mothers with a mental illness prior to imprisonment, personal distress was a major theme reported. Therefore, to understand how this theme intersected with other themes (e.g. substance use, homelessness, and victimisation), the number of times the mother reported another theme when discussing their levels of distress was counted and mapped. The purpose of content analysis within this study was to uncover the intersectionality evident in the lives of the participants. This study also used extreme case examples to examine participant experiences that deviate from the typical or representative cases (Patton 2002). As Patton (2002) acknowledges, these case provide opportunities for learning.

This study took a flexible approach to analysing the qualitative data, which including a mixture of inductive and deductive coding. Inductive coding generating themes from the data rather using predetermined themes developed from research questions, literature or conceptual frameworks (Miles, Huberman & Saldana 2014), while deductive coding was guided by the broader study data analysis plan and the literature discussed in 'Chapter Three: The Literature Review'. In addition, this study also recoded ideas, thoughts, and reflections that arose during the analysis. The purpose of this flexible approach was to ensure good quality and trustworthy results, as well as provide an audit trail (Creswell & Plano Clark 2011; Miles, Huberman & Saldana 2014).

4.5. The axiology: Ethical research and procedural ethics

Research in prison and forensic settings involves a number of considerations at the participant, researcher, and systemic levels. Such considerations are important, as social research is an value, and power laden enterprise (Mertens 2003) as well as a practical enterprise (Bryman 2012). Patton (2002) argues that researchers, particularly those engaged in interviews with participants, need to have an ethical framework that deals with practical issues as they arise. Thus, this section discusses the ethical issues and the associated ethical framework used within this study. Such discussion is warranted, but as Sutton (2011) reported, often ignored by prison researchers.

4.5.1 Multi-centred ethics

This present study required multisite ethical approval, with two ethics committees having oversight over this project: the Monash University Human Research Ethics Committee (MUHREC) who oversaw recruiting mothers within the community (refer to Appendix 10 for the certificate of approval), and the Department of Justice Human Research Ethics Committee (JHREC) who oversaw recruiting imprisoned and forensic mothers (refer to Appendix 11 for the certificate of approval). As seen in Figure 4.4 below, this study also required approval from two operational committees, and support to recruit via partner organisations who had direct contact with prisoners and their families, as well as the prison, and forensic facilities.

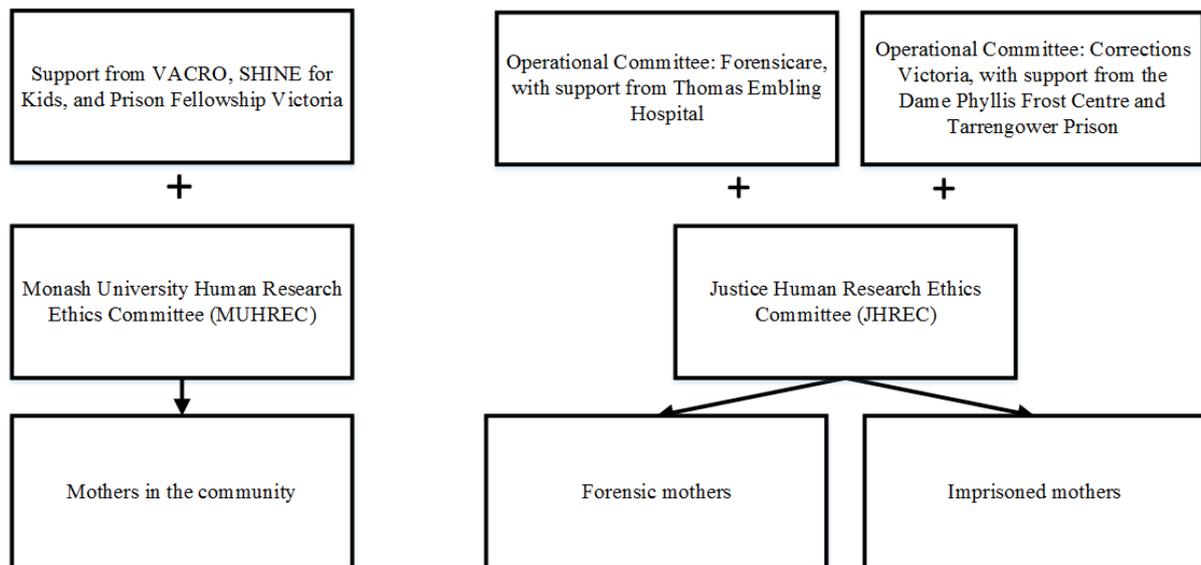


Figure 4. 4. The ethical and operational oversight of this study.

Multisite research was needed in order to access to a larger range of participants (McCauley-Elsom et al. 2009), improving the rigor of the present study. However, achieving ethical approval across multiple sites is a complicated time-consuming process, and involves attention to both the ethical (e.g. voluntary informed consent, and confidentiality) and methodological (e.g. recruitment strategy, and instruments used) issues (McCauley-Elsom et al. 2009). This attention is important, as Sarson-Lawrence et al. (2004) noted, multisite research can delay the commencement of a study. This is due in part to the need for multiple applications, inconsistent decisions, and repetition and duplications within the ethical process (Sarson-Lawrence et al. 2004). Such delays at the onset have significant flow-on effects across each stage of the study (e.g. recruitment, analysis, interpreting, and reporting), and impact the timely manner in which evidence can be disseminated (McCauley-Elsom et al. 2009). For example, it took six months from submitting the original ethical application to JHREC to gain approval for the present study. This resulted in delays to important milestones, such as recruiting the mothers, and analysing the results. Thus, in every sense of the word, such committees act as research gatekeepers.

The researcher-gatekeeper relationship is an integral component of research, from gaining access to conducting the study. Yet gaining and sustaining access is problematic when the participants are classed as vulnerable (Davies & Peters 2014; McCauley-Elsom et al. 2009).

Gatekeepers are useful for a number of reasons: they scrutinise researcher intentions, are useful sources of information, and can encourage participation by potential participants with whom they have a relationship. However, they can also make decisions on behalf of potential participants to exclude them, especially when they deem them to be vulnerable, or a safety risk to the researcher (Davies & Peters 2014). Davies and Peters (2014), in their discussion of the relationship between gatekeepers and researchers, highlight that there are multiple levels of gatekeepers, such as ethical committees, administrators, and staff, therefore ensuring cooperation at each level can be difficult. Furthermore, the assumption that researchers yield all the power is overestimated, due to the ethical and practical considerations involved with gaining access to closed settings (Davies & Peters 2014). Navigating multiple sites requires forethought, planning, and in many respects, mutual trust (Davies & Peters 2014; McCauley-Elsom et al. 2009).

Aside from ethical and operational committees, this study used gatekeepers in two ways: to assist with identifying potential participants, and by providing an organisational assessment of ability to provide consent. The purpose of the latter use of staff was to ensure that no harm came to participants, especially those in the forensic setting. In responding to these issues, a social work ethical framework underpinned this study (Australian Association of Social Workers 2010). Such steps were important given the vulnerability of the participant groups, both in terms of their mental health issues, and their imprisonment status.

4.5.2 The social work ethical framework

As discussed in ‘Chapter One: The Introduction’, the overarching ethical framework underpinning this study, comes from the AASW (2010) Code of Ethics. This value base makes a strong commitment to the “needs, rights and aspirations of individuals, groups and communities who are disadvantaged and discriminated against” (Smith 2012, p. 446), such as imprisoned mothers and their children. Therefore what constitutes good social work research is research that “promote[s] justice, social change and social inclusion” (Shaw 2007, p. 665). This value base had important implications for designing, implementing, and analysing the research (Smith 2012), and calls attention to the multi-faceted nature of vulnerability (or complexity) within research, as well as the responsibilities of the researcher (AASW 2010).

4.5.2.1 Acknowledging and responding to participant vulnerability

Imprisoned women, especially those who have a mental illness, represent a potentially vulnerable research population. While the label of ‘vulnerable population’ is socially

constructed, poorly defined, and rather fluid, it typically relates to those who lack autonomy, personal independence, and/or self-determination as the result of their biological, psychological, or social status (Davies & Peters 2014; Liamputtong 2007). Vulnerability is often used interchangeably with the terms ‘sensitive’, ‘hard-to-reach’, and ‘hidden populations’ (Liamputtong 2007). Moore and Miller (1999) further acknowledge that individuals can be ‘doubly vulnerable’ when they concurrently experience more than one factor which diminishes their autonomy. In this sense, imprisoned women with a mental illness are vulnerable not only because of their mental health status, “but also due to the realities of prison life” (Gostin, Vanchieri & Pope 2007, p. x). However, acknowledgement of ‘vulnerability’ must be balanced with providing participant’s ‘a voice’ (Hamilton, Downey & Catterall 2006). Systematically excluding a participant group, purely on the basis that they are ‘vulnerable’ ensures their perspectives and experiences remain hidden. Research within prisons has the potential for both burden and benefit (Gostin, Vanchieri & Pope 2007). Therefore, within this context, responding to participant ‘vulnerability’ involves acknowledgement and attending to the ethical principles of non-maleficence, informed consent, confidentiality, and privacy (AASW 2010; National Health and Medical Research Council [NHMRC] 2015). These principles must be balanced against ensuring participants right to give voice to their experiences.

Non-maleficence ('do no harm')

Ensuring no psychological harm comes to participants is important in any research, but doubly so when discussing potentially distressing issues (e.g. children, and mental illness) (AASW 2010; O’Leary 2014). One technique for managing potential sources of harm occurred prior to providing consent, as the researcher specifically highlighted with potential participants that discussing their children as well as mental health issues had the potential to be distressing. Therefore, each woman had the right to not participate, withdraw at any time during the interview, not answer certain questions, or take a break, and resume at a later time/day. This technique was reiterated during the interview, if an issue occurred, with suggestions provided to the mother to contact a support worker. This had particular relevance in the prison setting as two mothers cried throughout the interview. When this occurred, the researcher constantly checked in with the mother that they wanted to continue, a break was provided where a cup of tea was made for both the researcher and the mother, and finally a discussion occurred around the support services available within the prison. Referral to relevant support services only occurred with participant consent. In addition, another mother

became distressed during the interview, and after consultation with the researcher, chose to terminate the interview. Another technique included the use of a once-off interview. This reduced the practical and emotional burden on the participants. However, data collection procedures that involved more than one episode (e.g. two or more interviews) may have the potential to be safer as the participant knows the researcher. As an outcome of this acknowledgement, the researcher incorporated a number of techniques addressing the issues of voluntary consent, confidentiality and privacy, as well as research reflexivity to ensure non-maleficence.

Voluntary informed consent

Informed consent is considered the bedrock of ethical research and involves ensuring that participants understand the research, including the purpose, as well as the benefits and risks of participation (AASW 2010; Gostin, Vanchieri & Pope 2007). However, informed consent is a particular issue within prison-based research as imprisonment reduces an individual's right to decision-making autonomy (Gostin, Vanchieri & Pope 2007). There is a chance that participants may be unable to provide consent due to cognitive or psychological issues, or that they will feel coerced into participation by prison staff and the subsequent belief that they will be punished if they do not participate. Furthermore, the fact that participation enables the participant to be absent from work, or educational commitments, and interact with someone outside of the norm, can also be interpreted as a form of coercion (Moser et al. 2004). Therefore, the prison setting has been labelled 'inherently coercive' (Moser et al. 2004).

However, research which has specifically examined the decision-making capacity of prisoners (including those with a mental illness, and those in forensic settings) to participate in research demonstrates that they are able to provide informed consent (Edens et al. 2011; Magyar et al. 2012; Moser et al. 2004). Such results are unsurprising considering previous research has shown that individuals with severe psychiatric disorders, such as schizophrenia and bipolar disorder, are able to provide informed consent to research (Carpenter et al. 2000; Misra et al. 2010; Moser et al. 2002). Furthermore, while the prison environment may have played a role in their decision to participate (e.g. boredom, desire to help others, appear cooperative, and meet someone new), this role was not coercive (Copes, Hochstetler & Brown 2013; Moser et al. 2004). Similar results were found by Magyar et al. (2012) in forensic patients. Moser et al. (2004) suggest that researchers look beyond the dichotomous

view of competent versus not competent when determining capacity to provide consent, advocating instead for a continuous view, with researchers optimising each participant's decision making capacity (e.g. in-depth discussion of the research materials). As Moser et al. (2004, p. 7) reported "simply having a psychiatric diagnosis does not imply anything truly meaningful about an individual's ability to make an informed decision regarding research participation". There are however, gender differences within these groups. Eden et al. (2011) did report modest differences between men and women in prison, as women were more likely to report greater perceptions of pressure from staff and peers to participate in research. However, this gender difference did not appear to affect voluntariness or participation. Therefore, this suggests that while they may feel pressure, this does not necessary translate into participation.

With these recommendations in mind, the researcher went through the explanatory statement with each women prior to the signing of the consent form. This was an in-depth process about each section of the statement, including the study aims, what would be asked in the interview, and the boundaries of confidentiality. The mother was also asked to reiterate the research in her own words, to ensure comprehension. As this study used prison staff to recruit, it was reinforced by the researcher with each participant that involvement was voluntary, and they could refuse without fear of punishment. The considerable number of imprisoned mothers who refused, suggests that coercion was not widespread in this research. This is in line with the research discussed previously (Edens et al. 2011; Magyar et al. 2012; Moser et al. 2004).

Confidentiality and privacy

Confidentiality involves protecting the identity of those involved within research (AASW 2010; O'Leary 2014). However, confidentiality and privacy is difficult within the prison setting, due to the coercive and institutionalised contexts, and the highly controlled and public nature of this system (Gostin, Vanchieri & Pope 2007). As Gostin, Vanchieri, and Pope (2007) reported, maximising privacy within this system involves collaborative planning with correctional staff. With this in mind, the researcher worked with staff to ensure that all interviews occurred in a room within the prison's programs building, behind a closed door. In the community, interviews occurred in a café, away from other patrons. Furthermore, all mothers were informed before consenting that confidentiality could not be guaranteed if they disclosed a crime that has not gone before the courts, or if they were planning on committing a crime, or planning to hurt themselves or another person. Given the sensitive nature of the

interviews, all participants were given a participant code, with transcribing removing sensitive information from the data prior to analysis (e.g. children and partner's names were removed).

Implications of attending to these ethical issues

Acknowledging and attending to the aforementioned ethical principles of non-maleficence, informed consent, and confidentiality and privacy assists in building trust and rapport between the participant and the researcher. While there is no guaranteed way to build trust and rapport, O'Leary (2014) suggested that researchers must also attend to a number of issues that can affect this process, such as gender, age, ethnicity, socio-economic status and education, and level of privilege. For example, women may be more comfortable talking about issues relating to children, mental illness, and offending with other women, but when talking about children, having children and being older may be of an advantage. Therefore, and as discussed in the upcoming section, researcher reflexivity is important tool for responding to participant vulnerability (Davison 2004).

4.5.2.2 Acknowledging and responding to researcher vulnerability

Methodological discussions surrounding research with 'vulnerable populations' have typically focused on participant welfare; the issue of researcher welfare is rarely discussed (Hamilton, Downey & Catterall 2006). As Davison (2004, p. 381) notes "the capacity for harm is incumbent in any research – vulnerability and conflicting emotions can be linking experiences for both the research informant and the researcher". Social research involves a degree of intimacy and disclosure that can create personal and professional conflicts associated with collecting distressing material, especially the conflict between the 'social worker' role and the 'neutral researcher' role (Davison 2004). As Patton (2002) acknowledges, interviews affect people.

Gaining access to the prison system involves compliance with administration and security regulations, procedures, and rules. At a practical level, entry into prisons involves an identification check, an x-ray of all supplies entering the prison (e.g. interview schedules, pens, and lunch), and going through a metal detector; the forensic hospital additionally requires a retina scan. Once this is completed, the researcher must be escorted around the prison and hospital grounds, with wait times dependent on escort availability. Furthermore, the researcher also needs to be aware of procedures regarding what can be brought into the prison setting, the use of a duress alarm, and surprisingly, what is appropriate to wear

(Schlosser 2008). Therefore, gaining access into prisons overall, and on a day-to-day basis, requires researcher flexibility and patience. The researcher has very little control within this environment.

The prison environment also compounds participant-researcher vulnerability. In the beginning, this environment is novel for the researcher, but is one where they have limited power. In many respects, the participant is truly the expert here: knowing the rules, procedures, and prison timetable. Davison (2004, p. 388) calls this “shifting boundaries” where the assumption of researcher power is questionable, as the relationship between the participant-researcher is negotiated and shifts in response to the identities and experiences of those involved. In the sense, and as discussed previously, it is incorrect to assume that people in prison are automatically vulnerable. This reflects the earlier discussion on the power relationship between the researchers and the gatekeepers

In responding to the issue of researcher vulnerability, and by extension participant vulnerability, Davison (2004) advocated for researcher reflexivity. This involves reflection of the research context, acknowledgement that some ethical issues cannot be predicted or eliminated due to these contexts, and ownership of emotional reactions within the context (Davison 2004). Patton (2002) used the term ‘empathetic neutrality’ to discuss the middle ground between becoming too involved, which clouds judgement, or being too distant which reduces understanding. Neutrality does not mean detachment, but rather a non-judgemental stance that facilitates rapport, building a relationship between the researcher and the informant that is open and empathetic (Patton 2002). The importance of such a stance is highlighted by O’Leary (2014, p. 51) who acknowledges that pure neutrality in social research places the researcher at risk of ignoring issues pertaining to “race, class, and gender; hearing only the dominate voice; and disregarding the power of language”. Therefore, researchers must manage their ‘subjectivities’, or personal bias. This ensures that the results represent the view of the participants rather than the researcher (O’Leary 2014).

4.6. Implications of the methodology and associated methods

According to the principle of mixed methods research, good research involves balancing the strengths and limitations of the chosen approach (Johnson & Turner 2003). Therefore, this section briefly discusses the overarching strengths and limitations of this study. These issues are further examined in ‘Chapter Nine: The Discussion and Conclusion’.

4.6.1 Limitations of the research design

There are a number of overarching limitations associated with this study's methodology and associated methods. These limitations include a lack of validated measures, a once-off data collection strategy, and a lack of alternative perspectives.

Lack of validated measures

This study gathered quantitative data via closed questions (e.g. yes/no/maybe questions) and un-validated Likert scales (e.g. current mental health status) within a structured interview schedule; it was dependent on the subjective interpretation of the mother. The use of such questions often limited the analysis to categorical (dichotomous) variables. Gathering further data using more suplicated scales would have yielded results with more power. In addition, the use of validated scales, for example the Kessler Psychological Distress Scale (K-10) (See: Butler et al. 2005), would have provided additional information regarding the mother's current level of coping at imprisonment, provide evidence behind the mothers' subjective interpretations, and ensure that even undiagnosed mental health issues were captured. However, due to the exploratory nature of this study, the use of such tools was unnecessary. It is likely that further research examining this issue would benefit from the use of such tools.

Once off data collection strategy

The data collection strategy involved a once-off interview that took place in 2013. Therefore, this study has time and place limitations. For example, since the interview, there has been a government change in Victoria (from a conservative Liberal government to Labor in the November 2014 election), and as 'Chapter Two: Theoretical, Political, and Social Context' showed, such changes have significant implications for prison management. The Labor government has allocated funds to the expansion of mental health, counselling, and rehabilitation programs within Victoria's female prison system (Department of Treasury and Finance 2015; Noolan 2015). This has the potential to change the experiences of mothers with a mental illness at the point of imprisonment.

In addition to the issues associated with time, the data gathered during the structured interview was based on self-report. Therefore, the answers provided by the mothers may have been shaped by factors such as social desirability, acquiescence, the stigma attached to the issues of mental illness, mothering, and imprisonment, and lastly, the desire to protect their children, and/or their mothering identity (Bryman 2012). Such factors may have resulted in

the mothers minimising the difficulties they experienced as they navigated the criminal justice system. However, previous research has shown that prisoners are reliable and honest research participants (e.g. Bai et al. 2014; Schofield et al. 2011; Trotter, McIvor & Sheehan 2012).

Lack of an alternative perspective

Due to the limited research specifically examining mothers with a mental illness, this exploratory study limited its focus to examining the experiences of this group of mothers. In this study, children and current carers were not actively recruited. This was a pragmatic decision based on the exploratory nature of this study. The impact of this is minimised however as the broader study did include these two participant groups. Furthermore, and despite every effort made to recruit forensic mothers, the voice of mothers at the severe end of the mental illness spectrum is also missing. This issue is further compounded by the fact that this study did not have access to mothers in the management unit or the mental health unit (called Marmak) at DPFC, therefore only the voices of mothers in the general prison population were captured. The general population may represent a more stable population. The exclusion of these units was a decision made by prison staff in order to ensure prisoner, and researcher safety. In addition, the views reflected in this study represent a narrow range of imprisoned mothers, typically Caucasian. As previously mentioned, participants who were non-English speaking were excluded. This was due to difficulties organising meaningful interpreting services to join the interviews. Therefore, the results have limited relevance to the above-mentioned groups, and represent an important area for future research.

4.6.2 Strengths of the research design

Despite the aforementioned limitations, this study also has a number of strengths. The previous chapter highlighted the limitations of the existing body of knowledge that underpins this study, noting the siloed nature in which mental illness and motherhood has been examined. Therefore, this study builds upon this rather limited knowledge base, and represents the first Australian study to do so. Furthermore, this study has a retrospective component, paying attention to the key decision making-points within the criminal justice system, specifically the points of pre-prison, arrest, sentencing, and imprisonment. This is unlike previous studies that generally discuss the experiences of imprisoned mothers as a whole, or focus on the point of imprisonment. Indeed, Murray, Farrington, and Sekol (2012) acknowledge, these periods cause multiple difficulties for mothers and their children.

In addition, this study includes a well-developed analysis plan, grounded in theory, which allows for the examination complexity and diversity within the participant groups. The inclusion of mothers without a mental illness, as well as a within-group analysis plan for mothers with a mental illness allows for the in-depth exploration of the influence mental illness has on the women's navigation of the criminal justice system. This is important as the previous chapter noted the limitations of research that often examines imprisoned mothers as homogenous group. Furthermore, this study also actively recruited from both female prisons in Victoria, therefore takes into account the differences in population for women imprisoned in a maximum or minimum-security facility.

Lastly, this study is grounded within pragmatism, allowing the researcher to incorporate her social work training and value base in addressing the ethical and practical considerations of interviewing imprisoned mothers with a mental illness. This draws attention to the needs of the participant, the researchers, and to the needs of the prison, allowing for researcher reflexivity.

4.7 Summary and conclusion

This chapter reported on the design of the study. It highlights how the use of the pragmatic worldview, the theoretical perspectives, the exploratory mixed method methodology, and associated methods combine to ensure that this present study is contextually responsive to both the imprisoned mothers lived experiences, and to the research environment. For example, the worldview provided the freedom to develop a study design that not only answered the research questions, but also addressed ethical and environment issues relating to conducting research within a closed setting. The use of feminist intersectionality theory and complexity theory draws attention to the importance of examining how imprisoned mothers interacted with complex and multiple systems.

The purpose of this design is to answer the core research question: *'What are the experiences of mothers with a mental illness as they navigate the criminal justice system?'* This is an under researched area as the experiences of mental health issues for female prisoners is often conducted independently of their mothering role. Equally, research into mothering within the prison context concentrates on the experiences of 'mothers', independent of their mental health status, or other vulnerabilities. Focusing on this gap allows this study to develop further knowledge in the area, examining the experiences of mothers with a mental illness at the critical decision-making points of pre-prison, arrest, sentencing, and imprisonment.

Particular attention paid to how they engage with the criminal justice system to plan the care of their children. This present study also has four subsidiary questions: (1) What are the similarities and differences in the experiences of mothers with or without a mental illness as they navigate the criminal justice system? (2) What is the relationship between mental illness and motherhood as women intersect with the criminal justice system? (3) What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system? And lastly (4) How does the criminal justice system respond to this group of imprisoned mothers with a mental illness?

To answer these questions, this study used an exploratory embedded mixed method approach, in order to gather both quantitative and qualitative data within one interview. This reduced the research burden for both the mother and the prison. This was an important consideration given the ethical and practical consideration for conducting research with this participant group. Whilst this study is unable to make claims about the wider female prison population given the narrow definition of mother used, the data analysis plan allows the complexity and diversity within the participants to be examined. This coalesces well with the feminist intersectionality and complexity theory that guided the research process. This adds depth to the results, with the attention paid to the methodological rigour of this study ensuring the credibility of the results. Chapters Five, Six, and Seven report the findings of this study, beginning with the demographic results.

Introduction to the results:

The next three chapters present the findings in relation to the core research question: *What are the experiences of mothers with a mental illness as they navigate the criminal justice system?*, and the four subsidiary questions:

1. What are the similarities and differences in the experiences of mothers with or without a mental illness as they navigate the criminal justice system?
2. What is the relationship between mental illness and motherhood as women intersect with the criminal justice system?
3. What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system?
4. How does the criminal justice system respond to this group of imprisoned mothers with a mental illness?

To respond to these questions, the results are divided into three chapters. Chapter Five, describes and examines the characteristics of the participants with a mental illness (primary mothers) prior to their imprisonment. These characteristics are compared to participants without a mental illness (comparison mothers), as well to the wider available data on imprisoned women in Victoria, and Australia. This chapter has two important functions. Firstly it provides the context in which this research is situated, and highlights the representativeness of the primary mother group. Secondly, it engages in an in-depth examination of the key demographic characteristics of the two participant groups, in order to show the distinguishing features in terms of their age, ethnicity, offending history, and motherhood and parenting experiences (this determines whether the self-reported mental illness of the primary mother is the only distinguishing feature that separates these two groups). As such, Chapter Five addresses in part subsidiary question one.

Chapter Six, the most substantive results chapter, explores how the primary mothers navigate the criminal justice system. Addressing subsidiary question two, this chapter begins with an examination of the strained conditions that these families operate in prior to their entry into this system, and the factors that affect the mothers' mental health status. This chapter then moves to examining their participation through this system, highlighting the factors that help and hinder participation, and the consequences of this on responding to children's care and safety needs. This addresses in part subsidiary question three. This discussion also includes two extreme case examples, contrasting the experiences of the primary mothers who had low or high levels of involvement in planning their children's care. These case examples illustrate

the consequences of the factors that affect the primary mothers' engagement with and participation in the criminal justice system to plan the care of their children. This chapter concludes with an examination of gender responsive prison practice in responding to the primary mothers' mental health and parenting status. This addresses subsidiary question four.

Finally, Chapter Seven examines the primary mothers in more depth, exploring whether their experiences of multiple mental health issues, high or low prevalence disorders, and substance use, identified and discussed in Chapter Four, adds difficulty to their engagement with and participation in the criminal justice system to plan the care of their children. This within-group analysis emphasises the value of close analysis in uncovering hidden differences and complexity within this participant group, highlighting the need to examine and identify complexity within practice. Therefore, this chapter also addresses subsidiary question three.

The findings presented within these three chapters draw from the quantitative and qualitative data gathered in the interviews with the imprisoned mothers and the associated analysis process, as outlined in Chapter Four. The results from the thematic and content analysis are merged with the quantitative analysis. With regard to the qualitative data, any direct quotes presented within these three results chapters come from the primary mothers, and are all labelled by their participant number (i.e. PM1-21). The quantitative findings are presented using frequency and descriptive statistics, as well as, where appropriate, the Chi-square test for independence, the associated Fisher's Exact Test, and the two non-parametric statistical tests. However, given the small sample sizes of these subgroups, non-parametric statistical analysis was not appropriate for every question. The following abbreviations are used throughout these chapters:

Abbreviation/symbol	Definition
<i>N</i>	Total number of primary or comparison mothers
N	Total number of participations who answered a question; not every participant answered every question
n	Number of participants
χ^2	Chi-square statistic
U	Mann-Whitney U Test statistic
ϕ	Effect size for the Chi-square statistic
<i>r</i>	Effect size for non-parametric tests

Chapter Five: Characteristics of Mothers with a Mental Illness

“Look beneath the surface; let not the several quality of a thing nor its worth escape thee”

Marcus Aurelius

As discussed in ‘Chapter Three: The Literature Review’, research that broadly examines the experiences of incarcerated women and mothers has called attention to the individual, social, and systemic challenges that shape the lives of these women. Such challenges include economic disadvantage and financial debt, unemployment, and unstable housing, as well as health, mental health, parenting, and relationship issues (Celinska & Siegel 2010; Loucks 2004; Murray & Murray 2010; Corrections Victoria 2005). Little attention has been paid specifically to the subgroup of imprisoned mothers who have a mental illness, despite the high prevalence of mental illness within the prison population (Butler et al. 2005; Fazel & Danesh 2002; Fazel & Seewald 2012; Tye & Mullen 2006), and the known influence of mental illness on the parenting experiences of individuals within the general community (Blegen, Hummelvoll & Severinsson 2010; Reupert & Maybery 2007). These experiences of mental illness have the potential to shape both how women navigate the criminal justice system, and how they respond to their children during this process.

Therefore, this chapter examines in detail the characteristics of the study’s primary mothers: the 21 women who have a mental illness, beginning with a description of their demographic characteristics such as age, and ethnicity. An examination of their offending histories, and family circumstances, such as the family lifestyles and children’s care arrangements, are also included within this chapter. The chapter then concludes with a discussion of their mental health issues.

In order to justify the specific focus of this study, and comment on the wider application to prison and community population, the characteristics of the primary mothers are compared to the Australian Bureau of Statistics (ABS) (2013) data for prisoners in Australia for the year 2013. In addition, Victoria’s Department of Justice and Regulation (DOJR) (2015c) most recently available statistical profile of their prison system, which examines prisoner statistics from 2009-10 to 2013-14, is also used. These date ranges reflect the year in which recruitment occurred for the present study, and therefore more relevant than the more recent 2014 to 2016 data. Finally, the characteristics of the primary mothers are also compared to

the comparison mothers (the 19 women without a mental illness). This addresses subsidiary question one: ‘What are the similarities and differences in the experiences of mothers with or without a mental illness as they navigate the criminal justice system?’ This final comparison group was included as the broader data (e.g. ABS 2013; DOJR 2015) examines the experiences of imprisoned women rather than imprisoned mothers.

As noted previously, this chapter concludes with a discussion of the primary mothers mental health issues. Given such information is not included in the broader Victorian (e.g. DOJR 2015) or Australian (e.g. ABS 2013) prison data, the mental health characteristics are compared to the ABS’s (2008) most recent National Survey of Mental Health and Wellbeing as well as to Tye and Mullen’s (2006) study on mental illness in Victoria’s two female prisons. This allows for comparisons between the study’s sample and the broader population. All comparisons included in this chapter are displayed using frequency and descriptive statistics, and where appropriate statistical analysis. Please note that not every characteristic discussed lends itself to statistical analysis.

5.1 Age

Both national and Victorian data on women in prison highlight that a larger percentage of this population fall into the two age brackets of 25-29 years and 30-34 years (ABS 2013; DOJR 2015). This is reflected in the age brackets of the study participants, as shown below in Figure 5.1.

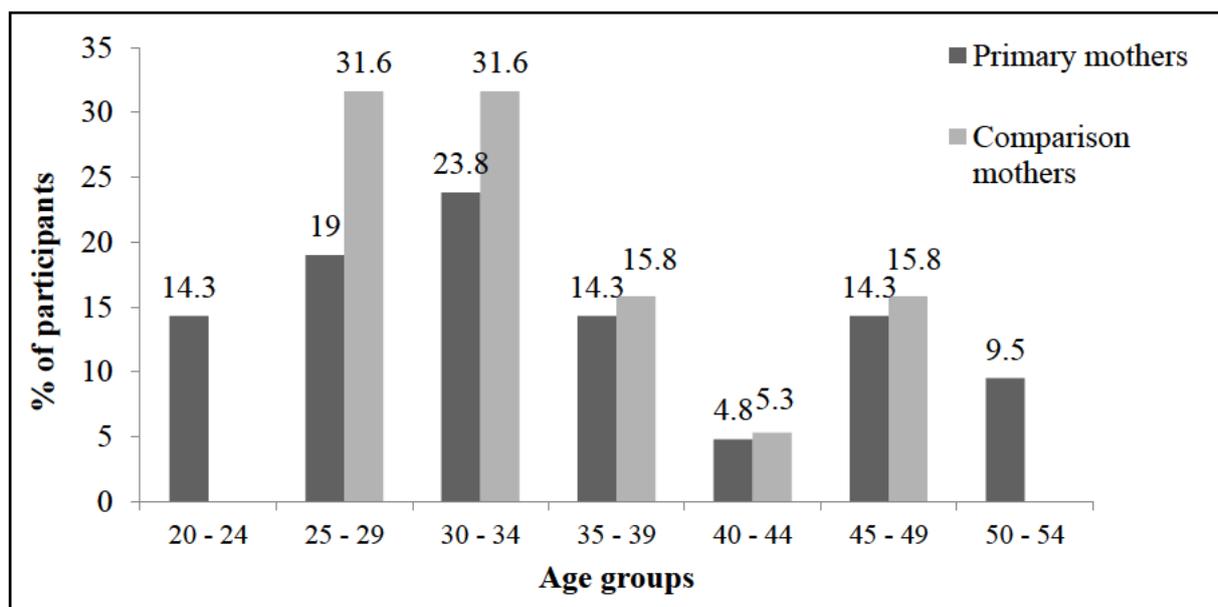


Figure 5. 1. Age distribution of the primary mothers ($N=21$) and the comparison mothers ($N=19$).

When examining median age, women imprisoned in Victoria have the highest median age at 36.2 years (DOJR 2015), followed by the national age (Md= 34.5) (ABS 2013), and finally the study participants: the primary mothers (Md=34), and the comparison mothers (Md=33). The somewhat younger comparative age of the study participants is likely the result of the focus of this study: on mothers with dependent children. This study recruited from a narrower age bracket, and focused on those within their reproductive years who had dependent children. As the median age of the comparison mother is slightly younger, a Mann-Whitney U Test was conducted. This test revealed no significant difference in the age of primary mothers (Md=34, $N=21$) and the comparison mothers (Md=33, $N=19$), $U=182.00$, $z=-.48$, $p=.64$, $r=-.08$.

Outside of this, and as evident above in Figure 5.1, there are differences between the two groups of participants, as there are no comparison mothers in the youngest (20-24 years) and the oldest (50-54 years) age brackets. Indeed, three primary mothers reported at interview that they were young mothers. Two primary mothers had their first child at age 15 years, and one primary mother at age 19 years. This has the potential to further increase the complexity in responding to them, given they are trying to meet their own, and their children's, developmental needs within a context of both mental health issues and offending. In addition, two primary mothers reported that they were older mothers. It is likely this result relates to their long sentences, as both mothers committed homicide (refer to 'Section 5.3 Offending history' for the discussion on offending) and were imprisoned over a decade ago. Therefore, while the median age of both participant groups were similar, only the primary mothers included mothers at the extreme ends of the age range. This presents additional challenges to responding to the complexity and diversity within the primary mothers.

5.2 Ethnicity

As shown in Table 5.1, the majority of the study participants were born in Australia, with 10 born overseas. There are no substantive differences between the two participant groups and their country of birth.

Table 5. 1. Country of birth for the primary mothers ($N=21$) and the comparison mothers ($N=19$).

Country of birth	Primary mothers n (%)	Comparison mothers n (%)
Australia	16 (76.2)	14 (73.7)
Vietnam	2 (9.5)	3 (15.8)
New Zealand		1 (5.3)
United Kingdom	1 (4.8)	
United States of America	1 (4.8)	
Papua New Guinea		1 (5.3)
Singapore	1 (4.8)	
Total	21 (100)	19 (100)

Of the participants who reported that they were born in Australia, four women described themselves as Aboriginal or Torres Strait Islander (with equal representation across both participant groups). In 2013, when this study was conducted, there were 28 Aboriginal and Torres Strait Islander women in Victorian prisons (ABS 2013). This means that this present study was able to capture 14% of this population. However, it is unlikely that this small sample truly reflects the experience of indigenous women as this was not the main focus of this present study. The ethnicity of the study participants cannot be compared and contrasted against the national and Victorian data on prisoners. Whilst this data does include country of birth, it is not analysed by gender (ABS 2013; DOJR 2015). As Table 5.1 above shows however, the majority of the study participants were born in Australia, with the second largest group born in Vietnam.

Therefore, the results show that both participant groups are similar in terms of their age and ethnicity.

5.3 Offending history

Due to the specific focus of the broader study and by extension this present study, which was on the care planning experiences of imprisoned primary carers, participants' offending histories was not explored in depth. Participants were simply asked about the offence they committed, any previous history of imprisonment, whether they were remanded prior to their sentence, and the length of their sentence.

5.3.1 Offences committed

As show below in Figure 5.2, the study participants reported a range of violent and non-violent offences. Three primary mothers and one comparison mother reported multiple offences. Therefore, the total number of offences is greater than the number of participants.

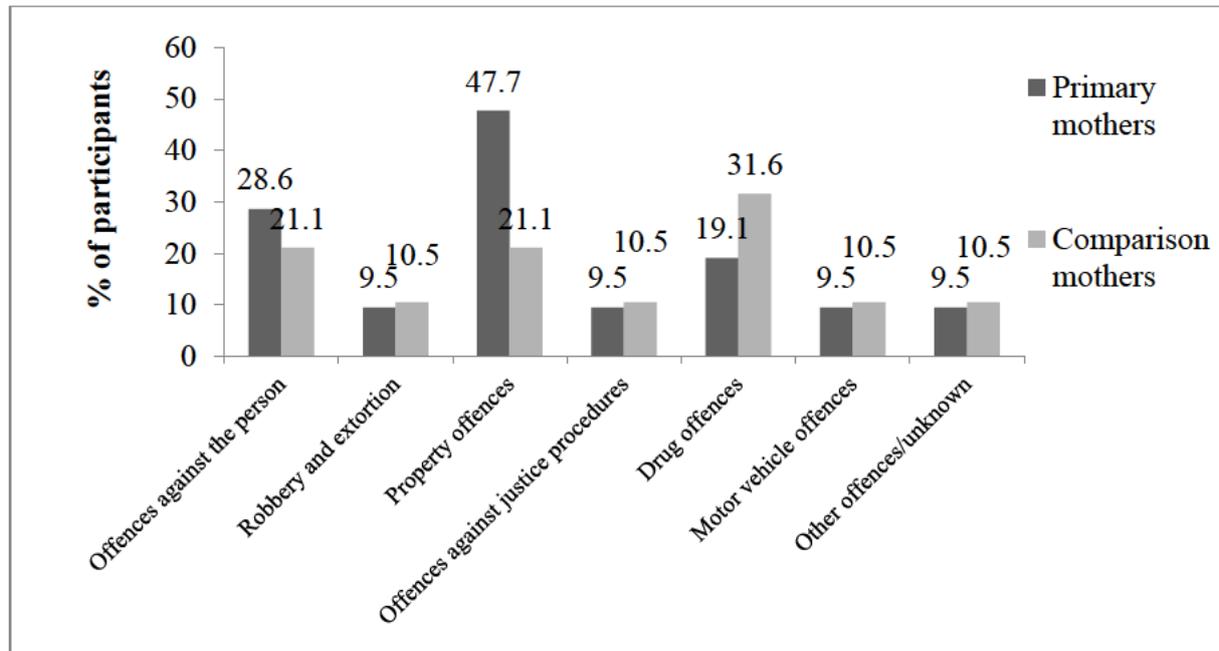


Figure 5. 2. Criminal offences by the primary mothers ($N=21$) and comparison mothers ($N=19$).

As shown in the above Figure 5.2, approximately one-half of the primary mothers reported property offences such as theft, deception, and handling stolen goods. In contrast, the comparison mothers commonly reported drug related offences such as drug trafficking, and drug cultivation. The primary mothers were also more likely to report offences against the person (e.g. homicide and assault) than the comparison mothers. It is important to note here, that it is difficult to compare this finding to national and Victorian data on imprisoned women as the offences captured in that data represent the ‘most serious offence’, the offence for which the prisoner received the longest sentence (ABS 2013; DOJR 2015). This present study captures all offences reported by the study participants. The Victorian data indicates that a larger proportion of imprisoned women commit offences against the person (23%), drug offences (19.9%), and property related offences (18.1%) (DOJR 2015). Whilst there are some similar trends in the present study, the primary mothers show more offences against the

person and property offences than the broader Victorian data. This could suggest that these crimes co-occur with other offending, that would not be captured in the Victorian data.

Figure 5.2 above also shows that there is a difference between the study participant groups and their commonly reported offences, especially for property and drug offences. The higher prevalence of property crime suggests that there may be an economic basis to it: occurs within the additional context of poverty. It is also interesting that the primary mothers were less likely to report imprisonment due to drug related offences than the comparison mothers, given their self-reported high levels of substance use (discussed in the upcoming ‘Section 5.5 Mental illness and comorbidity’). This suggests they are not heavily involved in the drug scene, with their substance use associated with other crimes.

5.3.2 Recidivism

According to the ABS (2013) just under half (or 47.2%) of women imprisoned in Australia have a history of prior imprisonment. The recidivism rate for the state of Victoria however is lower at 36.7% (DOJR 2015). In contrast, over half of the primary mothers (57.1%, $n=12$, $N=21$) reported a history of prior imprisonment, whilst the comparison mothers recidivism rate more closely reflects the state rate (38.9%, $n=7$, $N=19$). A Chi-square test for independence was used to examine the rate of recidivism across both participant groups. There was, however, no significant difference between the two groups and whether they had been previously imprisoned or not, $\chi^2(1, n=39) = 1.29$, $p = .21$, $\phi = .18$. Whilst there is no statistical difference between the participant groups, a larger percentage of primary mothers reported a history of prior imprisonment compared to the national and state data, as well as the comparison mothers, suggesting a greater level of complexity or vulnerability associated with this participant group that has them returning to prison. The insignificant result may relate to the small sample size evident in this study, and therefore warrants further investigation.

5.3.3 Taken to prison: Remand or a breach offence

Being taken straight into custody following arrest can represent a crisis for the family, as there is no time to prepare. Therefore, the rates of custody versus bail are relevant for both participant groups, and are shown below in Figure 5.3.

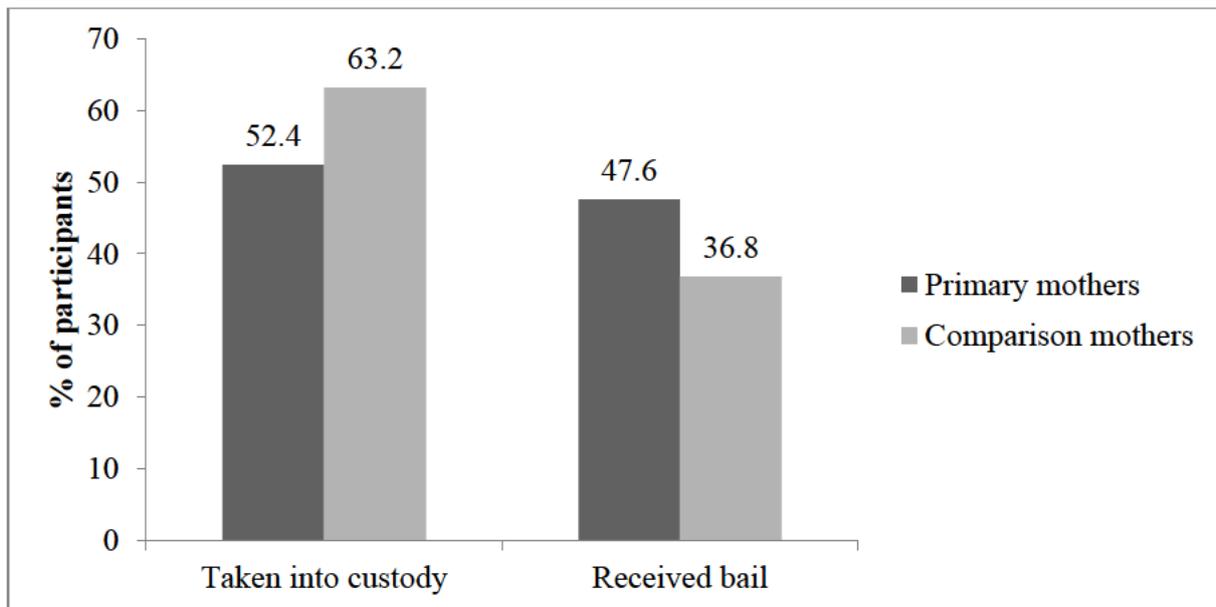


Figure 5. 3. Outcomes of the interaction with the police by the primary mothers ($N=21$) and comparison mothers ($N=19$).

Eleven primary mothers reported being taken into custody upon their arrest: nine were remanded awaiting their court appearance, while two breached their parole conditions. Similarly, 12 comparison mothers were also taken immediately into custody following their arrest: 10 were remanded, and two breached their parole or community-based order. The remaining study participants received bail. A Chi-square test for independence revealed no significant difference between the two participant groups and whether they were taken into custody or received bail following their arrest, $\chi^2(1, n=40) = .47, p = .54, \phi = .10$. This suggests that both participant groups were similar in their experiences of receiving bail or being taken into custody following their arrest.

However, as shown below in Figure 5.4, a larger number of primary mothers reported being on remand for lengthy periods, one to two years (55.6%, $n=5$), compared to their comparison counterparts. In addition, a larger number of comparison mothers reported remand periods of less than one year (80%, $n=8$), with the majority of these participants (70%, $n=7$) on remand for less than six months. Two primary mothers were on remand when they were interviewed for this study.

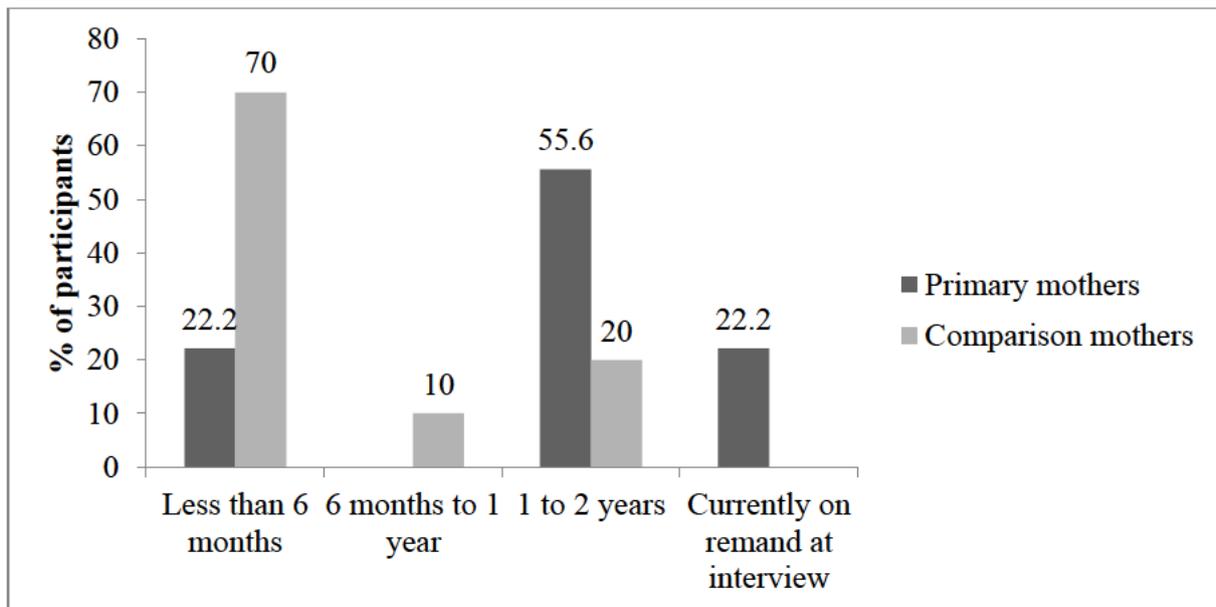


Figure 5. 4. Total time spent on remand for the primary mothers (n=9, N=21) and comparison mothers (n=10, N=19).

Due to the small number of participants who were remanded, a Fisher’s Exact Test was used to examine the differences between the two participant groups and the length of time spent on remand (less than one year versus one year and over). However, there was no association between the two participant groups and their length of time on remand, $p=.06$, $\phi=.51$. This result however, was just outside the conventional significance level set at $p<.05$, and it is likely that with more participants, this difference could have moved into the significant range.

Taking into consideration the statistically insignificant results, data suggest that primary mothers, whilst somewhat less likely to report being remanded, when they are remanded, they are more likely to spend longer periods of time on remand compared to the comparison mothers. This may be linked to their offences, as the primary mothers were more likely to commit more serious offences, such as offences against the person. Such offences would typically result in lengthy remand period in order to prepare for the court case. Unfortunately such comparative information was not provided by the DOJR (2015c), with the ABS (2013) not providing a gender breakdown. Remand represents a period of ‘unknown’, were there is no access to prison-based services, and no clear end-point. This creates difficulties for families when deciding children’s care arrangements. The issue of remand in regards to care planning will be further discussed in the upcoming chapters.

5.3.4 Sentence length

The length of the sentence received also has the potential to influence the care-planning process, specifically whether care plans need to be short or long term. As shown in Table 5.2, the majority of the primary mothers were sentenced to less than five years imprisonment, with this result mirrored in the comparison mothers. Given the fact that female offenders typically commit non-violent offences, this finding is to be expected. In addition, two primary mothers reported that they were still on remand at the interview.

Table 5. 2. Comparison of the sentence length by the primary mothers (N=19) and the comparison participants (N=19).

Expected time to serve	Primary mothers n (%)	Comparison mothers n (%)	Victoria's general female prison population*
Less than one year	7 (36.8)	7 (36.8)	37.3
One year to less than five years	9 (47.4)	9 (47.4)	44.6
Five years to less than ten years	1 (5.3)	3 (15.8)	11.8
Ten years and over	2 (10.5)	-	6.3
Total	19 (100)	19 (100)	-

Note: *(DOJR 2015)

Furthermore, as a larger number of the primary mothers committed homicide, the number of participants sentenced to 10 years and over is also expected. The figures presented in Table 5.2 are comparable to Victoria's female prison population, with similar frequencies in the sentence length found between this study and correctional data (DOJR 2015). Unfortunately such comparative information is not provided by the ABS (2013). Whilst the primary mothers had a slightly longer median sentence length, a Mann-Whitney U Test revealed no significant difference in the sentence length (months) for the primary mothers (Md=16, N=19) and the comparison mothers (Md=13, N=19), $U=177.00$, $z=-.10$, $p=.93$, $r=-.02$. Therefore, despite the slightly different offences committed by each participant group (e.g. property versus drug offences), their median sentence length was similar.

As shown in this discussion, both participant groups experience high levels of immediate removal from family and children following arrest due to remand or breach offences. However, the primary mothers are more likely to report longer periods spent on remand. This

increases the difficulty in developing care plans as ‘uncertainty’ underpins remand. Furthermore, both participant groups received a similar sentence length of approximately a year and a half, in which others need to care for their children.

5.4 Motherhood and parenting

This section describes and examines the partner status, number and age of children, and living arrangements prior to, at remand, and at imprisonment for both participant groups. This allows for an examination of the interaction between motherhood and parenting experiences for the primary mother group.

5.4.1 Sole and partnered mothers

Approximately two-thirds of the primary mothers reported that they were sole parents (61.9%, $n=13$, $N=21$). In contrast, and as shown below in Figure 5.5, the comparison mothers reported a slightly higher number of mothers who were sole parents (73.7%, $n=14$, $N=19$).

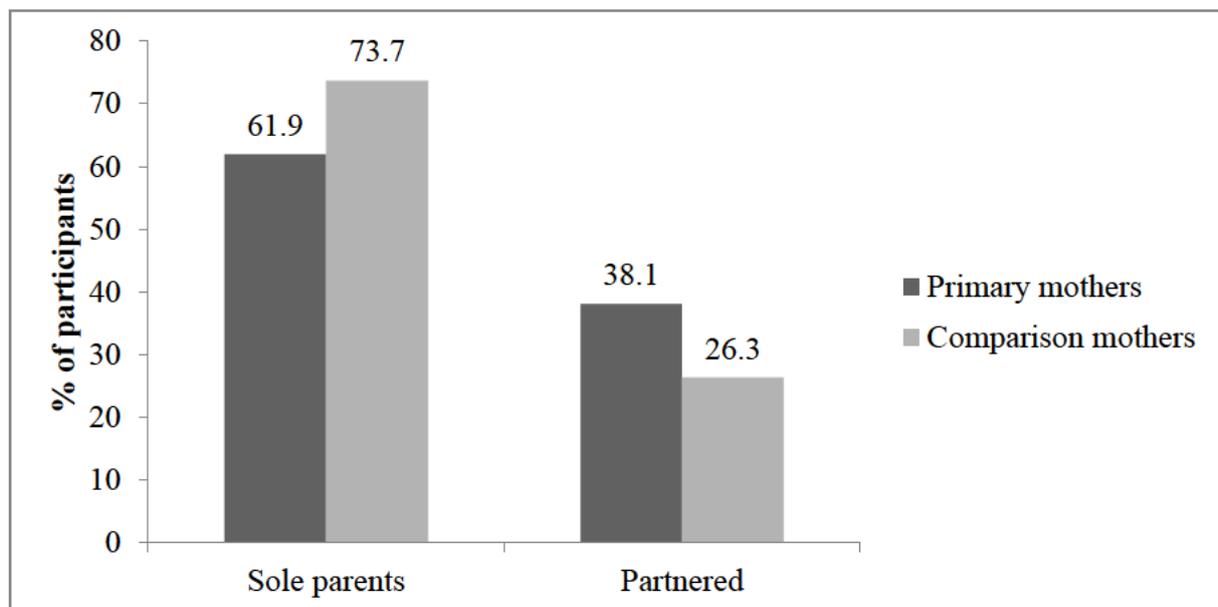


Figure 5. 5. Partner status by the primary mothers ($N=21$) and comparison mothers ($N=19$).

A Chi-square test for independence was conducted to examine the partner status of the primary mothers and the comparison mothers. There was no significant difference between both participant groups and whether they lived with partners or were sole parents, $\chi^2(1, n=40) = .63$, $p = .51$, $\phi = .13$. Therefore, both participant groups were more likely to report being sole parents.

5.4.2 Children

The study participants had 80 dependent children and eight non-dependent children (birth to 18 years) prior to their imprisonment. The majority of these children were biological, aside from one primary mother who reported three step-children. Figure 5.6 below shows the number of dependent children per participant group. As seen in this figure, the majority of the study participants reported that they had between one and three dependent children.

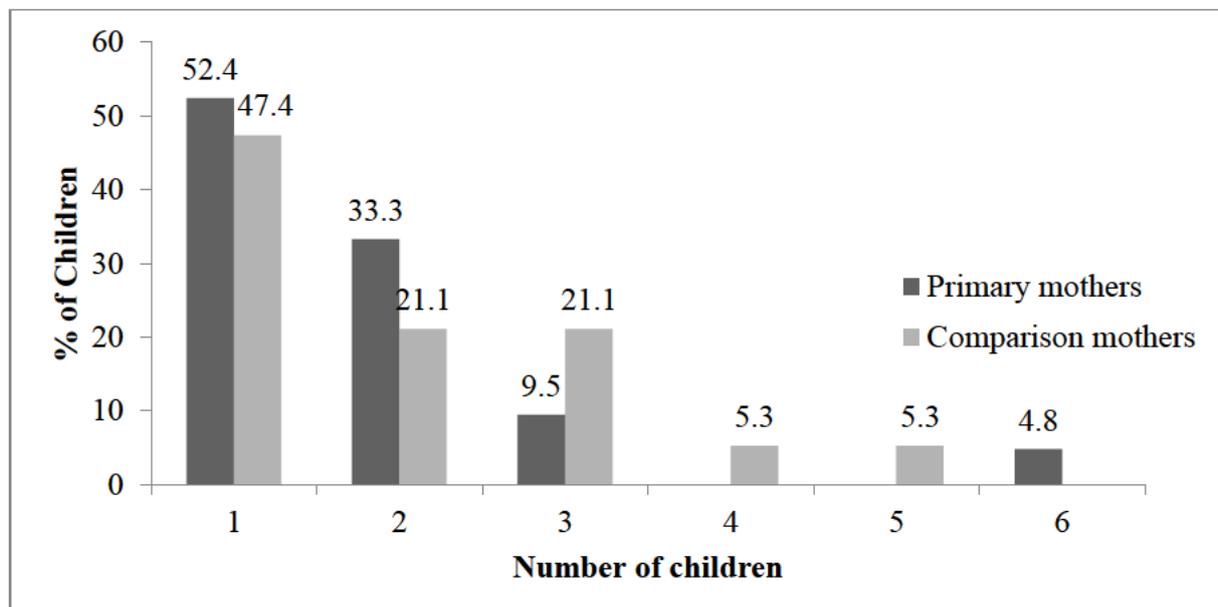


Figure 5. 6. Number of dependent children by the primary mothers ($N=21$) and the comparison participants ($N=19$).

The majority of the children were aged between five and 14 years when their mother was incarcerated, with the primary mothers having slightly younger children, as shown below in Figure 5.7. However, a Mann-Whitney U Test revealed that the age (years) of the primary mothers' children ($Mdn=8.5$, $N=40$) did not differ significantly from the age of the comparison mothers' children ($Mdn=9$, $N=40$), $U=746.50$, $z=-.52$, $p=.61$, $r=-.06$.

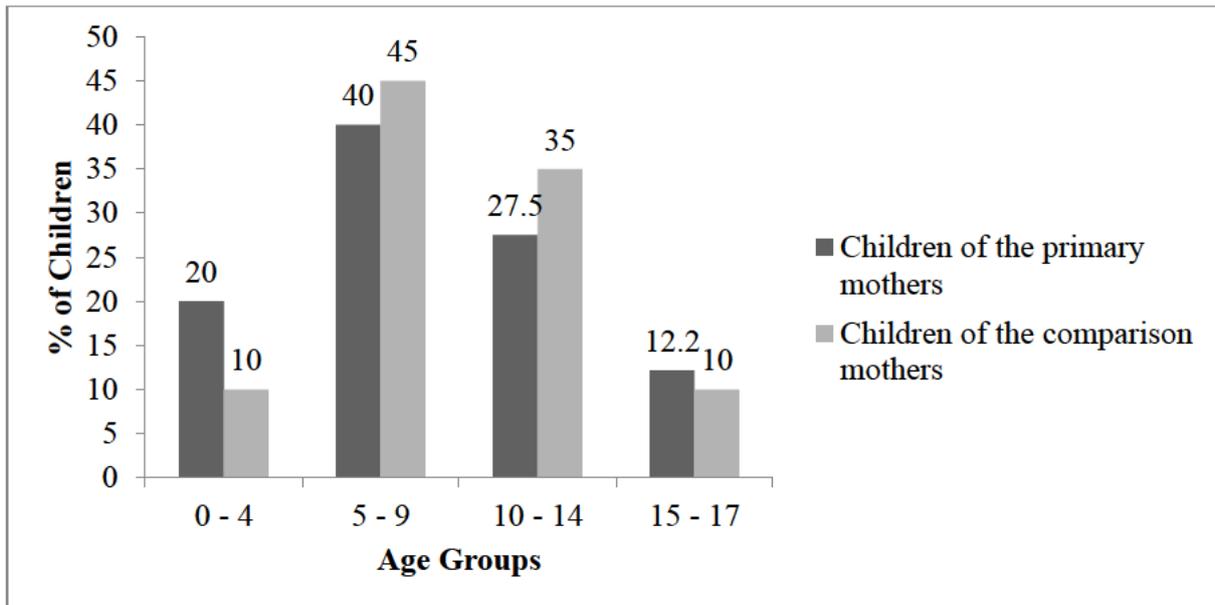


Figure 5. 7. Age distribution of children at the point of the primary mothers ($N=40$) and comparison mothers ($N=40$) imprisonment.

The results show little difference between the two participant groups in terms of the number and age of the children for whom the mother had direct care prior to imprisonment.

5.4.3 Living arrangements

This section describes the living arrangements of the children prior to their mothers' imprisonment, upon her remand, and during imprisonment.

5.4.3.1 Living arrangements prior to imprisonment

The vast majority of the children of the primary mothers lived with their mother prior to her imprisonment (77.8%, $n=35$), with five living in shared care arrangements with their other biological parent or grandparents. However, five children did not live with their primary mother prior to her imprisonment. As shown in Figure 5.8 below, this finding reflects the living arrangements of the comparison mothers.

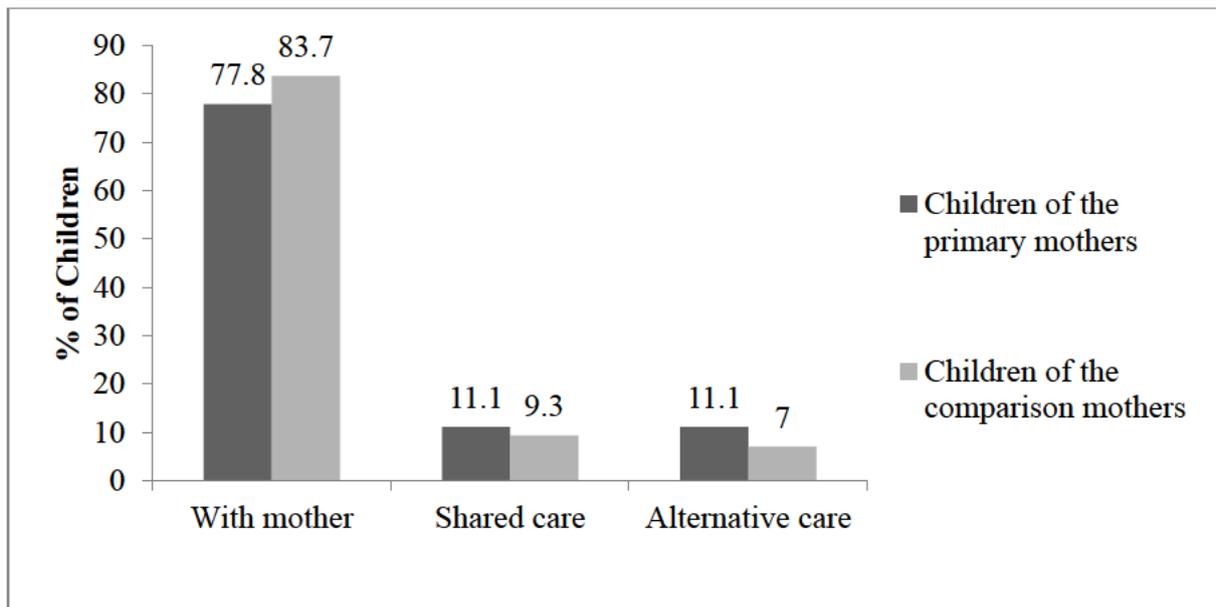


Figure 5. 8. Children’s care arrangements prior to imprisonment for the dependent and non-dependent children of the primary mothers (N=45) and the comparison mothers (N=43).

As there was a small difference apparent between the participant groups with children’s care arrangements before prison, a Chi-square test for independence was conducted. There was however no significant difference between these two participant groups and whether their children lived with their mother or in an ‘other’ care arrangement (shared or alternative care) prior to their mothers’ imprisonment, $\chi^2 (1, n=88) = .50, p=.59, \phi=.08$. This suggests that mental illness does not preclude the primary mothers from having a direct caring role; mental health issues may be another factor they juggle alongside their parenting role and other individual, social, and systemic challenges. However, it is important to note that the small sample size of this study could have mediated this insignificant result; with a larger sample, differences may have become apparent. This result is also affected by the recruitment strategy, as this study only recruited mothers who had the direct care of at least one child prior to their imprisonment (see ‘Chapter Four: The Methodology and Associated Methods’). In this sense, the insignificant result is unsurprising.

The primary mothers had five children who did not live with them prior to their imprisonment. This was typically due to statutory child protection orders, or the mother’s circumstances (e.g. drug use or criminal activity). As PM5 reported, “Youngest son lives with his father till I stop drinking”, with PM12 describing that she “lost them due to the nature of the offence [assault]”. The father or grandparents cared for these children. In contrast, the

comparison mothers had three non-dependent children who lived with their grandparents or were under the care of statutory child protection services. As shown in Figure 5.9 below, these care arrangements were typically longstanding, and therefore remained stable upon their mother’s imprisonment.

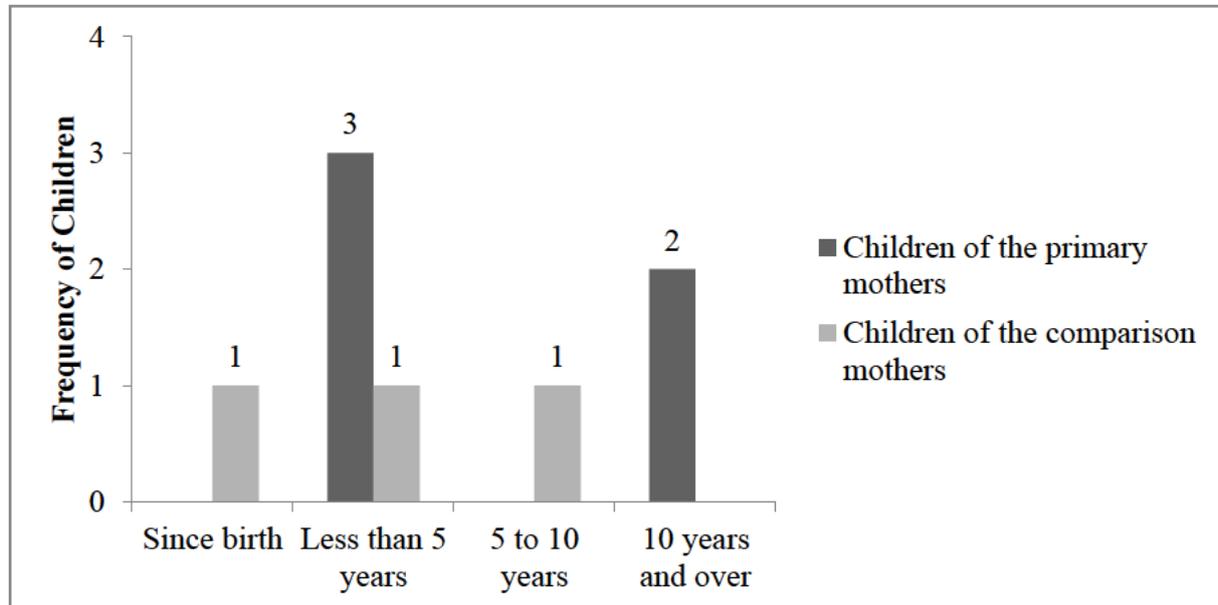


Figure 5. 9. Length of time in alternative care arrangements for the primary mothers’ (n=5) and the comparison mothers’ (n=3) non-dependent children.

Therefore, both participant groups were similar in terms of their partner status, typically sole parents, who had the direct care of their children prior to imprisonment.

5.4.3.2 Living arrangements upon remand or breach offence

The 11 primary mothers who were taken directly into custody had a total of 21 dependent children. The 12 comparison mothers who were taken directly into custody had a total of 23 dependent children. Table 5.3 below shows the care arrangements of all children whose mothers were remanded into custody, comparing the two participant groups.

Table 5. 3. Care arrangements for the primary mothers' children (n=21, N=40) and the comparison mothers' children (n=23, N=40) during remand or breach offence.

Care arrangements	Children of the primary mothers n (%)	Children of the comparison mothers n (%)
Father/partner	3 (14.3)	2 (8.7)
Grandparents	15 (71.4)	10 (43.5)
Other family member	1 (4.8)	9 (39.1)
Friends/associates	2 (9.5)	-
Self	-	-
Statutory child protection services	-	2 (8.7)
Mother-Baby Unit	-	-
Other	-	-
Total	21 (100)	23 (100)

As shown in the figure above, children of primary mothers were most likely to be cared for by their grandparents (71.4%, n=15) with the remaining six children cared for in other informal arrangements. The pattern for the children of the comparison mothers is quite different. There is a greater reliance on other extended family members beyond grandparents. Furthermore, two children of two comparison mothers were under the care of the statutory child protection service. Such data suggests that the primary mothers typically rely on grandparents during the crisis of remand, whereas the comparison mothers rely on a greater range of relatives, to care for their children. As the upcoming discussion will show, the care arrangements at remand differ from the care arrangements during imprisonment for both participant groups, highlighting the difference in care arrangements that occurs between emergency and longer-term care.

5.4.3.3 *Living arrangements at interview*

As shown below in Table 5.4, the children's care arrangements during their mothers' imprisonment differ from those at remand. The results presented below represent the children's care arrangements at the time of the interview.

Table 5. 4. The caregiving arrangements at interview for the children of the primary mothers ($N=40$) and the children of the comparison participants ($N=40$).

Care arrangements	Children of the primary mothers n (%)	Children of the comparison mothers n (%)
Father/partner	12 (30)	6 (15)
Grandparents	14 (35)	15 (37.5)
Other family member	5 (12.5)	8 (20)
Friends/associates	-	1 (2.5)
Self	4 (10)	2 (5)
Statutory child protection services	3 (7.5)	3 (7.5)
Mother-Baby Unit	1 (2.5)	2 (5)
Other	1 (2.5)	3 (7.5)
Total	40 (100)	40 (100)

As shown in Table 5.4, there is a greater range of care arrangements at interview, compared to the care arrangements at remand. There has also been an increase in the use of statutory child protection services. The children of the primary mothers were more likely to live with their grandparents (35%, $n=14$) or fathers (30%, $n=12$) during their mother's imprisonment. This shows that whilst primary mothers tended to rely on grandparents at remand, fathers take on a more significant role during imprisonment. Suggesting that for this group of mothers, grandparents may provide emergency care, these placements however may not always be appropriate over the longer term. Alternatively, it may suggest that this group of fathers/partners are more willing and/or able to care for their children. The same cannot be said for comparison mothers, whose children were more likely to live with grandparents (37.5%, $n=15$) or other family members (20%, $n=8$) rather than their fathers during their mothers' incarceration. There was however an increase in the number of the comparison mothers' children being placed with their fathers from remand to imprisonment (8.7%, $n=2$ versus 15%, $n=6$ respectively).

When looking exclusively at children with siblings: siblings in most cases were placed together, with children of the primary mothers slightly more likely (78.8%, $n=26$) than children of the comparison mothers (70.6%, $n=24$) to be placed with siblings. However, a Chi-square test for independence showed that this difference is not statistically different, $\chi^2(1, n = 67) = .60, p=.58, \phi = .09$. The remaining 17 children (seven primary mothers' children

and 10 comparison mothers' children) were placed on their own, with siblings in various care arrangements.

The primary mothers were also slightly more likely to report that their child moved at least once (77.5%, $n=31$, $N=40$) compared to the children of the comparison mothers (65%, $n=26$, $N=40$). However, a Chi-square test for independence showed that this association is not statistically different, $\chi^2(1, n = 80) = 1.53$, $p = .32$, $\phi = .14$. The remaining 23 children (nine primary mothers' children and 14 comparison mothers' children) children did not move.

The results indicate that during imprisonment, the primary mothers were more likely to report that their children were cared for by either grandparents or fathers/partners; showing a shift from the care arrangements at remand. In contrast, the comparison mothers commonly reported more diversely spread of care arrangements between grandparents and other family members. Furthermore, the primary mothers were more likely to report that their children moved at least once during their imprisonment, and that siblings were generally placed together. However, the latter results are not significantly different to the experiences of the children of the comparison mothers. This may relate to the small sample size of this study.

5.5 Mental illness and comorbidity

As described in 'Chapter Four: The Methodology and Associated Methods', the primary mothers are those who self-identified as having a mental illness. As the comparison mothers did not self-identify, this section cannot be compared across both participant groups. As such, the study by Tye and Mullen (2006) who examined mental illness prevalence rates within Victoria's two female prisons, and the Australian community data from the ABS (2008) National Survey of Mental Health and Wellbeing are used for the comparisons. Comparisons to other research has also been used as appropriate.

The most common mental disorders reported by the primary mothers were Affective and Anxiety Disorders (61.9%, $n=13$ and 38.1%, $n=8$ respectively). This result mirrors the previous research of Tye and Mullen (2006) and reflects ABS (2008) data. Indeed, the national survey found that Anxiety and Affective Disorders were the most common disorders reported in the adult population aged 16 to 85 years (14.4% and 6.2% of the adult population respectively) (ABS 2008). Furthermore, females experience higher rates of Anxiety Disorders than men (18% versus 11% respectively) and higher rates of Affective Disorders (7.1% versus 5.3% respectively) (ABS 2008). Therefore, this present study

captured a participant group whose characteristics are similar to wider Victorian prison research, as well as broader Australian mental illness data, despite the use of self-report.

The disorders reported by the primary mothers as well as classification and comorbidity is shown below in Table 5.5. Please refer to ‘Chapter Four: The Methodology and Associated Methods’ for an explanation on how classification and comorbidity was determined.

Table 5. 5. The primary mothers' (N=21) self-reported mental health issues, classification of disorder, and use of substances.

Participant mother:	Self-reported mental illness:	Classification of high/low prevalence disorder:	Use of substances:
1	Affective disorder	High	Alcohol; Drugs (unspecified)
2	Anxiety disorder	High	Cannabis; Drugs (unspecified)
3	Bipolar disorder	Low	Cannabis
4	Trauma and related disorder	High	Methamphetamine
5	Affective disorder; Anxiety disorder	High	Alcohol
6	Affective disorder; Anxiety disorder; Personality disorder; Eating disorder; Trauma and related disorder	High	-
7	Affective disorder; Anxiety disorder	High	Methamphetamine; Cannabis; Benzodiazepines
8	Affective disorder; Anxiety disorder; Bipolar disorder	Low	Heroin; Cannabis; Speed; Methamphetamine
9	Affective disorder	High	-
10	Affective disorder	High	Heroin
11	Trauma and related disorder	High	Heroin
12	Affective disorder; Anxiety disorder; Personality disorder; Trauma and related disorder	High	Cannabis; Alcohol
13	Personality disorder; Bipolar disorder	Low	-
14	Affective disorder; Trauma and related disorder	High	Heroin
15	Bipolar disorder	Low	Drugs (unspecified)
16	Bipolar disorder	Low	-
17	Affective disorder; Anxiety disorder	High	-
18	Schizophrenia	Low	Methamphetamine; Speed
19	Affective disorder	High	-
20	Affective disorder	High	Prescription drugs; sleeping pills; Ecstasy; Speed
21	Affective disorder; Anxiety disorder	High	Drugs (unspecified)

Mental health research typically examines comorbidity in relation to substance use. However, this present study also took a broader view extending comorbidity to multiple mental illness diagnosis. This view is also evident in other research on imprisoned women (e.g. Lynch et al. 2012). As seen in Table 5.5 above, 12 out of the 21 participant mothers reported one mental health condition (57.1%), with nine self-reporting more than one (42.9%). The majority of the participants who reported more than one mental health condition typically reported two mental disorders, most commonly Anxiety and Affective Disorders. The remaining three mothers reported a range of three to five mental health conditions. This level of comorbidity is less evident in the broader Australian community, with just 5.1% of adults aged between 16 and 85 years reporting disorders from different mental illness groups (e.g. one Affective and one Anxiety Disorder), and 3.4% reporting disorders within each group (e.g. two Affective disorders) (ABS 2008). However, this latter data does not include a gender breakdown. Given that women are more likely to experience a mental illness compared to men (ABS 2008), there may be also be a gender component to comorbidity. This comparison, while limited by a much smaller sample, suggests that the comorbidity of mental disorders for women is more prevalent within the correctional setting compared to those in the community setting (42.9% versus 8.5% respectively). This is in line with broader prison research which shows that the prevalence rates of mental illness are higher in the prison setting (Australian Institute of Health and Welfare 2010; Butler et al. 2005, 2006; Fazel & Danesh 2002), therefore it is unsurprising that the levels of comorbidity is higher as well.

In addition, as seen above in Table 5.5, comorbidity with substance use is also evident within this sample, with almost three-quarters of the primary mothers (71.4%, $n=15$, $N=21$) also reporting substance use issues. The substances commonly reported include: cannabis, methamphetamine (or 'ice'), and heroin. In addition, three mothers reported problematic alcohol consumption. The number of women who described comorbid substance use in the present study is higher than that reported by Tye and Mullan (2006) (63%). Comorbidity is important, as substance use has been a commonly reported method for managing the symptoms and associated distress of a mental illness (Green et al. 2005; Langan & Pelissier 2001; Laux et al. 2011), as well as being linked to offending (Johnson 2004a). This reflects the discussion in the upcoming 'Chapter Six: Navigating the Criminal Justice System', whereby the primary mothers identified using substances as a management tool for distress.

Comorbid substance use and mental illness is also evident in the wider Australian community, with two-thirds of adults (or 67%) who reported having a mental disorder also

report that they misuse drugs almost every day. Just under half of these adults report a Substance Use Disorder, 38% reported an Anxiety disorder, and 31% reported an Affective disorder (ABS 2008). In addition, 21% of those who report almost daily alcohol use also reported a mental illness, with Substance Use Disorder associated with adults who drank alcohol nearly every day, as opposed to those who drank once a month or less (10.5% and 1% respectively) (ABS 2008). There is however no gender breakdown for this data. Interestingly, not one primary mother self-reported a Substance Use Disorder. This may suggest that they have not received such a diagnosis, or may consider their problematic substance use as separate from a mental health condition. Furthermore, this may also reflect methodological issues, as the interview simply asked the primary mothers if they were using drugs and/or alcohol prior to their imprisonment. Substance Use Disorders were not prompted.

In addition to comorbidity, previous research has shown the link between mental illness and both childhood and adulthood victimisation (Lynch et al. 2012; Messina & Grella 2006). Therefore, the primary mothers were asked if they had experienced victimisation at some point in their lives, with almost all women ($n=20$, $N=21$) reporting such experiences. Of the 14 primary mothers who elaborated on their experiences, seven reported domestic violence from current or ex-partners, four reported experiences of abuse during childhood, two reported experiences of abuse during both childhood and adulthood, and lastly, one mother reported severe sexual harassment in her workplace. Whilst the previous research examined experiences of victimisation in female prisoners (Lynch et al. 2012; Messina & Grella 2006), this data extends this to mothers. Highlighting, that mothers with a mental illness are also highly traumatised correctional population. Due to ethical considerations, the data gathered in this study regarding experiences of victimisation was basic. The interview did not include prompts, asking the mothers to expand on their experiences of victimisation. Therefore, it is likely that there are gaps within this data.

A limitation of this aforementioned discussion is that the comparison mothers were not asked about their substance use or experiences of victimisation. Therefore, it is unknown whether the same level of substance use or victimisation is evident in those who do not self-identify as having a mental illness. As noted in Chapter Four, this limitation is the outcome of the study design, which focused on reducing the burden for both the participant and the prison environment. This focus has ensured that such comparisons were not included, and represents an important area to address in future research. Despite this limitation, the mental health of the primary mothers was compared to both Australian based prison research and to the wider

Australian community. This comparison shows that primary mothers are similar to previous research on imprisoned women as well as women in the community, especially in terms of the most common mental health issues reported (e.g. Anxiety and Affective Disorders). What is different however is that the primary mothers report higher levels of comorbidity with mental illness as well as with problematic substance use. This suggests that primary mothers, while facing similar mental health needs as the wider Australian population, represent a highly complex group due to the intersection between mental illness and a range of issues, such as offending, multiple mental health diagnoses, substance use, and experiences of victimisation.

5.6 Summary and conclusion

In order to respond to subsidiary question one: ‘What are the similarities and differences in the experiences of mothers with or without a mental illness as they navigate the criminal justice system’, this chapter described and examined the characteristics of the primary mothers, with contrasts made with the comparison mothers as well as with national data (ABS 2008, 2013), Victorian data (DOJR 2015), and where applicable, to broader research. The purpose of this is to situate the characteristics of this sample within a wider prison and community context, to examine similarities and differences between both participant groups, as well as with the wider community, and prison populations.

As shown in this chapter, there is a level of similarity in the characteristics of the primary mothers and the comparison mothers. Indeed, there are no statistically significant differences in terms of age, offending (e.g. prior history of imprisonment, experiences of remand, and sentence length), or motherhood and parenting characteristics (e.g. partner status, age and number of children, and living arrangements of children prior to imprisonment). However, this present study involves small participant groups which may influence the statistical results. It also includes characteristics (e.g. ethnicity, offences committed, care arrangements at remand and at imprisonment, and mental illness and comorbidity characteristics) that do not lend themselves well to statistical comparisons due to the nature of the data collected. Therefore, as this chapter has shown, statistical significance should not be the only marker of variation used, as there were apparent, although insignificant, differences between the two participant groups. For example, the primary mothers, when compared to the comparison mothers, tended to have a wider age range that included mothers at the younger and older ends of the age spectrum, which suggests a higher level of complexity when responding to these groups. With regards to offending, the primary mothers more commonly committed

property offences and offences against the person. They were more likely to have experienced a history of prior imprisonment, slightly less likely to be remanded into custody following their arrest, but more likely to report being on remand for longer periods. Furthermore, they are more likely to have slightly longer sentences. Such differences, while not statistically significant, suggest that the primary mothers experience more challenges when planning their children's care. This is due to the uncertainty associated with longer periods on remand, as well as a greater level of resources needed to plan care.

There were also no statistical differences between the participant groups in terms of partner status, age and number of dependent children, whether the child was placed with siblings, and the stability of such placements at imprisonment. However, the primary mothers were more likely report that whilst their children were generally placed with siblings, their children were slightly more likely to move at least once during their imprisonment. This may reflect the differences in the placements at remand and during imprisonment for the children of primary mothers, whereby grandparents commonly provided immediate short-term care, and fathers in association with grandparents provide longer-term care. This trend is not evident in the comparison mothers. Furthermore, these stability issues may also be an outcome of the aforementioned risks they experience in the care planning process, for example, longer remand periods.

These aforementioned characteristics of the primary mothers are further complicated by their experiences of mental illness and comorbidity. The primary mothers tended to have a range of mental health issues, most typically Affective and Anxiety Disorders. This result is unsurprising given the trends evident in the general community, as well as the gendered nature of mental health issues. Furthermore, just under half reporting comorbid mental health disorders, with the majority reporting drug and/or alcohol use, and histories of victimisation. This suggests high levels of complexity within this participant group due to the interrelatedness of mental health issues with substance use, and experiences victimisation.

This chapter has highlighted that the primary and comparison mothers are very similar in terms of a range of characteristics: their age, ethnicity, offending history, and motherhood and parenting characteristics. This chapter has also highlighted however, that subtle differences exist in many of these characteristics, such as longer periods on remand, and changes to carers between remand and during imprisonment. The key differentiating factor appears to be their self-reported levels of mental illness. As such, the upcoming chapters

focus further on the primary mothers, exploring and examining their experiences as they navigate the criminal justice system. Highlighting that whilst both participant groups ‘look’ very similar on the surface, key differences lie in how they interact with the criminal justice system. Gaining an understanding of these individual nuances and complexities is important in order to understand and respond effectively to mothers with a mental illness who come into contact with the criminal justice system.

Chapter Six: Navigating the Criminal Justice System

“The journey of a thousand miles begins with one step”

Lao Tzu

The previous chapter highlighted the similarities, and any differences that exist in terms of the age, ethnicity, offending history, and motherhood characteristics of the 21 primary mothers, and the 19 comparison mothers, arguing that the key differentiating factor between these two groups is the self-reported mental illness of the primary mothers. Therefore, this chapter explores in more detail the experiences of the primary mothers, beginning with an examination of women’s individual and social circumstances, and their level of mental health service utilisation as they intersected with the criminal justice system. This examination addresses subsidiary question two. In order to respond further to subsidiary question one, as well as subsidiary question three, this chapter then moves on to explore the primary mothers’ level of engagement with and participation in the criminal justice system as they navigate this system. The chapter focuses specifically on the individual factors, resources, and systemic responses that mediate this journey. The impact of the primary mothers’ participation in this system is also examined, looking at how these participants arrange care for their children and the overall level of satisfaction with this process. This discussion also includes two extreme case examples. These illustrate how the mothers’ criminal justice journeys can accumulate in high or low levels of involvement in their children’s care, providing a ‘voice’ to the data presented in this chapter. In order to address the final subsidiary question, this chapter concludes with an examination of gender-responsive prison practice in Victoria’s two female prisons, in terms of the primary mothers’ mental health and parenting status. Such examination is important as imprisoned mothers typically resume care of their children post-release.

6.1 Mothering in difficult contexts – Exploring the intersections

In order to address subsidiary question two: ‘What is the relationship between mental illness and motherhood as women intersect with the criminal justice system?’ this section explores the relationship between mental illness and motherhood as the primary mothers begin their navigation of the criminal justice system, during their offending and arrest. As such, this section begins with an examination of the factors that influence the primary mothers pre-

prison lives, and concludes with an examination of the factors that underpin their pathways into offending and later imprisonment.

Qualitative data was sought from the primary mothers, describing their lives prior to imprisonment. The responses are grouped according to the overarching themes presented in the data, with a content analysis used to examine the trends and patterns within these themes. The results from this analysis are presented below in Figure 6.1.

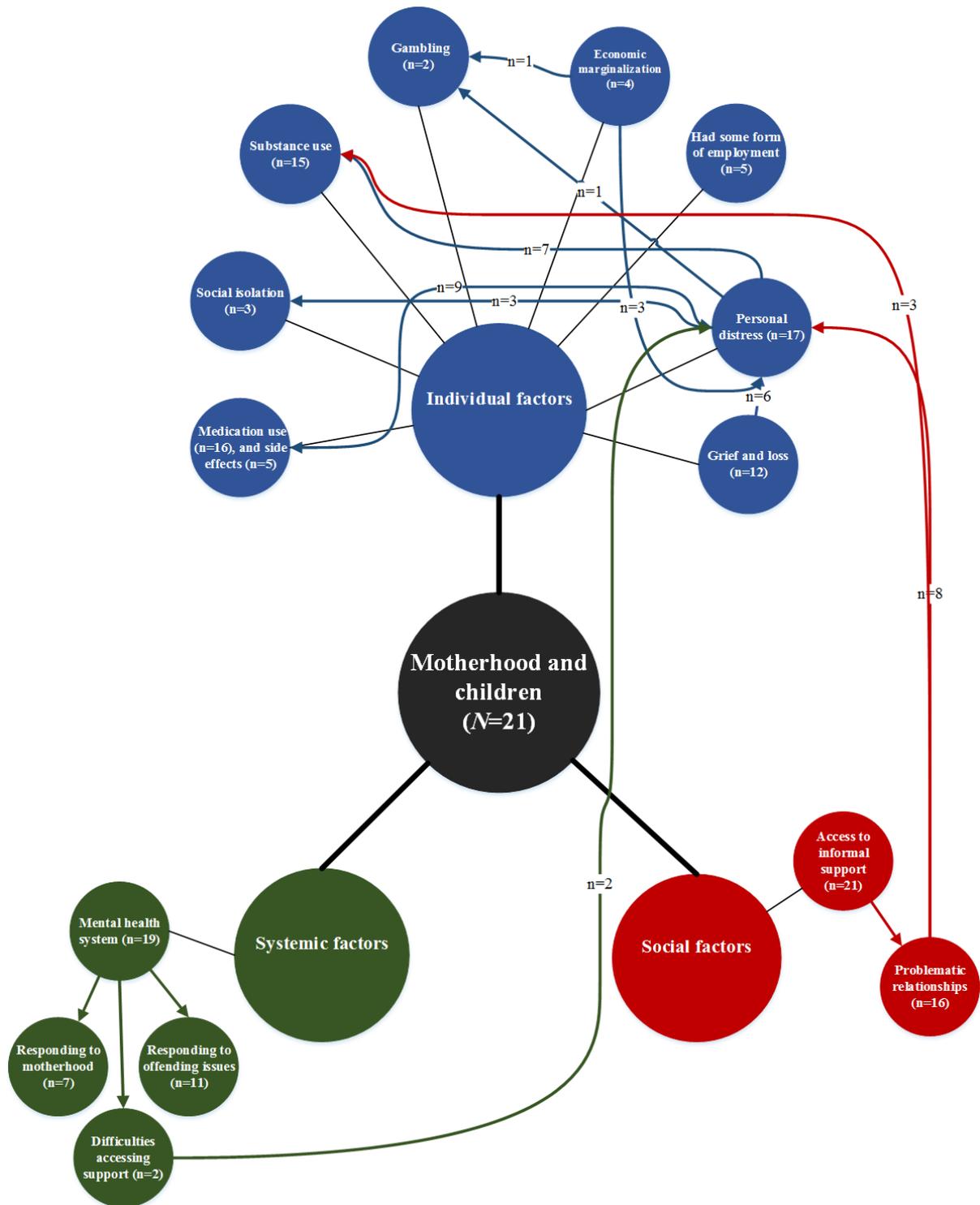


Figure 6. 1. The factors influential in the lives of primary mothers' (N=21) prior to imprisonment.

For each primary mother, narratives pertaining to motherhood and their children were interwoven and central to their descriptions of life prior to imprisonment; this is evident above in Figure 6.1. For example, 17 mothers provided descriptions of the direct ‘hands-on’ tasks of parenting, such as getting children organised for school, school pickups and drop offs, and domestic chores. Nine out of the 17 primary mothers highlighted that their children provided an important stabilising focus in their lives:

“Being a good mum to her because she didn’t have her dad” (PM1)

“Being a mum, doesn’t matter what happens to me, I look after them properly” (PM10).

“...My boys make me well managed” (PM13)

Given the focus of this present study was about mothers and their children, it is highly likely that the participants were primed to focus on parenting, even if the question was broad, and asked about their lives prior to prison rather than their parenting role. Social desirability may have also underpinned the prevalence of these narratives, with the mothers reporting such descriptions in order to be viewed favourably as a ‘good mother’. It is more likely however, that the centrality of motherhood and children may reflect the cultural assumptions underpinning parenting – generally a female task. It could also reflect the discussion in the previous chapter, whereby just over half of the primary mothers reported that they were sole parents.

As shown in Figure 6.1, the primary mothers also identified a number of individual (e.g. personal distress, grief and loss experiences, and substance use), social (e.g. access to informal support), and systemic (e.g. access to formal support and services) factors that underpinned their lives prior to imprisonment. This figure highlights the difficult contexts in which these women mother. Content analysis allows for the mapping of these factors, and the interconnections between them. The analysis reveals that the most commonly reported individual factor is personal distress. However, as illustrated in Figure 6.1 above, experiences of personal distress also had connections to other individual, as well as social and systemic factors. For example, individual factors such as experiences of grief and loss, and economic marginalisation, social factors such as problematic relationships with informal supports, and systemic factors such as difficulties accessing appropriate support all contributed to the primary mothers’ experiences of personal distress. Furthermore, personal distress is also seen

to contribute to other individual problems, such as medication use, substance use, and gambling. Therefore, experiences of personal distress do not occur in isolation, and intersect with other issues experienced by this group of mothers. As such, the upcoming discussion will discuss these individual, social, and systemic factors and the interconnections with personal distress.

6.1.1 The primary mothers' pre-prison individual factors

The primary mothers highlighted that they were juggling a range of individual difficulties. These difficulties, first illustrated in Figure 6.1, are presented below in Table 6.1, and show that the primary mothers identified multiple problems. The top two difficulties reported by approximately three-quarters of the primary mothers was personal distress and substance use.

Table 6. 1. The individual difficulties reported by the primary mothers ($N=21$) that affected their pre-prison lives.

Individual difficulties	Primary mothers n (%)
Personal distress	17 (81)
Substance use	15 (71.4)
Grief and loss	12 (57.1)
Side effects of medication	5 (23.8)
Employment	5 (23.8)
Economic marginalisation	4 (19)
Social isolation	3 (14.3)
Gambling issues	2 (9.5)

Note: A number of participants reported more than one individual difficulty, therefore the number of responses is greater than the number of participants who reported difficulties.

Personal distress

The vast majority of the primary mothers (81%, $n=17$) described levels of personal distress prior to their imprisonment. Six mothers specifically described the impact of personal distress on their lives. For example:

Being home by myself was hard because I'd do a lot of thinking. Every day was different; some days it would take its toll... it was unexpected... Half the time I'd be feeling shithouse but would put a 'front' on" (PM8)

“Normally, I’m a person who always swallows, pretending to be happy” (PM10)

“Could be very stressful if things didn’t go right, head would be running a mile, feel agitated, no such thing as an average day” (PM15)

“I was that unwell, I thought I was dying, so I didn’t care what I did” (PM17)

Such descriptions of distress were also interwoven with the tasks associated with motherhood and children, alongside other issues, particularly substance use:

“It was a really a hassle to get out of bed because of depression. Always got son to school, made his lunch. Then go to Mum’s to drink... Would always pick son up on time [from school] and then get dinner ready... I thought I was very happy but when I went to gaol I realised how bad it was. I was drinking every day and still thinking I was a good mother. I realised I was there physically but not emotionally” (PM1)

“Working as a professional cleaner, get up and get daughter to school, pick up grandchildren and look after them, get drunk every night, mental health was terrible... I was angry at the world, I didn’t even want to be in this world” (PM5)

“Great, I really immersed myself in being a mother, I liked doing arts and crafts with them to make the day interesting, dealing with issues as they arrive, I may not shower or eat but at least the kids were good” (PM12)

“I found it was really hard to get up out of bed and get going. When it was severe I wasn’t as organised as I usually was, I would do everything for the kids, but when they weren’t there I would fall apart, but then would get up for the kids, they kept me going” (PM19)

As shown in the above examples, most women described their children as providing an avenue to focus their energy, while just one primary mother acknowledged that these experiences reduced her level of insight and affected her parenting ability.

Substance use

As discussed in the previous chapter, 15 primary mothers reported substance use prior to imprisonment. However, this discussion was reliant on the participant initiating information, and thus is a noted limitation, as only 11 mothers included substance use in their pre-prison narratives. These mothers identified using prescription drugs (n=1), illicit drugs (n=9), and/or

alcohol (n=3). In addition, seven mothers described their substance use as associated with their high levels of distress at the time, with four mothers specifically labelling their substance use as a coping strategy:

“No, I was just drinking, I drowned it, I drowned the pain, I drowned the thoughts and I just drank” (PM5)

“Started because I got molested by uncle and sometimes it was harder than others and blocking it out with drugs” (PM9)

“I didn’t notice it [mental health issues] because I was using” (PM14)

Therefore, substance use as a self-management tool for personal distress is evident.

Experiences of grief and loss

In relation to their experiences of grief and loss, unexpected and sudden deaths were common features. Five primary mothers reported that the father of their child/ren had died, three mothers reported the death of a parent, two mothers reported the death of a family member, one mother reported the death of a friend, and one reported the death of her son at 11 days due to Sudden Infant Death Syndrome. The interconnection between grief and loss and personal distress noted in Figure 6.1 is emphasised by PM1 who reported: “I was depressed anyways and it got worse when my nanna died”, with PM14 recounting that the father of her son died of a heart attack alone in his house. She found him two weeks later, and had a ‘breakdown’ as a result: “I didn’t want to think, it was doing my head in, too much shit was going on”. The connection between grief and loss and personal distress also included two mothers who reported removal of their children by statutory child protection services. As PM2 reported: “I just lost my kids [to child protection services], they were my life, and because [oldest daughter] was older, I didn’t think she needed me as much”. In addition, two mothers reported that their children has been sexually abused, with PM18 connecting this knowledge with her level of personal distress “I had found out my husband had sexually molested my kids, spoke about it a lot, reactive, getting better from psychosis, but couldn’t cope as well”.

The side effects of prescribed medication

Whilst the majority of the primary mothers (76.2%, n=16) reported being on medication for their mental illness prior to prison, nine mothers discussed the effect of medication. This

effect was mixed, with the mothers reporting positive or negative experiences. For example, four mothers identified that medication allowed them to manage their levels of distress, for three however, the negative side effects of this medication dominated:

“I got off the Avanza because it was depressing me, I wasn’t feeling anything, it was just making me feel ‘meh’ [meaning not well]...” (PM4)

“It was stable then, no psychosis, I would be tired at night as the psych meds knock you out” (PM18)

Two primary mothers also found that their mental health medication did not help:

“My medication – I was taking it at night and we... tried to change it back to morning. Every day is different. Half the time I’d be feeling shithouse but would put a front on...” (PM6)

“Medication wouldn’t help, once it wears off would have panic attacks” (PM12)

Therefore, whilst a large number of the primary mothers reported using prescribed medication pre-prison, this medication did not always help manage symptoms or reduce their levels of personal distress. This could explain why a high number of mothers also reported problematic substance use.

Other individual factors – Social isolation, gambling, and economic marginalisation

Issues resulting from social isolation, gambling, and economic marginalisation also underpinned the narratives of the primary mothers. For three mothers, their reported personal distress was also connected to their experiences of social isolation:

“If I was having a bad day I wouldn’t want to do anything or go anywhere and I would isolate myself at home and just play with my son” (PM7)

“Always in pjs, didn’t like leaving the house” (PM17)

Furthermore, PM9 reported that her gambling issues were also interlinked with her distress levels as “Depression and self-loathing that caused the [gambling] addiction” while for PM21 reported that her gambling issues was linked to debt and substance use:

“It was a nightmare. I was working as a casual dental assistant, debt caught up with me, working and applying for loans and credit cards, couldn’t pay for the debt and

provide for children. Started gambling, got worse, borrowed money, started clubbing and taking drugs, kids were staying with mother while clubbing. Started using speed to work and drive children to school. [And as a result] started using sleeping pills to sleep”

Experiences of economic marginalisation were identified in three other primary mother narratives, with two also identifying housing issues. Indeed, only five primary mothers (23.8%) reported some form of legal employment prior to their imprisonment. In addition, to these individual factors, the primary mothers also identified the social factors that influenced their pre-prison lives.

6.1.2 The primary mothers’ pre-prison social supports

As show in Figure 6.1 at the beginning of this chapter, the social factors reported by the mothers related to their access to informal support. All primary mothers ($N=21$) described having some form of support prior to their imprisonment. As a number of the primary mothers described more than one source of support, the number of responses is greater than the number of participants who reported that they have support. The primary mothers typically reported support from family members such as parents, siblings, and older children ($n=18$), their partners and ex-partners ($n=6$); a small number also noted friends ($n=3$). As the mothers reported:

“If I didn’t have support from my family I would struggle to find care for my son”
(PM1)

“My parents have always been there for her and they’re aware of my mental health”
(PM8)

“...My mother and her father, main players in my circle” (PM9)

“If I got worse, he [partner] could tell, would look after the kids, he was a brilliant support, couldn’t do it without him. Friends were brilliant” (PM19)

“[My] family protective of the kids, wouldn’t let anything happen to them, always been there” (PM20)

Despite this level of engagement with informal support networks, 16 mothers reported issues with their sources of support. As a number of the primary mothers described more than one issue, the number of responses is greater than the number of participants. Four primary

mothers reported issues with their current partner who was not the father of her children. These issues included problematic relationships such as on-again/off-again relationships (n=1), their partner having an affair (n=1), domestic violence (n=3), and/or partner having a history of illicit substance use and imprisonment (n=2). In addition, two mothers reported difficulties with their own mothers due to their mother's problematic substance use (n=1), and/or having a relationship marred by conflict (n=2).

Many mothers (n=14) also reported problems pertaining to the biological father of their children. These issues included: father having a history of imprisonment (n=5), father being deceased (n=4), conflict between the mother and the father (n=3), father having a history of offending but not incarceration (n=3), father no longer involved with his children (n=2), and father having a history of substance use (n=2). Five mothers reported that their children had multiple fathers.

These issues relating to their social supports highlight that while the primary mothers have some form of informal support, these supports, typically biological fathers, often add complexity and difficulty to the women's lives. These further compounds the difficulties this specific group of mothers face. This is evident in three mothers reporting that the difficulties resulting from their informal networks were linked with their substance use, and eight mothers reporting that such difficulties were associated with their high levels of distress. For example:

“Very stressful, I did not know if husband was using drugs, how his moods are going to affect me or my children, he was on bail for drug possession, I was hoping he would go back to jail but he didn't, he was very controlling” (PM16)

“I got fooled by the father of my children who was on heroin, borrowed money for him, he got me hooked on E [ecstasy]. I thought we had a good relationship” (PM20).

In addition to informal supports, the primary mothers also reported engagement with a number of formal supports. Given the focus of this present study, this examination was limited to mental health service use.

6.1.3 The primary mothers' pre-prison service utilisation

As shown in Figure 6.1 at the beginning of the chapter, the majority of the primary mothers (90.5%, n=19) reported use of at least one type of 'mental health' service prior to their imprisonment; the remaining two mothers reported they did not use a mental health service.

The term mental health services was defined broadly and included specific professionals such as general practitioners (GP), psychiatrists, psychologists, social workers, or mental health nurses, as well as specific services such as a psychiatric hospitals. There was also a category called ‘other’ to capture responses outside of these, such as methadone doctor, local mental health service, Crisis Assessment and Treatment Team (CATT), a mental health care plan, and a domestic violence worker. As shown below in Table 6.2, the most commonly reported service used was the participants’ local GP, followed by a psychologist.

Table 6. 2. Mental health service use prior to imprisonment for the primary mothers (N=21).

Mental health service use	Total n (%)
General practitioner	16 (76.2)
Psychologist	9 (42.9)
Other	8 (38.1)
Psychiatrist	3 (14.3)
No service use	2 (9.5)

Note 1: A number of the primary mothers reported more than one service, therefore the number of responses is greater than the number of participants who reported service use.

As Table 6.2 above shows, most primary mothers were connected to some type of mental health service prior to prison. This result however also raises issues regarding the ability of these services to respond to complex mental health issues, particularly GPs. The majority of mothers accessed this specific service; however, they still reported experiences of personal distress. Furthermore, having access did not appear to divert them away from the criminal justice system.

These services also appear to have difficulty responding to the complexity that underpinned this participant group. Just over half of the mothers reported that their mental health support service was aware of their offending (57.9%, n=11, N=19). Typically because the mother had advised the service about this. Such experiences represent a missed opportunity to divert the mother away from the criminal justice system. Only three mothers, however, reported that the mental health service discussed their likelihood of imprisonment with them

In addition, the 19 primary mothers all reported that the mental health service accessed was aware that they had children, however only seven mothers reported that these services responded in any way to their children. The responses included two mothers who specifically reported that their GP was also their children's, and another two mothers who reported that the service referred them to playgroups. Only one primary mother could recall her service assisting her to write up a care plan for her children in case her mental health deteriorated and she required hospitalisation. This result suggests that these services are challenged to respond to complexity underpinning this participant group or to have a child and family focus. The focus was on the mothers' mental health needs independent of her offending and family context, whereas as the previous discussion showed, and as illustrated in Figure 6.1 at the beginning of this discussion, these issues are interlinked.

Systemic difficulty in responding to complexity is evident in the reports of two mothers (PM12 and PM18). These participants reported that a family member had sexually abused their children, and indicated that they needed support to address this issue. As PM12 reported "Services I was begging for didn't help, didn't refer on or explain... Just wish services would heed peoples warnings when they have no more coping strategies left, it wasn't my first ditch effort, it was my last ditch effort". These sentiments are echoed by PM18: "In a situation where abuse occurs, more support offered to the other parent so stupid decisions are not made". Both these mothers accessed a mental health service prior to their imprisonment, yet such services did not assist them in dealing with this experience, and as illustrated in Figure 6.1, also contributed to their distress prior to imprisonment.

This discussion has shown that for primary mothers, mothering and the associated parenting tasks are overwhelmingly the dominant activity reported, however such tasks occur within challenging and multi problem circumstances. The primary mothers' narratives highlight experiences of personal distress, interconnected with medication use, problematic substance use, and grief and loss amongst other issues. The mothers appear to have a large range of informal social supports, but these supports also add difficulties to the mothers' lives, and contribute to personal distress. Although these women generally access some type of mental health service, these services appear not to attend to their offending behaviours or to children, suggesting a level of difficulty and silo responses to the complexity inherent in this particular client group. This also suggests that the primary mothers are also poorly connected to both informal and formal supports when things go wrong. Therefore, this discussion shows that for this particular group, individual issues are important, as they often intersect and contribute to

multiple difficulties. In addition, the primary mothers' narratives also highlight that the interplay between the individual, social, and systemic factors contribute to their pathways into offending.

6.1.4 Pathways into offending: Impact of individual and social factors

The qualitative data sought from the primary mothers also included their pathways into prison. The responses were analysed thematically, and grouped according to the overarching themes presented in the data. Content analysis was used once again to examine the trends and patterns within these themes. The results from this analysis is presented below in Figure 6.2, and shows the individual and social factors that underpin the primary mothers' pathways into offending and the criminal justice system.

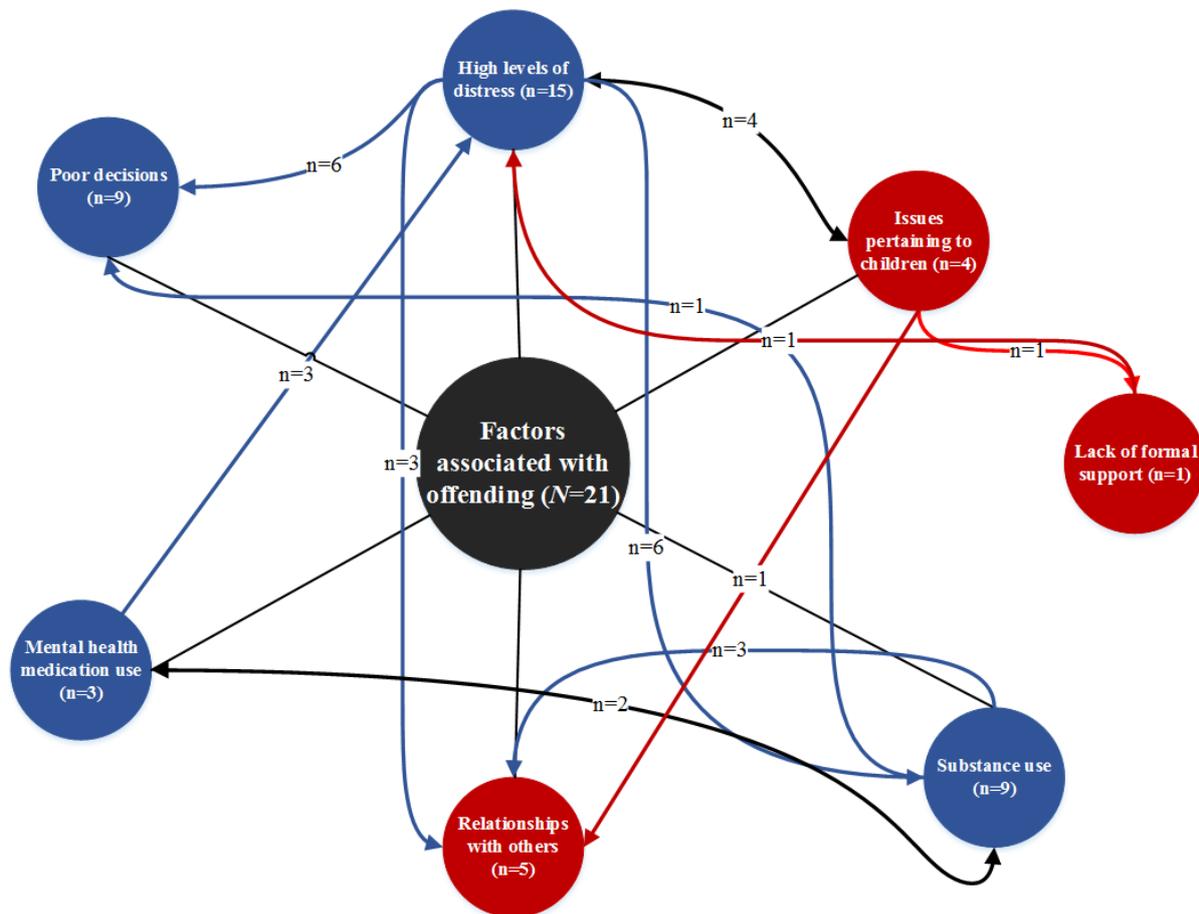


Figure 6. 2. The individual and social factors influential to the primary mothers' (N=21) pathways into offending.

The role of individual factors

As shown in the above figure, multiple and interlinked individual factors are associated with participant's offending. Fifteen primary mothers reported that high levels of distress contributed to their offending, with their comments reflecting the previous discussion. Nine primary mothers attributed their offending to poor decision-making. As PM3 acknowledged, "I didn't think about the consequences", with PM4 elaborating further: "My priors, and buying a van that was stolen, I should have known, it was just my own stupidity. I should have taken it into VicRoads [government organisation that manages roads and licences within Victoria] to get it checked". This suggests that some primary mothers perceive their offending as a solely individual event, shaped by their own choices and circumstances. However, six mothers further linked their experiences of poor decisions to their personal distress. For example:

"...just the feelings, anxiety, and sometimes I don't think about what I am doing"
(PM11)

"I don't think I was in the right frame of mind to make an decision" (PM16)

"If you are in a better head space, can think through it better, about the consequences, alcohol played a huge part" (PM18)

"I was taking some money from an employer when I was depressed, worked for him for eleven years, took money from them during the last three years due to really bad sexual harassment and issues with mum, I just made some bad decisions" (PM19)

This suggests that within the context of personal distress, alongside the individual, and social, factors identified previously, offending becomes a poor decision. Indeed, nine primary mothers described substance use contributing to their pathways into offending. For example, PM14 reported that she was "stealing to support a drug habit". Six mothers also attributed their substance use to their high levels of stress. As PM8 acknowledged, her offending was associated with "Drug life and crime and the relationship I was in at the time... because I was using the drugs to block a lot of it out". This again provides further evidence for the use of substances as a self-medication tool.

Three mothers reported that their mental health medication played a role in their offending. For one participant this was because she ceased taking her prescribed medication, and for the

remaining participants it was because of the side effects of the medication, in conjunction with illicit substance use. For example:

“Well, I was on Xanax [medication] for my anxiety and depressive state and they played a huge effect with the drugs. Without that, I wouldn’t have committed an armed robbery – no chance” (PM7)

“I took pills for my mental health but it made it worse, I didn’t realise I was shoplifting” (PM13)

In many respects it is concerning that this group of women are reporting consuming both prescription medication as well as reporting substance use, given the potential for drug interactions between both. It is then perhaps unsurprising that for a small number of mothers, their medication contributed to their offending.

The role of social factors

Five mothers reported that relationships with others, typically anti-social peers or partners contributed to their offending:

“My co-accused rang me the day after my nanna died. I didn’t have a big habit at the time, she conned me after she harassed me several times [participant reported she felt at the time that she had nothing else to lose]” (PM1)

“[Husband] caught up in the drug scene, selling drugs out of the house, one person he was selling drugs too, caused a car accident [out the front of participant’s house], fight happened [between the guy and husband] and he was killed after he stabbed my husband” (PM16)

Four primary mothers reported that their offending was associated in some way to their children. For two mothers, this was associated with removal of children by statutory child protection services. Indeed, PM2 described that when her offences occurred, her mental health was very poor, attributing this to “they took my son”. As previously mentioned, two of these participants described that their children had been sexually abused; this knowledge was interlinked with their offending. For example:

“Six months prior I had found out their father had molested them, police investigated but not charged, drinking with friends who were violent, decided we would go back to

his place to bash him and he was killed. [The offence was] Spontaneous and alcohol fuelled” (PM18)

In addition, PM12 acknowledged that she committed the offence, as she could not cope with what had happened to her children. She also described difficulty accessing formal support.

This discussion examined the relationship between mental illness and motherhood as women intersected with the criminal justice system, defined as the factors that underpin the primary mothers’ pre-prison lives, and their pathways into offending and later imprisonment. The narratives from the primary mothers’ highlight that offending occurs within challenging and multi-problem circumstances, where the primary mothers’ have the direct care of at least one child. Personal distress is the commonly identified theme within their narratives. Given the impact of individual, social, and systemic factors on the mothers’ lives and their pathways into prison, the chapter now turns to a discussion of the impact of such factors on the mothers’ engagement with and participation in the criminal justice system.

6.2 Participation within the criminal justice system

In order to address subsidiary question one, the previous chapter highlighted the similarities, and the subtle differences that exist between the 21 primary mothers, and the 19 comparison mothers. That analysis indicates the sample’s representativeness and shows that the primary mothers’ self-reported mental illness is a distinctive difference between these two groups. In addition, and as an outcome of this research question, a limited quantitative analysis was conducted with both participant groups to assess the level of participation in the criminal justice system with regards to their presenting responsibilities. As a result all study participants interviewed were asked to respond to the statement ‘I was fully involved in planning the placement of my child while I was in prison’ for each child using a five-point quantified Likert scale. As shown in Figure 6.3 below, more than two-thirds of the comparison mothers report being involved in the planning process for their children’s care. In contrast, the primary mothers had more diverse experiences, and were more likely to report that they strongly disagreed with the statement.

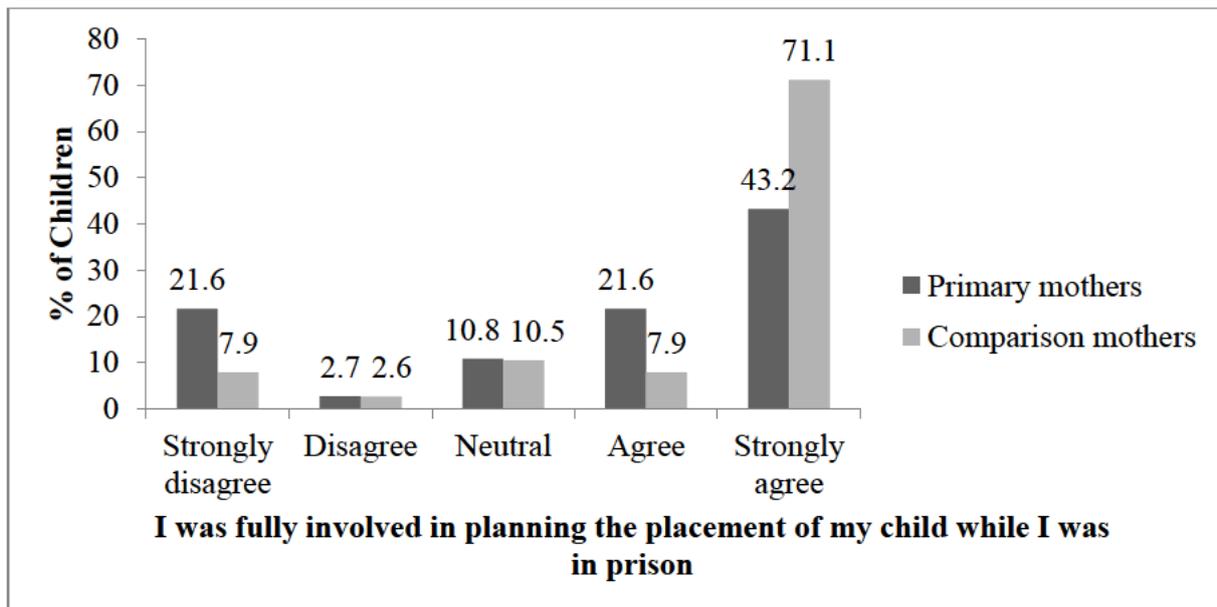


Figure 6. 3. The self-report level of involvement in planning the placement for each child across the primary mothers (n=37) and the comparison mothers (n=38).

In order to perform a statistical analysis on this data, to examine any difference between the two participant groups and their self-reported low or high levels of involvement in planning the care for each of their children, the Likert scale was transformed into a dichotomous variable. Within this variable, ‘low involvement’ included the categories of strongly disagree, disagree, neutral, and agree, while ‘high involvement’ included only those who responded that they strongly agreed. The purpose of this dichotomous variable was to capture the mothers who were highly involved in care planning process compared to those who were not as involved. A Chi-square test for independence showed that there was a significant difference between both participant groups and their levels of involvement in planning each of their children’s care, $\chi^2(1, n=75) = 5.93, p < .05$, with a small to moderate effect size, $\phi = .28$.

This analysis indicates that primary mothers were more likely to report low involvement in planning each of their children’s care (56.8%, n=21) than the comparison mothers (28.9%, n=11). This result highlights that the primary mothers’ capacity to participate in the planning of children’s care as they navigate the criminal justice system is compromised. It also lends support to the discussion in the previous chapter, which showed that while both participant groups look very similar on the surface, there are differences in how they interact with the criminal justice system.

6.2.1 Interactions with the criminal justice system: An outcome of individual and systemic factors

Qualitative data sought from the primary mothers was thematically analysed to identify the factors that mediate their engagement with and participation in this system. This analysis reveals that the primary mothers' individual factors and resources, and systemic responses, or lack of response, mediate their participation. This analysis therefore provided the foundation for subsidiary question three: 'What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system?' In order to answer this question, this section begins with an analysis of the individual factors and resources that underpin the women's experiences at arrest, and during sentencing. The analysis then moves on to examining the factors that mediate their ability to participate in the criminal justice system and plan the care of their children. It concludes with an examination of the impact of these factors on the stability and security of care arrangements, and on the mothers' level of satisfaction in the care planning process. This analysis also addresses in part subsidiary question four and shows how the criminal justice system responds to this group of mothers at arrest and during their hearing and sentencing.

6.2.1.1 Individual factors and resources

The primary mothers continued to identify the influence of their individual factors, such as high levels of distress, and substance use on their movement through and participation in the criminal justice system. Alongside their informal supports, such as parents, partners, other family members, and friends discussed previously, the primary mothers also identified a number of other resources: time ($N=21$), and knowledge of the criminal justice system policies and practices ($n=8$). These resources influence mothers' participation at arrest, and sentencing, in the planning their children's care.

The importance of time

The primary mothers' identified that time was a key element in navigating through the criminal justice system, and planning the care of their children. Over half of the primary mothers ($n=11$) reported that they had no time to organise their children's care, with the remaining women reporting having at least one week to plan, as shown in Figure 6.4 below.

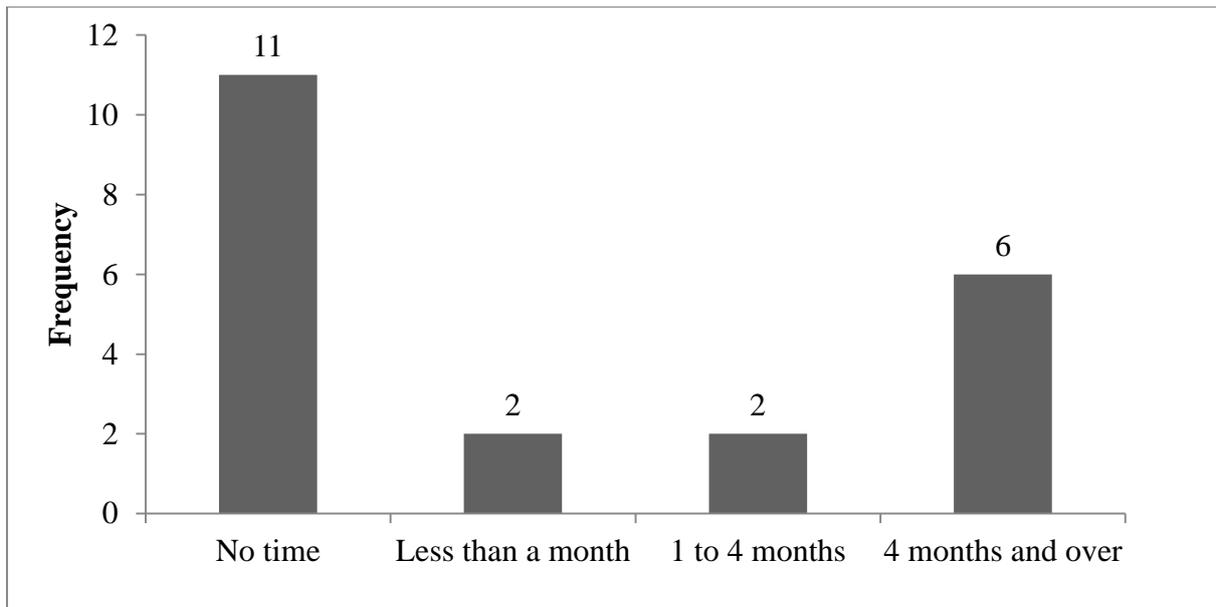


Figure 6. 4. Time available to the primary mothers ($N=21$) to organise their children's care.

When looking exclusively at the 11 participants who reported no time, 10 were taken into custody following their interaction with the police. A Fishers Exact Test indicated that there was a significant relationship between mothers who were taken into custody and having no time to plan the care of children, $p < .01$ with a large effect size $\phi = .81$. This suggests that while time represents an important resource for the primary mothers, having 'no time' was dependent on the specific response of the criminal justice system to the mother.

The primary mothers' narratives indicate that the experience of 'no time' tended to have consequences for both themselves and their children. For example PM5, who breached her parole and was returned immediately to prison upon her arrest, described that she "hadn't done grocery shopping, [daughter] went home to an empty house with no food, no nothing". Two other mothers also described the crisis for their children:

"[Son] lived with me and a friend, and when I went into gaol no one knew where I was... and no one could get a hold of me or his grandma" (PM4)

"Just happened, kids were removed [by statutory child protection services] from mum straight after I was locked up" (PM11)

Four mothers highlighted the impact of having 'no time' on their ability to arrange children's care:

“There was no planning process, just told” (PM5)

“None... I had no say in what happened to the children after I was arrested. I was arrested in September and I did not see them until October and that was just once” (PM6)

“Everything happened so quickly, just told, even if you wanted more input, other people had already made the decisions for you” (PM16)

“No time, mum just took the kids. Everything happens so fast and we don’t have the choice, you just gotta do what you have to do” (PM20)

In comparison, but perhaps unsurprising, having time appears to lead to better care outcomes for children. As PM1 reported “I had adjourned the case three times [over three months] so I had organised my son [providing the example of clothes packed and care organised]...” She went on to say “because I went to court, I wasn’t remanded, so I had time to plan”. Five other mothers echoed these sentiments.

However, for three primary mothers, having time did not always mean they used it effectively. For example, PM21 noted the impact of personal distress on her ability to make plans for her child:

“[I had] Two weeks [to plan], first week spent it depressed, didn’t come out my room, worried about losing my kids, first time I have ever been away from my kids”.

In addition, two mothers acknowledged that despite having time they were unable to develop concrete plans:

“I went to court, I gave them evidence and I didn’t know I was being sentenced that day, I thought I was going to provide evidence so I wasn’t able to plan, solicitor did not tell me how long I would go away for... It was very up in the air because didn’t know how long I was going away” (PM17)

“I kept thinking I might not have gone [to prison], not till court was anything thought about” (PM19)

These latter examples highlight the importance of realistic discussions with legal representative (discussed further in the ‘Section 6.2.1.2 Responses of the criminal justice

system'), as well as the importance of knowledge of the criminal justice system about policies and practices.

Knowledge of the criminal justice system policies and practices

Eight primary mothers highlighted the importance of knowledge of the criminal justice system in order to both plan the care of their children (n=4) and participate effectively (n=4). Four mothers reported that better knowledge of this system would have assisted them to plan the care of their children. This included knowledge to plan, as well as knowledge around what assistance was available. For example,

“I didn’t know they had a Mother-Baby Unit” (PM13)

“If you are told you were going to do time, told what program and how to apply for the Mother-Baby Unit, so you know what will happen...” (PM17)

“Things could have been clearer from a legal point of view. You speak to solicitors and no one gives you any idea how things would play out, the unknown plays on you...” “...What supports available on the outside before you go in [for your family]” (PM19)

In addition, four mothers reported that knowledge was also important to their own navigation through the criminal justice system. Indeed, the quote from PM17 in the previous discussion highlights the importance of at least understanding what will happen when appearing before a judge or magistrate. While PM21 reported that “I didn’t know nothing much about the court system so I missed the appeal period”. Such experiences were further described by PM6 who reported “...This is the first time I’ve been in trouble so I didn’t know what the procedures are” she then provided an example of being interviewed by the police despite her high level of distress at the time, reporting:

“I’ve heard from women that the first thing you get is a doctor to see if you’re okay to be interviewed [by the police] and that didn’t happen to me. I had no idea what was going on and no idea what was going to happen next...”

In addition, PM19 reported that she:

“Googled Dame Phyllis [Victoria’s maximum security prison] and Tarrengower [Victoria’s maximum security prison]. People don’t tell you enough about what will happen and the process, I had no idea – Can I take clothes [into prison]?”

These examples highlight the importance of some kind of knowledge for both care planning, as well as the mother’s participation at her arrest, and during her hearing to plan children’s care. The upcoming discussion highlights the role legal representative has in providing this knowledge. The primary mothers, outside of their individual factors and resources, also identified that systemic factors mediated their level of participation.

6.2.1.2 Responses of the criminal justice system

This discussion focuses on an examination of the criminal justice system’s responses to primary mothers as they navigate arrest, and their court appearance and sentencing. This examination also addresses subsidiary question four: ‘How does the criminal justice system respond to this group of imprisoned mothers with a mental illness?’

Awareness of and responses to mental illness

From data collected from the women themselves, there appears to be a general lack of awareness of the primary mothers’ mental health status at arrest. Sixty percent (n=12, N=20) of the primary mothers reported that the arresting police officers were unaware that they had a mental illness. This was due to two distinct reasons: either the mother did not want to inform the police, or they were simply not asked. In contrast, six mothers reported that the arresting police officers were aware of their mental illness. This was due to being ‘known’ to the police (n=3); the mother informing the police (n=2); or their behaviour at arrest (n=1). No mothers reported being asked about their mental health by the arresting police officers. Two mothers however were unsure.

Police officers being unaware of the mental health status of the mothers being arrested is troubling as 12 women (60%, N=20) reported that their mental illness affected their participation in their interview with the police. These women described this poor participation as being due to the symptoms associated with their mental illness, use of medication, or drug use. It resulted in a number of mothers reporting difficulty understanding or remembering the interview:

“Had to get them to repeat most of them [the questions]” (PM8)

“I didn’t understand what they were saying to me, I can’t remember the interview”
(PM13)

“I wasn’t really there, not coping, legally they were not supposed to speak to me”
(PM14)

“I can’t remember it” (PM15)

Furthermore, one mother reported that she fell asleep during the interview as the result of alcohol use, and another reported that she was “a zombie” due to medication.

A greater awareness of the primary mothers’ mental health status is reported during their court appearance, with more than two-thirds of the mothers (65%, n=13, N=20) reporting that their mental health status was discussed during the court case. This compares to the six mothers (30%) who reported that this conversation did not occur. One primary mother was unsure. Whilst it was usually raised as a mitigating factor by their legal representative, three primary mothers reported that their GP, psychologist, or psychiatrist discussed their mental illness during the court case. This study did not ask if this was at the request of the legal representative or the woman. Not one mother reported the use of any programs at the Magistrates Court of Victoria that service a range of mental health and social needs (as discussed in ‘Chapter Two’). This may be a limitation of self-reported data, relying on the participants to provide information, rather than being prompted. However, one primary mother who had Schizophrenia reported that she accessed a court-ordered psychiatrist.

Awareness of and responses to motherhood

Police awareness of and responses to mothers’ primary carer status was also inconsistent. For example, the majority of these participants (80%, n=16, N=20) reported that the arresting police officer was aware that they had dependent children. The primary mothers reported that this awareness, somewhat similarly to the issue of mental illness discussed above, was typically a result of the mother being known to the police (n=6), or the mother informing the police that she had children (n=6). Furthermore, six mothers reported that their children (eight children in total) were present at her arrest. However not one primary mother reported that the arresting police officer specifically asked if she had children. Despite this general awareness of children, only 26.3% (n=5, N=19) reported that the arresting officer then inquired about any care arrangements for children. Only six primary mothers (35.3%, N=17) reported that the police sergeant inquired about their children’s care at the police station. This

finding may be influenced in some way by the location of the mothers' arrests. One-half of the primary mothers (n=10) reported that they were arrested in the community rather than at home. Therefore, children are less likely to be present, and there would not be any visual clues to the parenting status of the arrestee (e.g. children's photos, or toys).

Outside of asking the primary mothers about their care arrangements, 12 mothers (60%, N=20) reported that the police, either the arresting officers or those at the station, responded to their parenting responsibilities in other ways. For example, four mothers reported that the police organised a phone call to their children or family, while three mothers reported that they were released on bail in time to collect their children from school. For example:

“They [police] had talked to my workplace, tried to come the day after daughter started school, just got the day wrong...” she later described “the police were plain clothed, not handcuffed, they were really good, treated me well, interview was more like a conversation...” and “...they [police] were conscious of the time and getting me back to do school pickups” (PM19)

In addition, one primary mother reported that her child sat with her during her interview, another reported that the police got statutory child protection services involved, while one primary mother reported that her house was searched for children. Therefore, there appears to be some reaction to the mothers' primary carer status at arrest. However, these responses tend to be inconsistent, with no unified or predictable intervention strategy.

When examining their experiences during their hearing and sentencing, the mothers described their legal representative, the client-professional relationship, as well as some limited data on the time spent with their legal representative. One-third of the primary mothers (33.3% n= 7) reported that they accessed legal aid, while 14 mothers did not specify who represented them (e.g. legal aid or private legal representative). In regards to the client-professional relationship, seven primary mothers reported that they had a positive relationship with their legal representative due to either a prior relationship (n=3) or the interpersonal skills of the professional (n=4). For example, PM9 discussed a situation where the solicitor worked together with her psychologist to prepare her for the trial. PM10 and PM11 described their legal representative as “honest”, with PM11 further elaborating: “...talked about chances of going to gaol, he was a really good lawyer, listened, gave a fuck, told me worst case scenario, best case scenario, he was honest”. In contrast, four mothers reported issues with their legal representative. This was related to their legal representative changing during their court case

due to legal aid funding issues, or the inappropriateness of the representative allocated. Furthermore, eight mothers provided information regarding the amount of time spent with their legal representative: this was typically less than two hours (n=5), while three women reported multiple contacts.

As previously acknowledged, legal representative can play an important role in mediating women's interaction with the criminal justice system, providing information that assists both the care planning process, as well as their navigation through the court system. Three-quarters of the primary mothers (76.5%, n=13, N=17) reported that they had discussions with their legal representative about the possibility of a prison sentence. Such conversations are particularly important in order to plan their children's care. However, these discussions did not always leave the participants feeling prepared. Three primary mothers reported that they were not adequately informed about the likely sentence length, or had unrealistic expectations regarding the outcomes of the hearing. This is highlighted by the following example:

“I was already on remand, they told me really unrealistic expectations such as pleading guilty and get two years. So I did and got four. This information is important when planning for your kids” (PM18)

Furthermore, four mothers reported that they were not informed by their legal representative that they would be receiving a sentence. This lack of information had practical and emotional implications:

“...barrister and I only met for a day, she told me I wouldn't be going to gaol. Me and son were just standing there crying” (PM5)

“They kept telling me there was no evidence against me, so I would be found not guilty and would go home” (PM6)

“...If anything I would [get] three months with a community order considering what he had done to the children. I was in a lot of shock when I was sentenced, I felt like this bloke took all the power I had” (PM12)

During their hearing, approximately three-quarters of the primary mothers (73.7%, n=14, N=19) reported that their legal representative discussed their children during the court case. Given that the majority of participants reported these discussions, the participants were also asked to describe the judges' response to their primary carer status, with almost equal

numbers reporting that their primary carer status did (n=7) or did not (n=6) make a difference to their sentence length.

This discussion highlights, alongside the primary mothers' individual factors and resources, that systemic responses to this group of women play a role in their navigation and participation in the criminal justice system. The mothers' narratives indicate that they have invisible issues. As the previous chapter reported, primary mothers commonly reported high prevalence disorders such as affective and anxiety disorders, therefore they are less likely to display extreme behaviours and act out. This appears to make it difficult for the relevant staff in the criminal justice system to 'see' and respond to their mental health issues, particularly at arrest. In comparison, parenting responsibilities and children were more visible at the stages of arrest and sentencing, but how the system responds to these issues was inconsistent. In many respects, children are 'seen' at these two stages, but not always responded to. For example, police typically do not ask about the care needs of children, and whilst legal representative may discuss the possibility of a prison sentence, this does not leave the mothers feeling prepared. This may explain the issues experienced by the primary mothers in terms of their ability to make care decisions, satisfaction with the overall care planning process, and the stability and security of their children's care arrangements.

6.2.2 Outcomes for the primary mothers and their children

As previously discussed, the primary mothers were significantly more likely to report that they were less involved in the care planning process for each child, with their pre-prison, arrest, and sentencing narratives highlighting a range of individual factors and resources, as well as systemic responses that mediated their ability to navigate this system. As an outcome, the following discussion examines how these experiences affect their ability to develop stable and secure care arrangements for their children, and the mothers' level of satisfaction with the resulting care plans.

6.2.2.1 Developing secure care arrangements for children

In order to examine the stability and security of the children's care arrangements⁵, Flynn's (2008) care planning typology (discussed in Chapter Three) was the basis for the

⁵ The experiences of PM19's three stepchildren were excluded from the following analysis. This was pragmatic decision as any impact of on these children would be reduced as their care arrangements remained the same – shared care between their biological parents. It is acknowledged however, that these children are still separated from PM19 who is one of their primary carers.

development of a dichotomous variable: 'secure' versus 'no care' arrangements. Within this variable, 'secure care arrangements' were defined as placements where the children were stable and safe. Such placements were underpinned by a clear care planning process that involved the mother and significant others (e.g. children, partners, other family members). In contrast, 'no care arrangements' were defined as where the mother's imprisonment resulted in a crisis for the family due to a lack of care plans, and where the care arrangements made often changed over time (Flynn 2008). Flynn's (2008) typology also included 'care by default' category where the children's basic care needs continued to be met, often via an existing arrangement, but with no clear planning process. In many respects, this category could lead to both stable and unstable care plans, and in this present study, represented the care plans for four children of three primary mothers. Therefore, these placements were grouped into the dichotomous categories according to the longer-term stability of these arrangements.

Data indicates that nearly two-thirds of the children (59.5%, $n=22$, $N=37$) had no care arrangements when their mother was imprisoned, with 15 children (40.5%) experiencing secure care. A Chi-square test for independence, and the associated Fisher's Exact Test were used to examine the factors associated with the security and stability of the children's care arrangements. The results are displayed below in Table 6.3.

Table 6. 3. The significant factors associated with the security and stability of the children’s care arrangements.

Factors		Secure care arrangements		No care arrangements		Test		
		n	(%)	n	(%)	p	φ	
Individual factors and resources	1	Time	15	(88.2)	2	(11.8)	.000 ^{a*}	.90
		No time	-	-	20	(100)		
	2	Mother main decision maker	12	(63.2)	7	(36.8)	.007 ^{a*}	.47
		Others made decisions	3	(16.7)	15	(83.3)		
	3	Father the main caregiver	9	(100)	-	-	.000 ^{b*}	.69
		Other person the main caregiver	6	(21.4)	22	(78.6)		
Systemic factors	4	Mother taken into custody	2	(9.5)	19	(90.5)	.000 ^{a*}	.72
		Mother bailed into the community	13	(81.2)	3	(18.8)		
	5	Sentence length (two years and under)	15	(65.2)	8	(34.8)	.000 ^{b*}	.61
		Sentence length (over two years)	-	-	11	(100)		

Note 1: ^aChi-square test for independence, ^bFisher’s Exact Test.

Note 2: * <.01

As shown in the above table, the factors significantly associated with the stability and security of care arrangements included time, the mother’s level of involvement in the care planning process, the child’s father as the main caregiver, the outcome of the interaction with the police (custody versus remand), and the length of the mother’s sentence. These factors had moderate to large effect sizes. Therefore, the following discussion examines the interplay between these factors on the mother’s ability to make stable and secure care plans.

The interplay between time, decision-making capability, and remand

The primary mothers reported a range of decision-makers involved in planning the care for each of their children. As shown in Figure 6.5 below, the mother was the sole decision-maker

for just half of the children (51.4%, n=19, N=37), with the remaining care decisions made by a range of other people, most notably child protection.

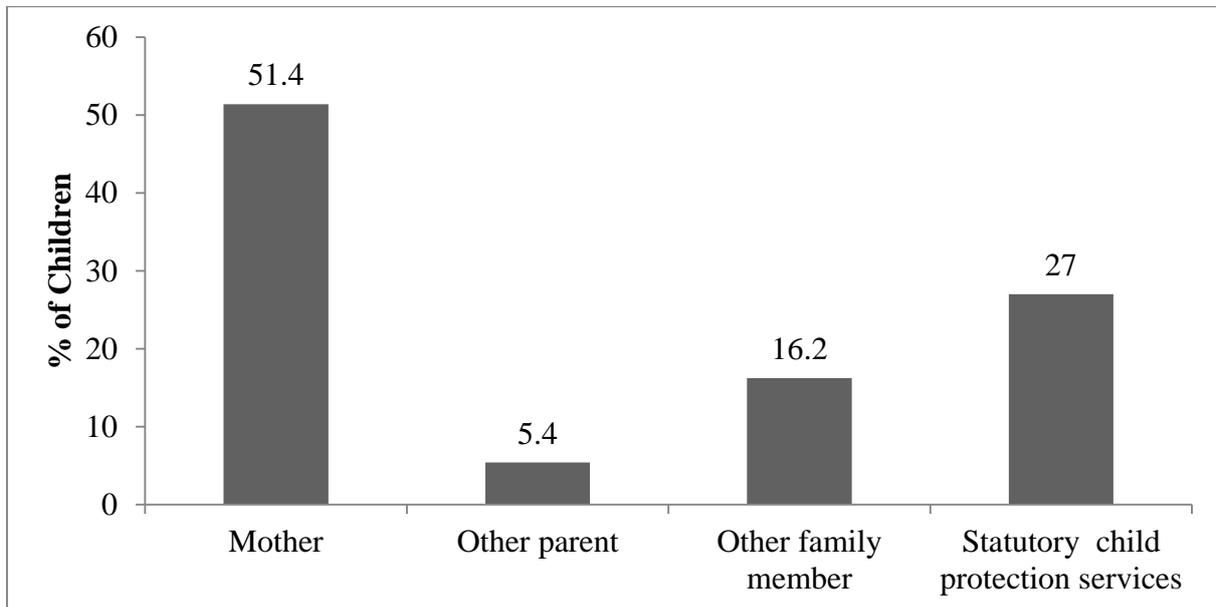


Figure 6. 5. The decision-makers who were involved in the care plan decision-making process for each of their children (N=37).

While 11 mothers reported being the sole decision-maker for their 19 children, they noted that they were often assisted by a range of people, typically their partner/ex-partner, parents, and siblings. Furthermore, four mothers reported that their children were also involved in these care discussions. For example:

“Once it got to August, had to sit down with partner to discuss the situation, partner was happy to care for [oldest daughter]. Discussed with [oldest daughter] as well” (PM1)

“We just came to an agreement. I asked [daughter] who she wanted to go to and [daughter] wanted to go to my mum’s” (PM14)

“Both myself and parents, [statutory child protection services] not involved. My brother and sister said they wouldn’t take the kids so the only option would be to put them into foster care [if parents did not take them]” (PM18)

Interestingly, PM9 reported that her psychologist also assisted in the care planning for her daughter, alongside her mother and her daughter’s father. This participant was the only one to

report this level of formal involvement with the care planning process. Therefore, such results suggest that when the primary mothers make care decisions, they are often assisted by at least one adult, usually from within their informal networks.

‘Other people’ were the sole decision-maker for the remaining 18 children. This included the other parent (n=2), and other family member such as grandparents or siblings (n=6). For example, PM1 reported “My dad decided because he was the closest to school, had space and the finances”, with PM19 describing “at [the] court-house [partner] and ex-husband were making the arrangements, it worked out okay”. Importantly, ‘other people’ also included the statutory child protection services, who were the sole decision makers for ten children (27%). In these cases, the mothers generally reported that they were excluded from care planning discussions, and often did not know that they were occurring. For example:

“They [statutory child protection services] had a meeting between my father and my cousins and my husband’s family and children. I was not present, and knew nothing about the meeting” (PM6)

“...just happened, kids were removed from mum straight after I was locked up... didn’t have a say because I was in here. I’m trying to get them with my dad” (PM11)

Only one primary mother reported some form of involvement when statutory child protection services made the decision:

“I had a preference and it was [my sister]. But if it hadn’t have been her he would have gone into foster care. But I knew he’d be able to stay with her because he stayed with her for a five week period when he was one [year old]” (PM7)

In order to examine the factors that affected the primary mothers’ ability to make care decisions, the decision makers were grouped into a dichotomous variable. Within this variable ‘mother’ included primary mothers who were the sole decision-maker for each of their children, and ‘other people’ included the other parent, family member, or statutory child protection who were the main decision-maker. As Table 6.3 at the beginning of this discussion shows, the primary mothers’ ability to make care decisions was significantly associated with stability and security of children’s care plans, $\chi^2 (1, n=37) = 8.29, p < .01$, with a moderate effect size, $\phi = .46$. Therefore, mothers who were the sole decision-makers were significantly more likely to report secure care arrangements for their children (63.2%, n=12, N=19) compared to mothers who reported that ‘others’ were the decision-makers (16.7%,

n=3, N=18). This suggests that involving mothers leads to better care outcomes for their children. It could also suggest that the mothers who were more involved in their children's care plan may be more stable, therefore more capable of participation.

In addition, time (e.g. having no time or having some time) was a significant factor associated with the primary mothers' ability to make care decisions. A Chi-square test for independence indicates a relationship between the primary mothers' levels of involvement in the care decisions and whether they had time to plan their children's care, $\chi^2 (1, n=37) = 7.94, p < .01$, with a moderate effect size, $\phi = .46$. Therefore, when the mothers were the sole decision-makers they were significantly more likely to report that they had time to plan the care of their children (68.4%, n=13, N=19) compared to mothers who were not the sole decision-maker (22.2%, n=4, N=18). Therefore, mothers who had time to plan are more likely to be involved in the process. Indeed, having time is also significantly associated with secure care arrangements, $\chi^2 (1, n=37) = 29.68, p < .01$, with a large effect size, $\phi = .90$.

As evident in Table 6.3 at the beginning of this discussion, the mothers who were taken into custody following their interaction with the police were significantly more likely to report their child/ren as having no care arrangements (90.5%, n=19, N=21) than mothers who were granted bail (18.8%, n=3, N=16). However, custody was not significantly associated with the mothers' ability to make care decisions, $\chi^2 (1, n=37) = 3.42, p = .10, \phi = .30$. This is surprising considering the previous finding that the time the mother has to plan the care of her children was significantly associated with being taken into custody following arrest. This suggests that while experiences of custody following arrest have a relationship with both children's care arrangements and the time the mother has to plan; only time has a relationship with the main decision-maker. This may be because time spent in custody, particularly on remand, may provide the women with time to 'firm up' their care arrangements for children.

The significant relationship between mothers' decision-making ability, and secure care arrangements, and the association with time, suggests that when they had some time, with the assistance of at least one adult usually within their informal networks, they generally made care arrangements that provided continuity of care for the children. In contrast, decision-making by others, such as the children's father, other family members, or by statutory child protection services, occurred when the mother had no time to plan their children's care and when there were no care arrangements put into place. This was most likely the result of being taken into custody following arrest.

Personal distress and the mothers' decision-making capability

As discussed at the beginning of this chapter, experiences of personal distress was a major theme identified by the primary mothers as they navigated the criminal justice system. Therefore, to assess the impact of mental illness on their ability to plan, all primary mothers interviewed were asked to respond to the statement 'My mental illness negatively impacted on my ability to be involved in planning the placement of my children' using a five-point quantified Likert scale. As shown in Figure 6.6 below, responses were divided, with 10 mothers reporting that their mental illness, and the associated levels of distress, played a role and 10 reporting that it did not play a role. One mother did not answer this question.

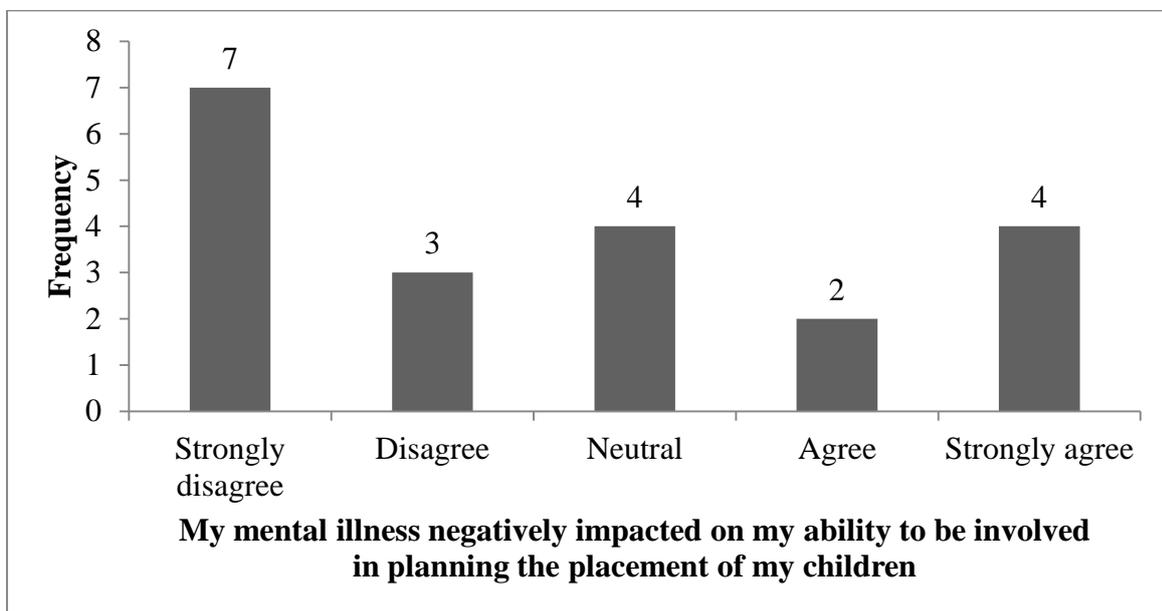


Figure 6. 6. The self-reported impact of mental illness on the care planning process (N=20).

In order to examine the impact of mental illness on the primary mothers' ability to make care decisions and be involved in the planning process, this Likert scale was transformed into a dichotomous variable. Within this variable 'mental illness did not have an impact' included the categories of strongly disagree and disagree. While 'mental illness had an impact' included the categories of agree and strongly agree. Neutral was excluded from analysis because it did not fit appropriately into either category. A Fisher's Exact Test showed that there was no significant difference between the self-reported impact of mental illness on the care planning process for each child, and the mothers' involvement in the decision making process, $p=1.00$, $\phi=.06$. This suggests that their levels of personal distress do not significantly

reduce their involvement in the care planning process. However, upon examination of the qualitative data, the primary mothers' narratives describe the additional challenges that result from their mental health issues.

Out of the 10 primary mothers who reported that their mental health issues did not play a role, four highlighted that they were still able to make decisions, and prioritise their children's needs:

“Children come first, mental illness second, I still have a sense of what's right and wrong. Mental issues can be an excuse for a lot of people, fall back on that rather than deal with the problem” (PM12)

“I wasn't particularly mentally ill at the time and capable of making the right decisions at the time” (PM18)

“When it came to organising the kids, my mental illness didn't have an impact. I wouldn't let that cloud my judgement” (PM19)

These aforementioned examples are interesting as they suggest a level of similarity in how these mothers see themselves, and how they construct the intersection between mental illness and their parenting role, particularly the notions of being a 'good mother'.

In addition, PM14 reported that she had “already made all the decisions before I came in” as she left her children with her mother when her mental health started to deteriorate, prior to her arrest. Interestingly, while one mother reported that her mental health did not have any impact, because child protection made all the care decisions, three other mothers reported that it did have an impact, also because others had made the care decisions for them.

In addition, four primary mothers described their mental health influencing their level of involvement, because it affected their everyday lives:

“It had a huge impact on everything. All decisions were taken out of my hands” (PM6)

“I think because my mental illness is a strong problem for me” (PM8)

“Impacts me every day” (PM15)

As PM17 acknowledged “just that you are always doubting yourself, doubting your choices, don’t want to make another mistake, blame yourself, and it becomes a vicious cycle”.

Therefore, despite the lack of statistical significance between mental illness and care planning, the primary mothers’ narratives suggest that for some mothers, their experiences of personal distress limit their involvement in making care decisions for their children, while other mothers are able to focus on the needs of their children, and put their levels of personal distress aside. This suggests that the primary mothers’ perceptions of the impact of personal distress on their care planning process is rather individualised. Thus this inconclusive result highlights an area for future research. In addition, and as Table 6.3 at the beginning of this discussion shows, the children’s caregiver plays a role in the stability and security of care arrangements.

The children’s main caregiver

The previous chapter highlighted that the primary mothers’ 37 children were being cared for by their grandparents (37.8%, n=14), fathers (24.3%, n=9), and other family members (13.5%, n=5). The remaining nine children were in ‘other’ care arrangements (e.g. self, DHS, and the MBU). These results however represent the children’s care arrangements at the interview, rather than at the initial point of imprisonment. Therefore, the quantitative and qualitative data sought from the primary mothers regarding their children’s care arrangements and care planning experiences allowed for their children’s placements to be mapped over time. Results from this analysis are presented below, with Table 6.4 showing the placement experiences of children who had secure care arrangements.

Table 6. 4. The primary mothers’ children (n=15, N=37) who experienced secure care arrangements at the point of their mothers’ custody.

Primary mother	Child	Carer
1	1	Grandparents
2	1	Father (not biological parent)
3	1	Grandparents
8	1	Grandparents
9	1	Father
12	1	Father
	2	Father
	3	Father
	4	Father
	5	Father
14	1	Grandparents
	2	Grandparents
19	1	Father
	2	Father
21	1	Self

As Table 6.4 indicates, the 16 children who experienced secure care arrangements were more likely to be looked after by their father (60%, n=9), followed by grandparents (33.3%, n=5). The remaining child cared for himself (6.7%, n=1). For these children, care arrangements did not change over time, highlighting the importance of some form of care planning. In addition, a Fisher’s Exact Test, as displayed in Table 6.3 at the beginning of this discussion, showed that fathers were the only caregiver significantly associated with secure care, $p < .01$, with a large effect size, $\phi = .69$. Care arrangements with fathers were more likely to be defined as secure (100%, N=9) compared to care arrangements with others, including grandparents, other family members, self, statutory child protection services, and MBU (21.4%, n=6, N=28). This finding suggests that while the primary mothers’ pre-prison narratives often noted difficulties with the biological fathers of their children, the parents were somehow able to work together to arrange children’s care so that it is secure and stable over time.

The placements for children who had no care arrangements at the point of their mothers’ custody are displayed below in Table 6.5.

Table 6. 5. The primary mothers' children (n= 22, N=37) who experienced no care arrangements at the point of their mothers' custody.

Primary mother	Child	Carer	Multiple placements
4	1	Mother's friend → Grandparents	Yes
5	1	Self → Other family (Sister)	Yes
6	1	Grandparents → Foster care → Friends → Self	Yes
	2	Grandparents → Friends → Other family (Sister)	Yes
7	1	Foster care → Other family (Aunty)	Yes
10	1	Grandparents	No
	2	Grandparents	No
	3	Grandparents	No
11	1	Grandparents → Foster care	Yes
	2	Grandparents → Foster care	Yes
12	6	Foster care	Yes
13	1	Grandparents	No
	2	Grandparents	No
15	1	Other arrangement - Father and Grandparents	Yes
16	1	Father → Self	Yes
	2	Friends → Self	Yes
17	1	Family → MBU	Yes
18	1	Grandparents	No
	2	Grandparents	No
	3	Grandparents	No
20	1	Other family member (Aunty)	No
	2	Other family member (Aunty)	No

As Table 6.5 shows above, one-half of the children (n=11) who experienced no care arrangements had multiple placements during their mothers' custody, that is, they moved at least once after the initial placement. The remaining children experienced one care arrangement: eight with their grandparents (36.4%), two with a family member (9.1%), and one child (4.5%) in a shared care arrangement between their father and grandparents. There are however, some interesting trends noted in the above table relating to the children who had multiple care arrangements: sentence length, care by statutory child protection services, and grandparents carers.

Sentence length plays a role in multiple care arrangements for children. For example, PM6

and PM16 committed offences against the person (e.g. homicide) and at interview they had been imprisoned for over a decade; therefore, their children were grown up. This explains their final placement, with the oldest daughter taking over the care of her sister. Such examples suggest that longer sentence lengths may affect the stability of placements. However, a Fisher's Exact Test found a non-significant relationship between sentence length (two years and under versus over two years) and moving at least once after the initial placement, $p=.05$. This result was just outside the accepted significance range, and suggests that children of mothers sentenced to over two years may be more likely to move at least once after their initial placement (54.5%, $n=6$, $N=11$) than children whose mothers are sentenced to periods less than that (17.4%, $n=4$, $N=23$). With a larger sample size this may have moved into the significant range.

As previously discussed, statutory child protection services made the care decisions for 10 children. Eight of these children experienced multiple placements, with five placed in the foster care system, as evident in Table 6.5 above. This suggests that when child protection services make the care decisions, placements are often unstable. A Fisher's Exact Test showed that there was a significant relationship between when child protection services made the care decisions and to moving at least once after their initial placement, $p<.01$, with a large effect size, $\phi = .67$. Therefore, child protection involvement in care arrangements were more likely to be associated with multiple moves (80%, $n=8$, $N=10$), compared to when other's made the care decision (e.g. mothers, grandparents and other family members, and fathers) (11.1%, $n=3$, $N=27$). General instability of foster care placements is known to be common.

Lastly, as evident in Table 6.5 above, 14 children experienced placements with grandparents at some point during their mothers' imprisonment. This provides further evidence, for the result first presented in the previous chapter that mothers in a crisis typically rely on grandparents when they are imprisoned. It appears that fathers only care for their children, when there is clear care planning process; mothers do not rely on them in a crisis. This may be explained by primary mothers' pre-prison narratives, which noted difficulties with the biological fathers of their children, such as a history of imprisonment, and substance use. Therefore, the fathers involved in the secure placement discussed previously were those that were more stable. In addition, the number of children also appears to add difficulty in care arrangements. For example, PM12 had six children, with five cared for securely by their respective fathers, but her youngest child was in statutory care. In many respects, this also highlights the importance of the informal supports available to the primary mother.

As this discussion has shown, having no care arrangements at the point of being taken into custody are associated with multiple changes in caregiver over the course of the mother’s imprisonment. In these instances, mothers appear to rely more on grandparents when they are first imprisoned. Having no care arrangements are also associated with longer sentence lengths, and the involvement of child protection services. In contrast, secure care arrangements typically occur with fathers and are more stable.

6.2.2.2 Satisfaction with the care planning process

The primary mothers were asked to rate their satisfaction with their children’s current living arrangements. The majority of the mothers reported that they were happy to very happy (81%, n=30, N=37); the remaining mothers reported that they were neutral. These evaluations were usually related to children having a good relationship with carer, and being loved, happy, and stable. However, the primary mothers’ overall level of satisfaction with the care planning *process* for each child was considerably more polarised. As shown in Figure 6.7 below, the mothers reported that for 16 children (43.2%) this process was poor while a similar number (40.5%, n=15) the overall care planning process was good.

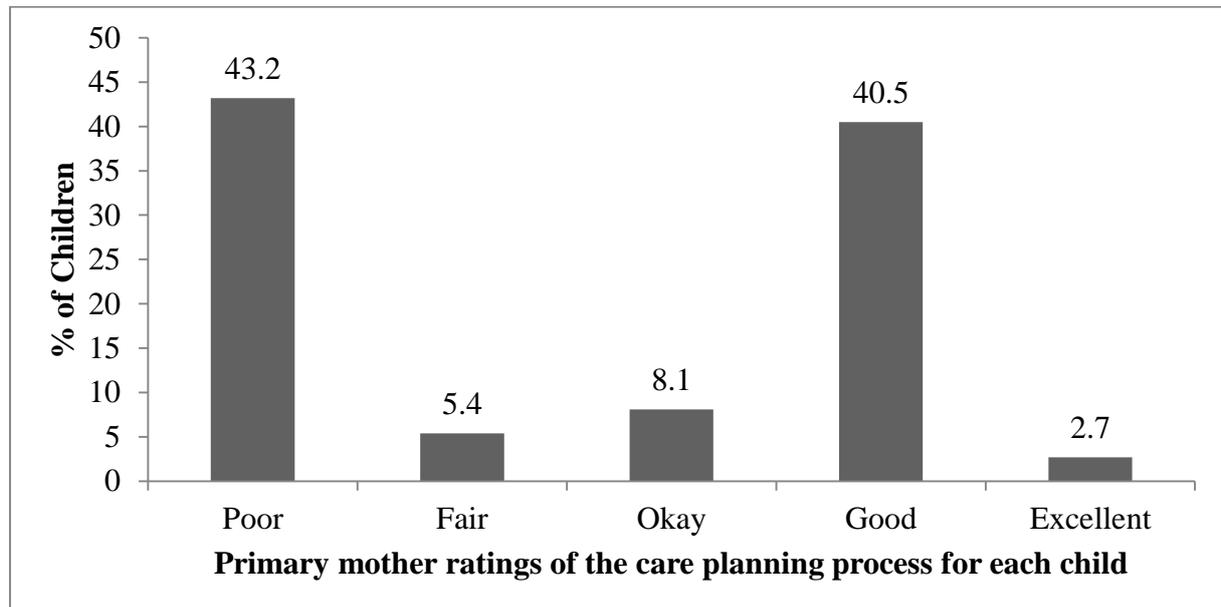


Figure 6. 7. The primary mothers’ levels of satisfaction with the care planning process per child (N=37).

These results suggest that whilst the primary mothers were generally happy with the outcome, they were less satisfied with the processes. Therefore, this Likert scale was transformed into a

dichotomous variable in order to examine the factors associated with mothers' satisfaction with the care planning process for each child. Within this variable 'dissatisfied' included the categories of poor and fair, while 'satisfied' included the categories of good and excellent. 'Okay' was excluded from analysis because it did not fit appropriately into either category. The Chi-square test for independence and the associated Fisher's Exact Test was then used to examine the factors significantly associated with mothers' levels of satisfaction, with the results displayed below in Table 6.6.

Table 6. 6. The significant factors associated with the primary mothers' satisfaction with the care planning process for each of her children (N=34).

	Factors	Dissatisfied		Satisfied		Test	
		n	(%)	n	(%)	p	φ
1	Time to plan	2	(14.3)	12	(85.7)	.000 ^{a*}	.65
	No time no time	16	(80)	4	(20)		
2	Mother the sole decision-maker	5	(29.4)	12	(70.6)	.009 ^{a*}	.46
	Others made the care decisions	13	(76.5)	4	(23.5)		
3	Father the main care giver	-	-	9	(100)	.000 ^{b*}	.64
	Other person the main caregiver	18	(72)	7	(28)		
4	Secure care arrangements	1	(8.3)	11	(91.7)	.000 ^{a*}	.66
	No care arrangements	17	(77.3)	5	(22.7)		

Note 1: ^aChi-square test for independence, ^bFisher's Exact Test.

Note 2: * <.01

As shown in the above Table 6.6, the same factors that were significantly associated with the stability and security of children's care arrangements also underpinned the mother's overall level of satisfaction with the care planning process for each child. This is perhaps unsurprising: children having secure and stable care arrangement reduce the mothers' concerns over their safety, and likely leads to increased satisfaction. In addition, when mothers had time to plan and were the main decision maker in this process they were also satisfied. This may be because being included in the care planning process, they maintained some control over the outcomes for their children.

6.2.2.3 *Why participation matters – Impact of individual factors and resources, and systemic responses*

The primary mothers’ narratives of their experiences pre-prison, at arrest, and at sentencing, highlighted that a range of individual factors and resources, as well as systemic responses underpinned their ability to develop stable and secure care arrangements for their children. This has been conceptualised below Table 6.7.

Table 6. 7. Summary of the factors underpinning children’s (N=37) care arrangements.

	Secure arrangements:	No care arrangements:	Mediated by:
Individual factors	<ul style="list-style-type: none"> • Mother was the main decision maker 	<ul style="list-style-type: none"> • Others made the care decisions 	<ul style="list-style-type: none"> • Personal distress • Substance use • Medication use and side effects • Experiences of grief and loss • Social isolation • Gambling • Economic marginalisation
Individual resources	<ul style="list-style-type: none"> • Having some time to plan • Father is the main caregiver 	<ul style="list-style-type: none"> • Having no time to plan • Others are the main caregivers i.e. grandparents, other family members, or statutory child protection services 	<ul style="list-style-type: none"> • Access to mental health support • Relationships with informal supports • Knowledge of the criminal justice system
Systemic responses	<ul style="list-style-type: none"> • Mother bailed into the community • Shorter sentences 	<ul style="list-style-type: none"> • Mother taken into custody following arrest (remand or for a breach offence) • Longer sentences 	<ul style="list-style-type: none"> • Invisibility of mental health issues • Inconsistent responses to parenting status • Relationship with legal representative

Specifically, as this table above shows, the stability and security of care arrangements was associated with who the main decision-maker was, the time provided to make care plans, the informal supports available to the mother, and the systemic responses to mothers when they were arrested, that is whether they were taken into custody following arrest, or bailed into the community, as well as the length of their sentence. These factors also affect the mothers’ levels of satisfaction with their overall care planning process, with the discussion showing

that while mothers were generally happy with the outcomes for their children (e.g. stable and safe placements) they were not happy with the care planning process. This is likely to be related to their individual factors such as levels of personal distress, informal and formal resources, as well as their engagement and participation in the criminal justice system.

In order to illustrate how the mothers' individual, social, and systemic experiences as they navigate the criminal justice system mediate levels of involvement in planning children's care, two extreme case examples were purposively selected (Patton 2002). Extreme cases allow for the examination of cases that differ from the representative or typical cases (Bryman 2012), and as Patton (Patton 2002, p. 243) highlights, provides opportunities to learn "from unusual manifestations of the phenomenon of interest, for example successes/notable failures". Therefore, the cases chosen represent the extreme ends of the variation evident in the high or low levels of involvement the primary mothers had in planning their children's care, as displayed previously in Figure 6.3. The mothers' level of involvement was the basis for the selection of these two extreme cases as 'involvement' was the only factor, outside of mental illness, that was significantly different between the between the primary and comparison mothers. In this section, unlike the previous discussions, the participants and their children were ascribed a name to aid reading-ability.

Case one: Participant 5 - Jody – An example of a mother who was reported low involvement in planning her daughter's care

Jody is a 48-year-old mother of six children, ranging from 28 years to 15 years old, and is the grandmother to three grandchildren. Only her youngest daughter, Claire (15 years), lived with her prior to her incarceration. Jody has a diagnosis of Affective and Anxiety Disorder, and worked "as a professional cleaner" prior to her imprisonment. Her days consisted of "getting [Claire] to school, picking up grandchildren and looking after them". At interview, Jody was nearing the end of her three-month sentence. This was her third conviction. Her first conviction was three decades ago when she was 15 years old, and her second was the year before the interview, after she "assaulted ex-partner after I found him in bed with the wife of his brother". This sentence was a breach of parole of the previous year's sentence.

Participation in the criminal justice system

Reflecting on her experiences at arrest and with the police, Jody reported that she was arrested in the community at a parole meeting, recounting that the "police came in with

warrant”. She asked them about her “daughter who was in the car, asked for a day to sort out daughter, told no,” so she was arrested and “brought to the divvy van [police van], daughter was brought to say goodbye, she was crying...” Therefore, whilst the police were aware that she had a child, they did not respond to Claire’s care and safety needs. Jody did not report how Claire got home.

In addition, the police were unaware that Jody had a mental health issue. However, Jody was one of the few who reported that her mental illness did not affect the arrest process, largely because she was a ‘breach of parole’ therefore no interview was needed. Jody was held in the police cells for two nights before being transferred to DPFC. Jody spent these early days “worried about where my daughter was and no one would tell me” further elaborating “...They could have at least found her somewhere to stay. so I knew where she was or discuss with me where she was going. It was only later I found a friend to come down to look after her”. Indeed, Jody reported that she had not done the grocery shopping so Claire “went home to an empty house with no food, no nothing”. Furthermore, Claire stayed home alone for the first two nights before she moved in with Jody’s oldest daughter, Alex.

Given the breach of parole, Jody went straight to prison. She reflected on her experiences during her trial and sentencing for the initial sentence the previous year, reporting that she was informed by her legal representative that she “wouldn’t be going to gaol”. This resulted in significant distress for herself and Claire when she was sentenced. Furthermore, her mental health issues were not presented during the court case. This may relate to the fact that she had very little contact with her legal representative.

The care planning process

As an outcome of these experiences, Jody had no time to plan care for Claire, and thus she had no involvement in the care planning process. As previously mentioned, Jody did not know what had happened to Claire for the first two weeks after her entry into DPFC. This cumulated in a conference call with statutory child protection services, Claire, and Alex, where she was informed of Claire’s whereabouts. She found this call “very stressful”. Jody reported that she is very happy with Claire’s current care arrangements because “she is with her sister, [statutory child protection service] not really involved and are just supervising, not taking over”. This experience reflects the experiences of many mothers who were remanded into prison following their offences.

Jody has had very limited contact with Claire throughout her imprisonment, having only spoken to her once. She is in regular telephone contact with Alex in order to be kept up-to-date with Claire. It is unsurprising then that she reports that she is currently unhappy with her relationship with Claire, “what relationship? It’s non-existent”.

The intersection with mental illness

Jody’s mental health functioning as she navigated the criminal justice system has been conceptualised below in Figure 6.8.

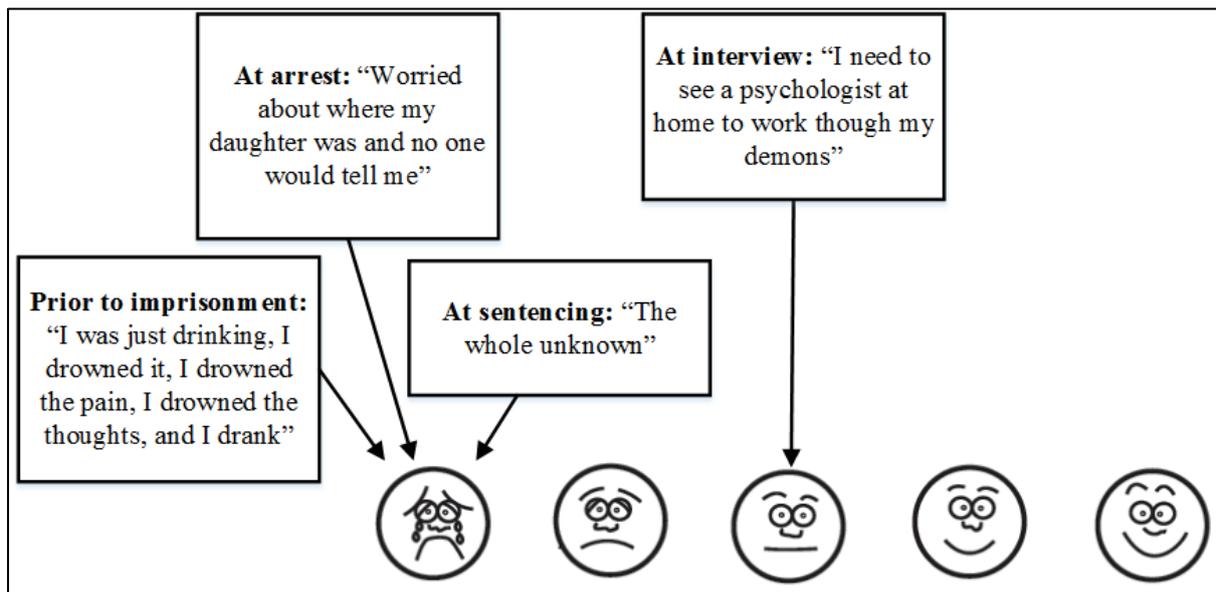


Figure 6. 8. Jody’s self-reported level of mental health functioning as she navigated the criminal justice system.

As shown in the above figure, Jody’s self-reported mental health was very poor prior to and at arrest, poor at sentencing, and had stabilised somewhat by the time of the interview; indicating high levels of distress as she entered prison. This is despite being under the care of her GP (also the family doctor), and taking mental health medication prior to her imprisonment. Her case highlights issues regarding the appropriateness of formal ‘mental health’ supports that she accessed in the community.

Jody acknowledged a number of factors that may have affected her mental health prior to and at arrest. She was consuming alcohol at problematic levels, reporting she would “get drunk every night”, as well as the “death of a friend of 30 years and partner cheating on me”. In addition, Jody acknowledged that she experienced childhood physical, sexual, and emotional

abuse by her biological father and when she was in state care; later as an adult, she experienced domestic violence. In Jody’s own words: “I was angry at the world, I didn’t even want to be in the world”. This high level of distress continued up until her imprisonment, at which point there was an improvement. This may relate to her continued use of mental health medication during her sentence, and to her cessation of alcohol. Jody acknowledged that her mental health issues have affected her children, reporting, “I was hurting and abusing them when I was drunk, I was nasty and horrible. They told me they wanted their old mum back”.

Post-release plans

After her release, Jody plans for Claire to return to her care. Jody also plans to see a psychiatrist “to work through my demons”. She concluded the interview reporting, “I want to go home! I want my kids, I want to be a nanna and a mum. It’s all I’m good at”.

Summary of Jody’s care planning experiences

As this discussion has shown, the factors affecting Jody’s engagement with and participation in the criminal justice system to plan Claire’s care has been conceptualised below in Table 6.8. This table shows the individual factors and resources as well as systemic responses that ensured that Claire did not have a care arrangement in place when Jody was taken into prison.

Table 6. 8. Summary of the factors underpinning Jody’s care planning process for Claire.

No care arrangement arrangements:		Mediated by:
Individual factors	<ul style="list-style-type: none"> • Others made the care decisions 	<ul style="list-style-type: none"> • Personal distress • Substance use • Experiences of grief and loss
Individual resources	<ul style="list-style-type: none"> • Having no time to plan 	<ul style="list-style-type: none"> • Access to mental health support but issues with appropriateness • Relationships with informal supports – oldest daughter cares for Claire • Previous history of imprisonment
Systemic responses	<ul style="list-style-type: none"> • ‘Breach of parole’ offence so she was taken straight in to prison 	<ul style="list-style-type: none"> • Invisibility of mental health issues at arrest and sentencing • Invisibility parenting status at arrest

Jody was excluded from her daughter's care planning process as she was taken into custody following her interaction with the police. As a result, she reported dissatisfaction with the overall care planning process, despite being very happy with Claire's current care arrangements. Her example highlights the need for the criminal justice system, when parents are physically removed, to acknowledge and respond to the parenting status of arrestees.

In stark contrast to Jody's experiences, the following extreme case example represents a mother who had high involvement in planning her daughter's care.

Case two: Participant 9 - Ellen – An example of a mother who reported high involvement in her daughters care.

Ellen is a 47-year-old sole parent to her eight-year-old daughter, Jo. She has a diagnosis of Affective disorder. Ellen was not engaged in paid employment prior to imprisonment, and her days consisted of "getting up after not much sleep; pretend everything is okay and get daughter to school. [Come home] go to bed, pick daughter up from school, and do the mummy thing. Then put her to bed and not sleep again". At interview, Ellen was nearing the end of her 18 month prison sentence for "fraudulently obtaining funds to fuel [gambling] addiction", and reported that her "depression and self-loathing caused the [gambling] addiction". This was Ellen's first conviction and prison sentence.

Participation in the criminal justice system

Ellen was arrested at home by five police officers at "seven am, on a school morning", therefore Jo was present. Ellen recounted that she had to "call [daughter's] father to come and take her to school". Whilst the arresting police officers were aware of Jo, there were no discussions at the police station regarding care plans for Jo while Ellen was in custody. This was likely due to Ellen being held for four hours, before being released "in time to pick daughter up from school".

The police were unaware that Ellen had a mental health issue. This is troubling as Ellen reported that her mental illness, and associated level of distress, affected her participation in the interview with the police officers. She reported that she took diazepam to relieve her anxiety over her arrest, whereby "I was in a zombie state, just wanted to be told what would happen next".

Ellen cannot recall her hearing and sentencing as she reported: “handled my court case by pretending to be watching a TV show and being medicated”. Her mental health issues were discussed during the court case, as Ellen indicated that her legal representative “told me it helped with the sentence length”. In addition, during the week of her hearing and sentencing, Ellen spent five days on remand at DPFC, she reported that this was difficult, as she had “no support during those days except for the psych nurse and the other girls”.

The care planning process

In the 15 months between her arrest and hearing, and upon promoting from her mother, Ellen started seeing a psychologist who specialised in gambling addictions. As a result, Ellen represents the only participant who had formal support in her care planning process. This contributed to her high level of involvement in the care planning process. Indeed, her psychologist and Ellen’s barrister were in communication, and it was the psychologist who “told me I would be incarcerated”. Ellen reported that the care arrangements for her daughter upon her incarceration were developed between herself, her mother, her daughter’s father, and the psychologist. Jo however, was not involved in this planning process. As Ellen reported:

“We were aware early on [regarding the possibility of a prison sentence], and I had a magnificent mother, and daughter’s father wanted to help with the psychologist, and I think we did fantastic. It was a horrible situation but my daughter was everyone’s number one priority”.

As a result, Ellen and her daughter went to live with the daughter’s father prior to her hearing and imprisonment. The goal of this was to ease the transition for the daughter, but it created difficulties for Ellen:

“For me, there was no support at home, an adult to love me, bounce things off, instead I had someone [ex-partner] who despised me” (PM9)

Ellen noted the benefits of the assistance from her psychologist in this care planning process, as the psychologist “was able to make me see things I couldn’t see – the best place for her to be”, further elaborating “I was lucky, I had so much time and good legal advice”. As a result, Jo experienced a more straight forward transition process when Ellen was remanded and imprisoned, with Ellen’s mother who “comes every morning to take my daughter to school” assisting Jo’s father.

Ellen reported that she is very happy regarding her daughter’s care arrangements. Initially she was unhappy when she was first imprisoned, but her “mother is involved so daughter gets the nurturing she needs, which was not her father’s strength, and I can see that he has done a fab job”. Ellen has had regular contact with Jo throughout her imprisonment, having daily telephone calls and visits once a month. Ellen reported that Jo’s father will not bring her in, so her brother brings Jo and their mother in. Ellen does not communicate with Jo’s father “unless I have to tell him something”. During these visits, the daughter participates in the prison based Fun with Mum program, and Ellen has used the Family Support Service to remain in contact with Jo’s school, and have the school send Jo’s academic reports.

The intersection with mental illness

Ellen’s mental health functioning as she navigated the criminal justice system has been conceptualised below in Figure 6.9.

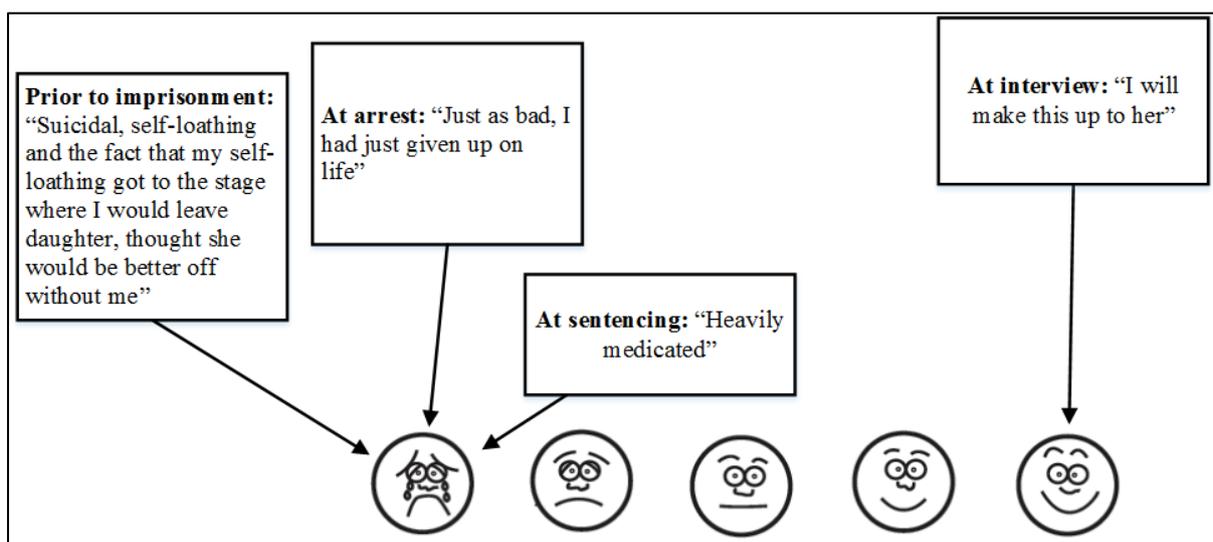


Figure 6. 9. Ellen’s self-reported level of mental health functioning as she navigated the criminal justice system.

As shown in the above figure, Ellen’s self-reported mental health was very poor prior to and at her arrest and sentencing; indicating high levels of distress as she entered prison. This is despite being under initially under the care of her GP, then a psychologist after her arrest, and taking prescribed medication. Ellen identified a number of factors that affected her mental health prior to incarceration, such as difficulty sleeping, feeling depressed, and her suicidal ideation. Furthermore, Ellen also identified that her gambling addiction also played a role.

During the interview, Ellen indicated that due to her high levels of personal distress, the only thing she could focus on was her daughter. In contrast, Ellen’s self-reported mental health was very good at interview. This improvement could be related to access to the prison mental health service. However, it could also be related to the removal of multiple stressors that underpinned her life in relation to her daughter and her offending.

Post-release plans

After her release, Ellen will return to her ex-husband’s house as she reported that she is on a long waiting list for housing, with custody of her daughter yet to be decided. Ellen concluded the interview reporting, “I will make this up to her”.

Summary of Ellen’s care planning experiences

The factors affecting Ellen’s engagement with and participation in the criminal justice system to plan Jo’s care are conceptualised below in Table 6.9. This table shows the individual factors and resources as well as systemic responses that allowed Ellen to make a secure care arrangement for Jo, and be highly involved in the decision making process.

Table 6. 9. Summary of the factors underpinning Ellen’s care planning process for Jo.

	Stable care arrangements:	Mediated by:
Individual factors	<ul style="list-style-type: none"> • Mother was the main decision maker 	<ul style="list-style-type: none"> • High levels of personal distress – symptoms of depression, difficulty sleeping, and suicidal ideation • Medication use, and side effects • Gambling
Individual resources	<ul style="list-style-type: none"> • Having some time to plan – 15 months 	<ul style="list-style-type: none"> • Access to a psychologist • Supportive mother and received assistance from daughter’s father despite problematic relationship • Both informal and formal supports assisted the mother in making the care decisions
Systemic responses	<ul style="list-style-type: none"> • Mother bailed into the community 	<ul style="list-style-type: none"> • Invisibility of mental health issues at arrest, but not at sentencing • Inconsistent responses to parenting status. • Legal representative who worked with psychologist - partnership

Due to her high levels of personal distress, Ellen experienced difficulty engaging with the criminal justice system. She used medication to deal with her interactions with the police and

during her trial and sentencing, often disconnecting herself from these experiences. Despite her high levels of distress, and with assistance from both her informal networks and from her psychologist and legal representative, Ellen was able to develop a care arrangement for Jo has remained stable and secure for the duration of her imprisonment. This highlights the importance of partnerships between the mother, and her informal supports. Such partnerships provided a buffer to the high levels of personal distress experienced by Ellen, and result in Ellen being happy with Jo's current care arrangement, as well as satisfied with the overall care planning process.

The two extreme case examples highlight the mothers' experiences of low and high involvement in the care planning process. Jody's case highlights the crisis that occurs when the mother has no time to plan care. As a result, Jody did not know about the care and safety of her daughter for a significant period of time following her imprisonment. Importantly, Jody's case highlights how the responses of the criminal justice system at the point of a parent's removal have severe consequences for the family unit. In contrast, Ellen's case highlights the importance of time in developing secure care arrangements. Ellen received bail, therefore she was able to develop care plans for Jo prior to their separation. Furthermore, Ellen represents the only participant whose formal support assisted the care planning process. Her psychologist worked in partnership with Ellen, and her informal supports, and with her legal representative to ensure that Ellen was prepared for the possibility of prison, and to ensure that care plans were in place; highlighting the important role formal supports can have in drawing attention to and assisting the care planning process. Furthermore, both extreme case examples noted the improvement in the primary mother's mental health at imprisonment, compared to pre-prison, and at arrest, and sentencing. Gender-responsive programs and practice may have played a role in this improvement.

6.3 Gender-responsive prison practice

The previous discussion has highlighted that responses to the primary mother's mental health status and parenting responsibilities are inconsistent at the points of arrest and sentencing, highlighting the general invisibility of these issues at these time points. However, this invisibility is less evident upon their imprisonment. Therefore, this section examines the primary mothers' engagement with prison-based programs that support their mental health and parenting status. This addresses in part, the fourth subsidiary question: 'How does the criminal justice system respond to this group of imprisoned mothers with a mental illness?'

6.3.1 Programs that acknowledge health and welfare

As shown in Chapter Two and Three, prison programs that address mental health issues are an important component in ensuring gender-responsive practice within prisons. Therefore, access to and the use of such services for primary mothers is important, considering the qualitative analysis has highlighted the impact of the primary mothers' high levels of distress, not only on their mothering prior to imprisonment, but also on how they participate in the criminal justice system processes, and plan the care of their children.

Nineteen primary mothers (or 90.5%) reported that they used a mental health service during their imprisonment. As shown below in Table 6.10, the most commonly reported service was the psychologist.

Table 6. 10. Prison based mental health service use by the primary mothers (N=21).

Prison mental health service use	Total n (%)
Psychologist	11 (52.4)
Other service use	7 (33.3)
Marrmak (inpatient or outpatient)	5 (23.8)
Mental health nurse	5 (23.8)
Psychiatrist	4 (19)
No service use	2 (9.5)

Note 1: A number of participants reported more than one service, therefore the number of responses is greater than the number of participants who reported service use.

Note 2: 'Other service use' includes the prison health service (n=4), Out of the Dark family violence program (n=2), and Thomas Embling Hospital (n=1).

Two mothers reported that they did not access a mental health service, with PM17 reporting why: "You don't get much in here unless you're drug addicted or alcoholic". The two mothers who did not access prison based mental health services did access such services in the community (e.g. GP, psychologist, and the CATT team), and indicated they would return to these services upon their release. Furthermore, these two participants reported that they were currently taking mental health medication during their imprisonment, indicating some form of service use. In addition to this service use, Figure 6.10 below shows the use of mental health medication prior to and while in prison.

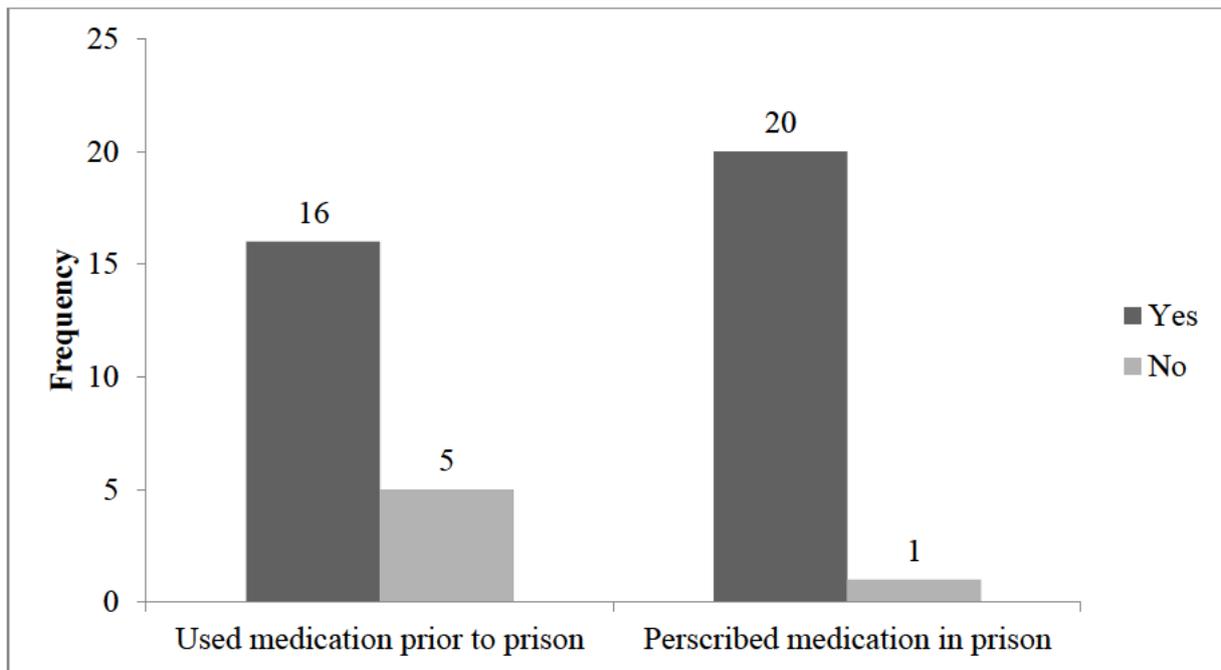


Figure 6. 10. Primary mothers' ($N=21$) medication use prior to prison and in prison.

As mentioned in the previous chapter, three-quarters of the primary mothers were prescribed medication prior to imprisonment, with this number increasing upon imprisonment. All but one participant who did not use medication prior to prison, used it in prison. In addition, over half of the mothers (60%, $n=12$, $N=20$) reported that their medication changed at some point during their imprisonment. This was because the mothers chose to reduce the dose or chose to cease taking the medication ($n=4$); the brand/type of medication used prior to prison was not available in prison ($n=4$); and lastly four mothers reported negative side effects of the medication. In addition, three primary mothers highlighted the difficulties experienced when their medication changed during the transition into prison:

“Every time I go in they take me off Avansa [an antidepressant], it makes me go crazy, can't sleep, you shake, it's terrible. It's a time [prison] when you want your family and you get more depressed. Not a time to change” (PM1)

“[Medication used prior] stopped completely, I did get Valium; I didn't sleep properly, I felt nervous for a long time” (PM2)

“I wanted to continue it when I was at Deer Park [DPFC] but needed to contact GP and I came in on a weekend, so was on different medication for two weeks. It's a terrible system” (PM19)

One mother reported that she was not prescribed mental health medication prior to and while in prison, describing that she chose not to after been informed of the potential side effects by her sister who is a pharmacist. Instead, she accessed a psychiatrist while incarcerated.

Reflecting the results above, nine primary mothers indicated that going to prison provided them with access to relevant services and treatment. For example:

“Gaol is the only place I find where I can get help” (PM1)

“As a child, [I experienced] sexual abuse, but I didn’t realise it was that until I thought about it. Never really told anyone until I came into the drug unit” (PM7)

“There is stuff in here, you just gotta want to do it” (PM14)

In addition, participation in the domestic violence program ‘Out of the Dark’ allowed PM21 “to open up and get everything out that I have had for a long time”. Importantly, PM6 reported that she was first diagnosed when she came into prison:

“I didn’t know I had a mental illness. I was unaware of it until I came to prison....”

“...My mental state deteriorated whilst I was on remand, it deteriorated even further in 2002 when I was found guilty, to the point that I had a complete break down and ended up at Thomas Embling... I was put on psych meds and over the years it has changed until they stabilised me. It took me until last year [2012, from 2000, with five admissions in total to Thomas Embling Hospital] to stabilise me. I was at Marmak and for years I suffered [from the wrong treatment] then the moment I changed to [a new type of medication], I’ve been stable ever since”.

Therefore, in many respects, prison provided the primary mothers with some form of mental health service. For example, the two primary mothers who reported no mental health service use prior to their imprisonment (as mentioned in ‘Section 6.1.3 The primary mothers pre-prison service utilisation’) accessed services while in prison, and all but one participant who reported no medication use, accessed medication while in prison.

Access to such services and medication may explain the primary mothers’ improvement in their level of mental health functioning as they progressed through the criminal justice system. This is shown below in Figure 6.11, where the primary mothers were asked to quantify their self-reported level of mental health functioning prior to, at arrest, during their

trial and sentencing, and at imprisonment on a five-point Likert scale ranging from one (very poor) to five (very good).

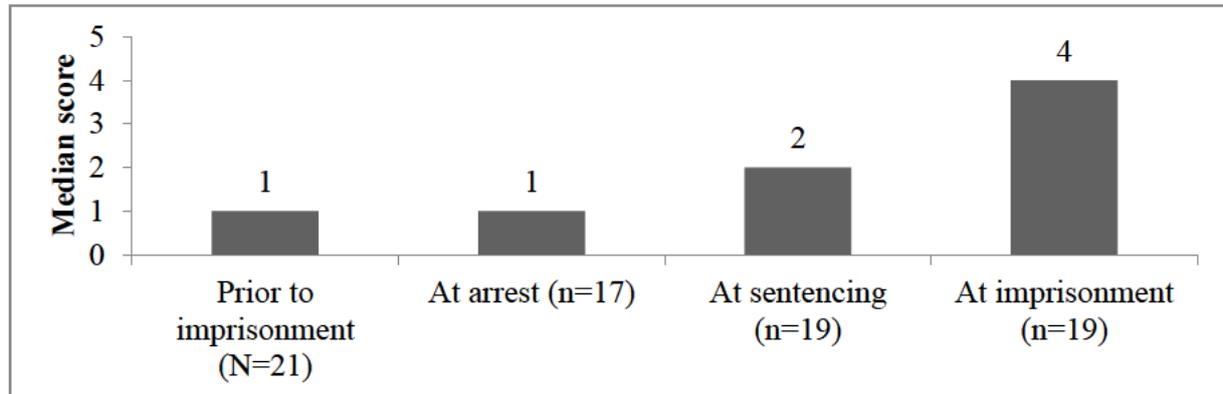


Figure 6. 11. The primary mothers’ median score as they navigated the criminal justice system.

As the above Figure 6.13 highlights, the primary mothers’ self-reported level of mental health functioning improved as they moved through the criminal justice system (refer to Appendix 12 for the frequency of responses to this Likert scale). A Wilcoxon Signed-Rank Test was performed to determine if there were any significant differences between the mothers’ self-reported level of mental health functioning at these four stages of the criminal justice system (see Chapter Four for the discussion on this analysis). Therefore, six analysis were undertaken to compare the self-reported level of mental health functioning: prior to imprisonment and during imprisonment; at arrest and during imprisonment; at sentencing and during imprisonment; prior to imprisonment and at arrest; prior to imprisonment and at sentencing; and lastly, comparing the level of mental health functioning between arrest and sentencing. The results from these tests are displayed below in Table 6.11.

Table 6. 11. Wilcoxon Signed Rank Test scores for the primary mothers’ self-reported level of mental health functioning as they navigated the criminal justice system.

Level of mental health functioning at:	Z	p	r
1 Prior to imprisonment and during imprisonment	-3.41	.001**	.54
2 Arrest and during imprisonment	-3.41	.001**	.57
3 Sentencing and during imprisonment	-3.45	.001**	.55
4 Prior to imprisonment and arrest	-1.29	.20	.21
5 Prior to imprisonment and sentencing	-.58	.57	.09
6 Arrest and sentencing	-2.12	.04*	.58

Note: *<.05; **<.01

As shown above in Table 6.11, the mental health status of the primary mothers significantly improved as they navigated the criminal justice system. Self-reported level of mental health functioning was higher during imprisonment (at interview, at least three months into sentence) (Mdn= 4) compared to prior to imprisonment (Mdn =1), or arrest (Mdn =1), or sentencing (Mdn= 2). Furthermore, their level of mental health functioning was also significantly higher at sentencing (Mdn= 2) compared to the stage of arrest (Mdn= 1). This result supports the qualitative discussion throughout this chapter regarding the levels of personal distress experienced by the primary mothers pre-prison, and at arrest and sentencing, and provides quantitative evidence that the mothers' self-reported levels of distress improve at imprisonment.

However, the factors behind this improvement are unclear. A limitation of this present study is that the primary mothers were not specifically asked what factors affected their mental health at imprisonment. This was not the key focus of the study and was therefore not explored in depth. Qualitative analysis of data from all 21 primary mothers indicates that the improvement in the level of mental health functioning could be related to the previously discussed access to prison-based mental health services, including medication. In addition, the narratives of three primary mothers also indicated that prison provides a 'break', with two of these mothers describing that this break allowed them to reflect on their behaviour:

“[Participant was at the Koori court where the judge said], hopefully this time will make me a better mum, in the back of my head, I knew it was true, [I was] running amok and leaving it to mum” (PM11)

“Prison was a break to get my head together – did I want to be a mum or did I want to be a part-time mum?” (PM20)

This improvement could also be linked to the primary mothers' knowing the outcome of their legal issues and no longer living in uncertainty, or may be linked to the knowledge that their children are safe. In addition, this improvement could also be linked to access to programs that support the primary mothers parenting status.

6.3.2 Programs that acknowledge primary carer status

Programs that acknowledge the primary carer status of the mothers include contact maintenance programs, and parenting programs.

6.3.2.1 Contact maintenance programs

The primary mothers were asked to describe what parenting role they had over the course of their imprisonment. Their responses were grouped according to the three main themes underpinning their descriptions and are presented below in Figure 6.12.

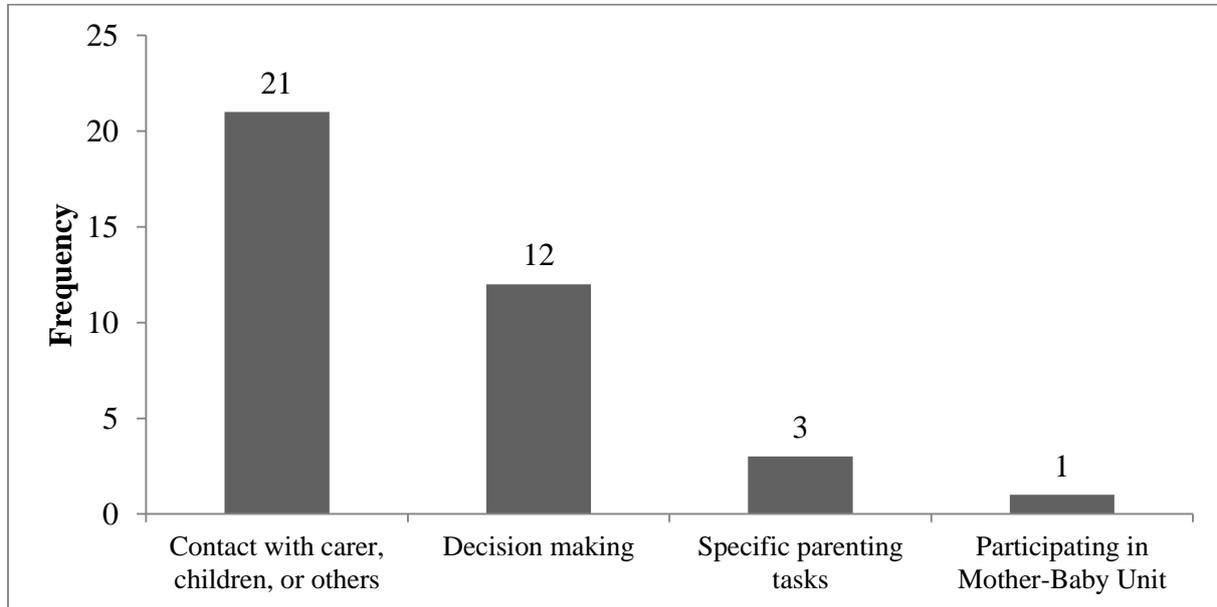


Figure 6. 12. The primary mothers ($N=21$) descriptions of their parenting roles during imprisonment.

As shown in Figure 6.12 above, all participants described keeping in contact with their children via phone calls, visits, and/or letters, as well as with their children’s carer, and/or with a significant others (e.g. children’s school). In addition, 12 mothers discussed their decision-making capabilities, with only five mothers reporting that they were still involved in the decision making process for their children. For example, PM3 highlighted: “Decision making, what she does, where she goes, when and how”. The remaining seven participants reported that their decision-making capabilities were rather limited. This was typically due to relationship difficulties with the children’s carers:

“Carers wouldn’t talk to me, they refused. The court order said they were required to talk to me, but they kept on breaching the court orders” (PM6)

“I don’t really talk to my mother, we are not really that close. I tried but mum wanted to do it her way, I don’t know if she does the stuff I say” (PM10)

“May have a parenting role but whether your wishes are adhered to are a different matter. Sometimes people just tell you what you want to hear” (PM16)

“I don’t have much control now they are in other people’s hands. They are dictating the schedules and ignoring my wishes, it is frustrating” (PM19)

“Can’t make any decisions, my sister and mum has a schedule so anything I want needs to fit the schedule. They [sister and mum] make all the decisions, I have no say, it’s hard because I have no power over my children” (PM20)

Therefore, the primary mothers’ relationships with their social resources mediate their relationships with their children during their sentence. This can be problematic as the narratives of nine mothers highlight difficult relationships with their children’s carers such as family members (n=4), fathers (n=3), and foster carers (n=1).

In addition, two primary mothers reported that they were only involved in major decisions such as deciding where their children would go to school, as PM18 acknowledged “No day-to-day decision-making, only on the big things”. Three primary mothers’ also described specific parenting tasks such as engaging with schools, completing homework together, and setting rules. Only one mother was participating in the prison Mother-Baby Unit at Tarrengower therefore; she was actively involved in the day-to-day care of her child.

As previously mentioned, and as shown in Figure 6.13 below, all primary mothers described some form of contact with their children, and/or their children’s carer. As the majority of the mothers (81%, n=17) reported more than one form of contact, the number of responses is greater than the number of mothers who reported service use.

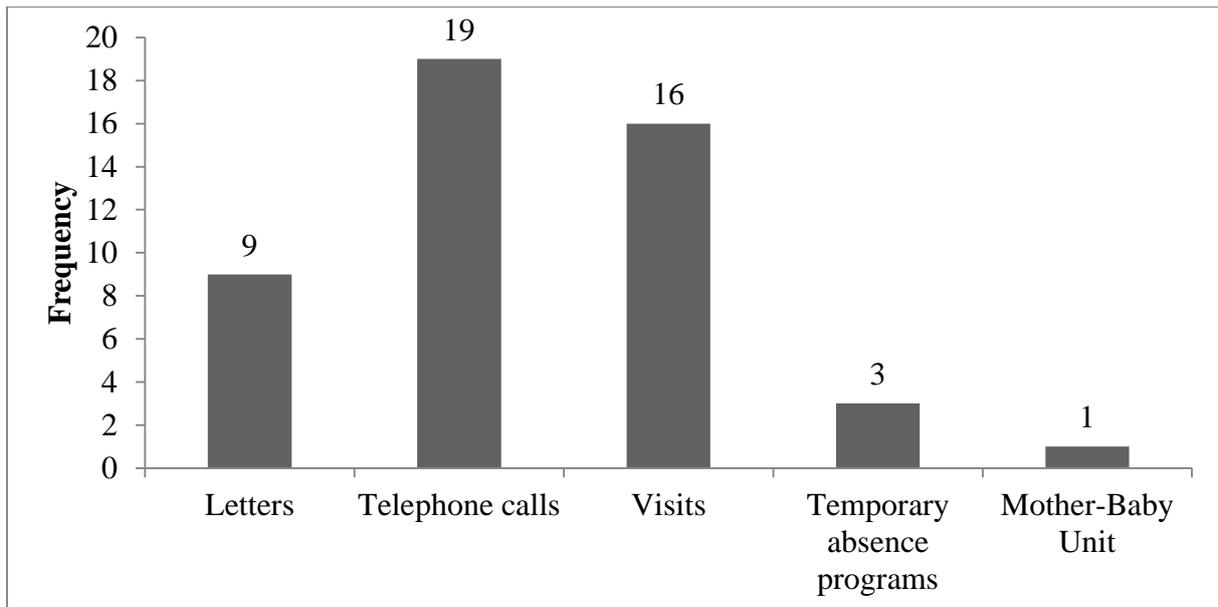


Figure 6. 13. Types of contact maintenance programs reported by the primary mothers (N=21).

As shown in the above figure, telephone calls and visits were the most utilised programs. However two primary mothers reported that cost was often a barrier to telephoning children, as well as the children’s age (n=1), and desire to talk on the phone (n=1). Furthermore, PM19 reported “rang them a couple of times but it just upsets them [her children]”. Carers typically facilitated visits, but two mothers reported that other family members and/or a community-based program (e.g. Prison Network Ministries) facilitated their visits. Two mothers reported that statutory child protection services provided supervised access to their children. Three mothers also reported that their children were reluctant to visit:

My biggest hurdle was getting her [daughter] for a visit due to her reluctance, if it wasn’t for [Prison] Network Ministries, I wouldn’t see her. It’s hard enough to only see her twice a month (PM9)

“Previous sentences [daughter] visited. [Daughter] no longer wants to come in” (PM14)

“[Son] doesn’t like coming here and [daughter] comes when she can” (PM16)

This reluctance may be related to the prison environment, as PM17 highlighted “It’s hard for your kids to see you in those green jumpsuits”. This mother also discussed the inability to

“bring in favourite toys or books in to the visits centre” and the lack of healthy food available in the visits centre.

In addition, three mothers reported that distance was a barrier to their children visiting:

“Help with transport to Tarra [Tarrengower]. I saw him once at DPFC because his mentor brought him in” (PM1)

“There is nothing you can do because you are here. They live too far away and my mum works so I only see them once a month” (PM10)

“Because it’s far for my family, 2-4 hour drive, so speak on the phone once a week” (PM20)

Four mothers reported limited contact with their children. For PM3 this was because “daughter does not know I’m in here, she thinks I’m on a holiday interstate as she didn’t like visiting last time”. Instead she calls her daughter, and is in regular communication with her daughter’s carers. In addition, PM5 has only spoken to her daughter once during her imprisonment, but sends letters and receives weekly calls from her daughter’s carer, with PM4 reported that initially due to problems with carers she only had three calls and four visits a year. But due to her lengthy sentence this has changed over time, with the mother now reporting that she now has “unlimited [contact]. That’s because they’re living together. Court orders are until they are 18, but since they’re living together I’ll talk to them when I want”. There were also differences between participants’ locations, as the only primary mothers who accessed Temporary Absence Programs (n=3), and the Mother-Baby Unit were located at Tarrengower (n=1).

6.3.2.2 Programs that acknowledged parenting status

As shown in Chapter Two and Three, prison parenting programs are an important component in ensuring gender-responsive practice within prisons. Fifteen primary mothers (71.4%, N=21) reported that they accessed some type of program that acknowledged their primary carer status, with 11 also reporting that they accessed more than one program. The programs accessed are shown below in Table 6.12, with parenting programs and the Family support worker being the two most commonly reported parenting service accessed.

Table 6. 12. Prison based parenting programs used by the primary mothers (N=21).

Programs that acknowledge primary carer status	Primary mothers n (%)
Parenting education	7 (33.3)
Family support worker	7 (33.3)
No service use	6 (28.6)
Fun with Mum	5 (23.8)
Shine for Kids	3 (14.3)
Other program*	3 (14.3)
Mother-baby program	1 (4.8)

Note: *Other includes counselling services, Prison Network Ministry, and aboriginal services.

All of the programs reported by the primary mothers, as listed in the figure above, have slightly different purposes. For example, Fun with Mum and SHINE for Kids represent informal visiting programs for mothers and their children; parenting education programs are focused on improving their parenting skills and knowledge; the Family Support Worker supports mothers in the parenting role; and lastly the Mother-Baby program provides a specialised unit that allows young children to reside with their mother during her imprisonment.

As shown in Table 6.12, the primary mothers were most likely to report accessing parenting programs, and a family support worker. Only one primary mother (PM17) reported using the Mother-Baby Unit despite six other mothers having seven children aged less than four years. Indeed, PM10 reported that she applied but was declined, however she did not elaborate on why this was, with PM7 in the process of applying to the unit at the interview.

In addition, 14 primary mothers discussed the helpfulness of these programs, with the majority reporting (92.9%, n=13) that such programs were helpful. This was because the programs provided parenting advice, assistance with and access to children, as well as emotional support. For example, PM12 reported that the family support worker was “great, tie up a lot of loose ends to put your mind at ease, any doubts they chase it up”, while PM17 highlighted the benefits of the Mother-Baby Unit “I hold [worker] on a pedestal, [son] has more in here than ‘out there’, story time, play group, and it keeps us mothers sane”. The one mother who reported that such programs were not helpful related this to the age of her children as her children were now older and the programs are typically aimed at primary

school children and younger, and to the length of her sentence. Six mothers reported that they did not access these services. As PM20 reported “I don’t think I need it”.

This discussion has highlighted that despite the general invisibility of participants’ mental health and parenting responsibilities at arrest and sentencing, this invisibility is less evident in the prison system. Both prison settings provide the mothers with access to mental health support, including services and medication, and provided access to a number of programs that assisted the mothers in maintaining some form of connection with their children. These programs may explain why the mothers’ level of mental health functioning improved during her imprisonment, compared to the high levels of personal distress that underpinned the primary mothers’ experience prior to imprisonment. Indeed, such programs are important as the primary mothers reported in most case that their children (70.3%, n=26, N=37) would return to their care following their release from prison.

6.4 Summary and Conclusion

The previous chapter noted the similarity in the characteristics of the primary and comparison mothers and the subtle differences. This chapter built upon this result and highlighted that the one important difference between the primary and comparison mothers, outside of their mental health status, is that the primary mothers are significantly more likely to report low involvement in the care planning process for her children. This suggests that their ability to engage with the criminal justice system to adequately respond to the care and safety needs of her children is compromised. Therefore, this chapter described and examined the experiences of mothers with a mental illness as they intersected with and navigated the criminal justice system.

To address subsidiary question two ‘What is the relationship between mental illness and motherhood as women intersect with the criminal justice system?’ the findings presented, show that mothers parent within challenging and multi-problem circumstances. Personal distress was the commonly identified theme within their narratives, with distress interlinked with experiences of grief and loss, and substance abuse, amongst other issues. Difficulties within their informal support networks, such as relationships marred by conflict, added complexity to their lives, with the mental health services accessed often responding to their mental health status independent of their parenting and offending needs. Mothers with a mental illness also appear to function rather poorly in the community despite some

connection to services and informal supports. These challenges provided a distinctive way for this group of women to commit crime and journey through the criminal justice system.

To address subsidiary question three ‘What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system?’ the findings presented in this chapter identified the role of individual factors and resources, along with systemic responses. Indeed, individual factors, particularly high levels of distress and substance use, as well as resources such as social supports, time, and knowledge represent the factors that the primary mothers bring with them as they navigate the criminal justice system. Their participation is also affected by how the criminal justice system often fails to identify and respond to the specific needs of this group. These factors had consequences for the children in regards to the stability and security of their care arrangements. Most children did not have secure care arrangements in place when their mother was taken into custody.

In order to answer the final subsidiary question, ‘How does the criminal justice system respond to this group of imprisoned mothers with a mental illness?’ the findings showed that this system responds poorly to this group at the stages of arrest, and during her court appearance and sentencing. Indeed, their parenting status and mental health issues are relatively invisible. However, prisons are better equipped to respond to this group of mothers, as they provide a number of mental health and parenting programs. Such access may explain in part why the primary mothers levels of distress improved significantly during their imprisonment.

This chapter described and examined the experiences of the primary mothers. The final results chapter builds upon this and examines the complexity and diversity within the experiences of this group of participants.

Chapter Seven: Examining Complexity within the Primary Mother Group

“It is not our differences that divide us. It is our inability to recognize, accept, and celebrate those differences”

Audre Lorde

Chapter Five noted the similarities and subtle differences that exist between the primary and comparison mothers, with Chapter Six highlighting that the primary mothers were significantly less involved in the care planning process for their children, due to the interplay between individual factors, and resources as well as systematic responses. This suggests that differences exist in how the primary mothers engage and participate within the criminal justice system to plan their children’s care arrangements. Therefore the purpose of this chapter is to examine the within group differences, rather than the between-group differences that directed the previous chapters.

Spierings (2012) advocated that quantitative analysis can be used effectively to examine the complexity and diversity that exists within a participant group. Therefore a within-groups analysis, as outlined in detail in Chapter Four, was conducted to examine whether having comorbid mental illnesses (Sub-group one), or high/low prevalence disorders (Sub-group two), or substance use (Sub-group three) added greater difficulty to the primary mothers’ navigation through and participation in this system. To respond to subsidiary question three: ‘What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system’ this chapter includes a quantitative examination of the primary mothers’ experiences at arrest, and during their hearing and sentencing with respect to how they can plan the care of their children. All non-significant results have been noted, with the non-significant analyses located in Appendix 13.

7.1 Association between the primary mother sub-groups

In order to ensure that the primary mother Sub-group one (comorbid mental illness), Sub-group two (high/low prevalence disorders), and Sub-group three (substance use) were independent, a Fisher’s Exact Test examined the relationships within these sub-groups, with the results displayed below in Table 7.1.

Table 7. 1. The associations between the three primary mother sub-groups.

Test:	p	φ
Sub-group 1 and Sub-group 2	.66	.12
Sub-group 1 and Sub-group 3	1.00	.09
Sub-group 2 and Sub-group 1	.66	.12
Sub-group 2 and Sub-group 3	1.00	.07
Sub-group 3 and Sub-group 1	1.00	.09
Sub-group 3 and Sub-group 2	1.00	.07

As shown in the above table, there were no relationships between each of the three primary mother sub-groups; therefore, it is reasonable to assume that these groups do not intersect in a significant way. Appendix 13 includes more detail on these non-significant results.

7.2 Participation within criminal justice system

As the previous chapter highlighted, the primary mothers, when compared to the comparison mothers, were significantly more likely to report low involvement in arranging their children’s care. Therefore, this result was also analysed by the three primary mother sub-groups, with the results displayed below in Table 7.2.

Table 7. 2. Level of involvement in planning the placement for each child (N=37) by the three primary mother sub-groups.

		Low involvement		High involvement		Test	
Primary mother sub-groups		n	(%)	n	(%)	p	φ
1	Did not report comorbid mental illness	12	(60)	8	(40)	.75 ^a	.07
	Reported comorbid mental illness	9	(52.9)	8	(47.1)		
2	Low prevalence disorders	7	(77.8)	2	(22.2)	.25 ^b	.24
	High prevalence disorders	14	(50)	14	(50)		
3	Did not report problematic substance use	9	(90)	1	(10)	.02 ^{b*}	.41
	Reported problematic substance use	12	(44.4)	15	(55.6)		

Note: ^aChi-square test for independence; ^bFisher’s Exact Test
 Note 2: * <.05

As shown in Table 7.2, there is no significant relationship between the primary mother Sub-group one and two and their level of involvement in planning each child's care. However, a Fisher's Exact Test indicates that there is a significant relationship between Sub-group three and their levels of involvement in planning each child's care, $p < .05$, with a moderate effect size $\phi = .41$. Therefore, unexpectedly, primary mothers who did *not* report problematic substance use were more likely to report low involvement in planning each of their children's care (90%, $n=9$, $N=10$), than mothers who reported problematic substance use (44.4%, $n=12$, $N=27$). This result may be influenced by the decision-making capacity of this group of participants. A Fisher's Exact Test indicated that there was a significant relationship within Sub-group three and the mothers ability to be the main decision maker, $p < .05$, with a moderate effect size, $\phi = .59$. Therefore, primary mothers who did not report problematic substance use were significantly more likely to report that others made the care decisions for their children (80%, $n=8$, $N=10$) compared to mothers who reported substance use (37%, $n=10$, $N=27$).

This result could relate to the partner status given a Fisher's Exact Test indicated that primary mothers who did not report problematic substance were significantly more likely to be partnered, $p < .05$, with a large effect size, $\phi = .59$. However, further analysis revealed that partners rarely made the care decisions. For the ten children of mothers who did not report a problematic substance use, statutory child protection services made the care decisions for six children, the other parent made the care decisions for two children, and one mother made the care decision for the remaining children. Indeed, a Fisher's Exact Test indicated a significant relationship between statutory child protection involvement and mothers who did not report problematic substance use, $p < .05$, with a moderate effect size, $\phi = .45$. Therefore, mothers who did not report substance use were more likely to report that child protection services were involved in the care planning process (60%, $n=6$, $N=10$), than mothers who reported substance use (14.8%, $n=4$, $N=27$). This suggests that despite the partnered status of this group of primary mothers, they experience issues within their informal supports when arranging care that requires formal intervention. Therefore, resources outside of the family unit are important in care planning.

The time available (e.g. 'no time' versus 'some time') to the primary mother after contact with the police was identified in Chapter Six as a factor that influenced their participation in planning the care of their children. Particularly important was that 'no time' was significantly associated with being taken into custody following arrest and having 'some time' was

associated with being bailed into the community. There was however no significant difference in the three primary mother sub-groups and the time given to plan children's care, or whether they were taken into custody or not (refer to Appendix 13 for details). This suggests that having 'no time' was a more generalised experience for the primary mothers remanded in custody, regardless of their sub-group status.

7.2.1 Systemic responses of the criminal justice system

Chapter Six showed how systemic awareness of and responses to mental illness and parenting at arrest and sentencing are factors that mediated the primary mother's navigation of the criminal justice system. There was however no significant differences between the three primary mother sub-groups and police awareness of mental illness, the impact of mental illness on participation in the interview with police, or the acknowledgement of mental illness during the court case. There were also no significant differences between the primary mother sub-groups and the police awareness of primary carer status; inquiry into the children's care; or the presence of children at arrest; with more detail on these non-significant results in Appendix 13. Such results suggest that these experiences were also generalised for all primary mothers.

However, there were significant differences in two factors: the location of the arrest, and discussions with legal representatives about the possibility of a prison sentence. One further analysis, examining the primary mothers' participation in their interview with police', fell just outside the conventional significance level of $p < .05$. All three will now be discussed

Location of arrest

As Chapter Six highlighted, just over one-half of the primary mothers were arrested outside their home. The location of arrest has implications for arresting police officers 'seeing' children, as the home will typically contain visual clues (i.e. children's toys and photos) as to the parenting status of the arrestee. Therefore, arrest location was analysed by the three primary mother sub-groups, with the results displayed in Table 7.3 below.

Table 7. 3. Location of arrest by the three primary mothers' (N=20) sub-groups.

Primary mother sub-groups	Home		Outside the home		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	7	(63.6)	4	(36.4)	.37	.30
	3	(33.3)	6	(66.7)		
2 Low prevalence disorders	-	-	5	(100)	.03*	.58
	10	(66.7)	5	(33.3)		
3 Did not report problematic substance use	3	(50)	3	(50)	1.00	.00
	7	(50)	7	(50)		

Note: <.05

As shown above in Table 7.3 there was no significant relationship between the primary mother Sub-group one and three and whether they were arrested at home or elsewhere. In contrast, a Fisher's Exact Test indicated that there was a significant relationship within sub-group two and the location of their arrest, $p < .05$, with a strong effect size, $\phi = .58$. Therefore, the mothers who reported a low prevalence disorder (e.g. Schizophrenia or Bipolar Disorder) were significantly more likely to be arrested outside the home (100%, $N=5$), than mothers who reported a high prevalence disorder (33.3%, $n=5$, $N=15$). Whilst the reason for this relationship is unclear, it may be related to the actions and behaviour of mothers who report low prevalence disorders, perhaps calling attention to themselves in a public environment and then being arrested. Arrests in a public environment, away from the home, can indicate challenges for the mothers, as these arrests are typically not planned.

Participation in the police interview

Just over one-half of the primary mothers (60%, $n=12$, $N=20$) reported that their mental health status affected their participation in their interview with the police. Of these 12 mothers, five reported a low prevalence disorder. As shown below in Table 7.4, this result fell just outside the conventional significant level set at $p < .05$.

Table 7. 4. Impact of mental illness on the participation in the interview by the three primary mothers' (N=20) sub-groups.

Primary mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	6	(54.5)	5	(45.5)	.20	.33
Reported comorbid mental illness	2	(22.2)	7	(77.8)		
2 Low prevalence disorders	-	-	5	(100)	.06	.47
High prevalence disorders	8	(53.3)	7	(46.7)		
3 Did not report problematic substance use	1	(16.7)	5	(83.3)	.33	.31
Reported problematic substance use	7	(50)	7	(50)		

Note: * <.05

This result is worth examining, despite being not statistically significant, because every primary mother who reported low prevalence disorders reported their mental illness influenced their participation in the interview at the police station. This compares to the results from the mothers with high prevalence disorders, who were almost as likely to report that their mental health symptoms did/did not affect their participation in this interview. This suggests that the mothers who reported low prevalence disorders, with the associated symptoms, experienced difficulty engaging with the police during their interview.

Discussions with legal representation

As discussed in the previous chapter, approximately three-quarters of the primary mothers (76.5%, n=13, N=17) report being informed about the possibility of a prison sentence. In light of this, the results were analysed by the three primary mother sub-groups as displayed in Table 7.5.

Table 7. 5. Discussions with legal representative about the possibility of a prison sentence by the three primary mothers' (N=17) sub-groups.

Primary mother sub-groups	No, not informed		Yes, informed		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	-	-	9	(100)	.03*	.59
Reported comorbid mental illness	4	(50)	4	(50)		
2 Low prevalence disorders		-	3	(100)	.54	.26
High prevalence disorders	4	(28.6)	10	(71.4)		
3 Did not report problematic substance use	2	(40)	3	(60)	.54	.25
Reported problematic substance use	2	(16.7)	10	(83.3)		

Note: * <.05

As shown in the above table there was no significant relationship between the primary mother sub-group two and three and whether discussions occurred with their legal representation regarding the possibility of a prison sentence. In contrast, a Fisher's Exact Test indicates that there is a significant relationship within Sub-group one and these discussions, $p < .05$, with a strong effect size, $\phi = .59$. Therefore, the primary mothers who reported a comorbid mental illness were significantly less likely to report that they were informed about the possibility of a sentence (40%, $n=4$, $N=8$) than mothers who did not report comorbidity. This has implications for their ability to plan the care of their children. However, this result may also be an outcome of this group of mothers' failing to recall such discussions.

These results suggest, rather tentatively, that having complex mental health issues means the criminal justice system struggles to respond. The primary mothers who report low prevalence disorders were more likely to be arrested outside the home in potentially unplanned arrests and more likely to report that their mental health issues affect their engagement and participation in the interview with police. Whilst, this latter result was just outside statistical significance, it is highly likely that with more participants, this difference could have moved into the significant range. Finally, mothers who reported comorbid mental illness report

being less likely to be informed about the possibility of a sentence. Therefore, complex mental health issues add an extra level of vulnerability at the stages of arrest and sentencing.

A surprising finding of this analysis is that mothers without problematic substance use were significantly more likely to report low involvement in the care planning process. The independent nature of these three sub-groups, suggests for example that it is unlikely that the exact cause of this difficulty is related to this group of mothers also having low prevalence disorders. Therefore, other factors appear to be at play, with the design of this study unable to pick them up. However, such results could simply be the product of the relatively small sample sizes evident in the sub-groups. Therefore, caution must be taken when interpreting the results. This highlights an area for future research.

7.2.2 Outcomes for the primary mothers and their children

Chapter Six described the range of factors, resources, and responses that mediate the ability of the primary mothers to navigate the criminal justice system to plan the care of their children. This chapter also described how these experiences affected the primary mothers' ability to develop stable and secure care arrangements for their children, and the mothers' level of satisfaction with the resulting care plans.

There was no significant difference between the three primary mother sub-groups and the stability and security of care arrangements. However, there was a significant difference in the three sub-groups and their levels of satisfaction with the care planning process. There was also no significant difference in the primary mother sub-groups and their perceptions of the impact of their high levels of distress on the care planning process (more detail is available in Appendix 13).

Developing secure care arrangements for children

In Chapter Six, the impact of the care planning experiences of the primary mothers on their children's care was conceptualised as the stability and security of their care arrangements. Therefore, care arrangements was also compared across the three primary mother sub-groups. Whilst there was no statistical difference between the primary mother sub-groups, as Table 7.6 shows below, one result fell just outside the conventional significance level.

Table 7. 6. The stability and security of care arrangements per child (N=37) by the three primary sub-groups.

Primary mother sub-groups	Secure care arrangements		No care arrangements		Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	6	(30)	14	(70)	.19 ^a	.23
	9	(52.9)	8	(47.1)		
2 Low prevalence disorders	1	(11.1)	8	(88.9)	.06 ^b	.34
	14	(50)	14	(50)		
3 Did not report problematic substance use	3	(30)	7	(70)	.48 ^b	.13
	12	(44.4)	15	(55.6)		

Note1 : ^aChi-square test for independence; ^bFisher's Exact Test

Note 2: * <.05

This result is worth examining, despite not being statistically significant, like the participation in police interview, majority of primary mothers who reported low prevalence disorders reported that their child had no care arrangements when she was taken into custody. Whereas, the results from the mothers who report high prevalence disorders were divided between stable and unstable care arrangements. This suggests that children of mothers with low prevalence disorders may be more vulnerable to having no care arrangements in place.

Satisfaction with the care planning process

Chapter Six showed that while the primary mothers were generally happy with their children's current care arrangements, they were usually dissatisfied with the overall care planning process. This result was analysed by the three sub-groups, and displayed below in Table 7.7.

Table 7. 7. Satisfaction with the care planning process per child (N=34) by the three primary sub-groups.

Primary mother sub-groups		Dissatisfied		Satisfied		Test	
		n	(%)	n	(%)	p	φ
1	Did not report multiple mental illnesses	11	(61.1)	7	(38.9)	.49 ^a	.17
	Reported multiple mental illnesses	7	(43.8)	9	(56.2)		
2	Low prevalence disorders	7	(87.5)	1	(12.5)	.04 ^{b*}	.38
	High prevalence disorders	11	(42.3)	15	(57.7)		
3	Did not report problematic substance use	7	(70)	3	(30)	.15 ^b	.26
	Reported problematic substance use	11	(45.8)	13	(54.2)		

Note: ^aChi-square test for independence; ^bFisher's Exact Test

Note 2: * <.05

As shown in the above table there was no significant relationship between the primary mother Sub-group one and three and satisfaction with the overall care planning process. In contrast, a Fisher's Exact Test indicates that there is a significant relationship within Sub-group two and satisfaction, $p < .05$, with a moderate effect size, $\phi = .38$. Therefore, the primary mothers who reported low prevalence disorders were significantly more likely to report that they were dissatisfied with their overall care planning process (87.5%, $n=7$, $N=8$), than mothers who reported high prevalence disorders (42.3%, $n=11$, $N=26$). Chapter Six showed the satisfaction was associated with the stability and security of care arrangements, with the previous Table 7.6 also showing that mothers' who report low prevalence disorders, were more likely to report that their children experienced no care arrangements. It is likely therefore that these two findings are connected.

These results highlighted that within the primary mothers' sub-groups, their experiences as they navigated the criminal justice system had consequences for the stability and security of care arrangements for their children, as well as their level of satisfaction with the resulting care plans. The primary mothers who reported low prevalence disorders were more likely to be report that their children had no care arrangements upon their imprisonment, and that they were unsatisfied with the care planning process. However, the former result was just outside

statistical significance; but it is highly likely that with more participants, this difference could have moved into the significant range.

7.3 Summary and conclusion

In answering subsidiary question three: ‘What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system?’ these findings particularly highlight that having a low prevalence disorder, and rather surprisingly, having no substance use issues adds greater difficulty to the primary mothers’ navigation through and participation in the criminal justice system to plan the care of her children.

Mothers with low prevalence disorders represent a problem for the criminal justice system. They are more likely to be arrested in an unplanned way, outside of the home where their primary carer status is less obvious. This is due to the lack of visual clues (i.e. children’s toys and photos). In addition, they are more likely to report that their mental health issues affect their engagement with the police during the interview. They are subsequently less aware of these legal discussions. It is common for their children to have no care arrangements in place upon imprisonment. Such experiences may also explain these mothers’ significantly lower levels of satisfaction with the overall care planning process. Despite two results being just outside statistical significance, they suggest a greater level of complexity when this group of primary mothers navigates through the criminal justice system, which accumulates, and has consequences for themselves and their children. Mothers who have a low prevalence disorder clearly represent a small but vulnerable criminal justice group who needs specific attention.

A surprising result relates to mothers who do not report comorbid substance use. This suggests that it cannot be automatically assumed that the combination of these two issues (i.e. mental illness and substance use) results in a greater level of complexity and difficulty in navigating and participating in the criminal justice system. Mothers who do not report problematic substance use experience much more difficulty in the care planning process; they are significantly less likely to be involved in the decision-making for their children, with others, particularly statutory child protection services, making the care decisions. Lastly, this chapter identified that having comorbid mental illness does not reduce engagement and participation in the criminal justice system to plan the care of their children.

As previously mentioned, such results, while interesting, could simply be the product of the relatively small sample sizes evident within the sub-groups. Therefore, caution must be taken

when interpreting the results. What this chapter does highlight however is the need to examine the complexity and diversity that exists within a participant group, as well as important areas for future research.

This chapter builds upon the previous results chapters. Chapter Five highlighted the similarities and subtle differences that exist between the primary mothers and the wider female prison population. That chapter showed that the mothers' mental health was the only distinctive characteristic separating these two groups. Chapter Six specifically examined the experiences of the primary mothers as they navigate the criminal justice system, noting their lower levels of involvement in planning their children's care compared to the comparison mothers. This present chapter highlights the complexity within the primary mother groups, and shows the factors that add an extra level of difficulty to their navigation of the criminal justice system. Therefore, the results chapters moved from a between-groups, to a within-groups analysis, and highlights the heterogeneity evident within the experiences of the primary mothers. Indeed, mothers with a mental illness are not a homogenous population.

The next chapter discusses the findings presented in the three results chapters. This discussion includes a comparison to the issues raised in the research, policy, and practice literature, and reflects on the implications of these findings for practice going forward.

Chapter Eight: The Discussion and Conclusion

Little attention has been paid to imprisoned mothers who have a mental illness. This gap is evident in policy and practice, as well as research. Therefore, this study sought to examine this intersection and answer the core research question: ‘What are the experiences of mothers with a mental illness as they navigate the criminal justice system?’ In order to answer this question, this study also had four subsidiary questions: (1) What are the similarities and differences in the experiences of mothers with or without a mental illness as they navigate the criminal justice system? (2) What is the relationship between mental illness and motherhood as women intersect with the criminal justice system? (3) What are the factors that affect engagement and participation for mothers with a mental illness as they navigate the criminal justice system? And lastly, (4) How does the criminal justice system respond to this group of imprisoned mothers with a mental illness? It is anticipated that the outcomes of this study will highlight ways to improve how the criminal justice system responds to primary carer mothers with a mental illness as they engage with and move through this system.

In order to address subsidiary question one, Chapter Five examined the similarities and subtle differences that exist within the characteristics of the mothers with and without a mental illness, noting that mental illness was the only distinctive feature separating these two groups. Chapter Six, in answering subsidiary question two, examined the pre-prison lives of mothers with a mental illness, noting particularly the levels of personal distress evident in their narratives. Chapter Six also addressed subsidiary questions three and four, and investigated how the experiences of mothers with a mental illness at critical decision-making points mediated their ability to engage with and participate in the criminal justice system to plan the care of their children. Indeed, imprisoned mothers with a mental illness experienced greater difficulty planning their children’s care, compared to the comparison group. The mothers’ mental health and parenting needs upon imprisonment were also explored within this chapter. Lastly, Chapter Seven investigated the within-group differences of the mothers with a mental illness, highlighting the difficulties experienced by mothers who have low prevalence disorders, and surprisingly those who do not have comorbid substance use. This chapter addressed subsidiary question three.

This study can claim five substantive findings in relation to the experiences of mothers with a mental illness as they navigate the criminal justice system:

1. Whilst there is a level of similarity between imprisoned mothers with and without a mental illness, this similarity serves to hide the distinct needs of mothers with a mental illness.
2. Mothers with a mental illness experience high levels of distress prior to, at arrest, and during their court case and sentencing. Their experiences of distress, combined with other interlinked issues, reduce their engagement with and participation in the care planning process for their children.
3. There is a general invisibility of these mothers' issues at arrest and sentencing. In contrast, prisons are better able to respond, likely due to established gender-responsive practices that underpin correctional service delivery. This was evident in the mothers' improved mental health.
4. Mothers with a low prevalence disorder experience a greater level of vulnerability as they navigate the criminal justice system to plan the care of their children.
5. The appropriateness of community-based services accessed by mothers with a mental illness prior to imprisonment is questionable. Participants reported high levels of personal distress despite having access to mental health services; these services did not divert the mothers' away from the criminal justice system.

Therefore, this study finds that mental illness creates a barrier to engagement with and participation in the criminal justice system. This is due to the interplay between the needs of the mothers with a mental illness, especially those with a low prevalence disorder, and how the criminal justice system responds to these needs. As such, this chapter examines the findings of this study with links made to current Victorian policy and practice, as well as relevant literature. This chapter begins with a discussion of the individual factors and resources that the mothers bring with them into the criminal justice system. The chapter then moves on to discussing how the criminal justice system currently responds to this group of mothers. An examination of the implications of this study for policy and practice is also addressed, along with the strengths and limitations of this study, and areas for future research.

8.1 The experiences of mothers with a mental illness as they navigate the criminal justice system: Mental illness as an ‘invisible’ barrier

This study found that ‘on the surface’ mothers with a mental illness share many of the characteristics of the broader group of imprisoned mothers and women. These characteristics include age, ethnicity, offending (e.g. prior history of imprisonment, experiences of custody, and sentence length), and motherhood and parenting characteristics (e.g. partner status, age and number of children, and living arrangements prior to and during imprisonment). In many respects, the only distinctive difference is their mental health status. However, when looking at how these two groups interact with and participate in the criminal justice system, it becomes apparent that mothers with a mental illness are far less involved. This is because the individual issues experienced by these women intersect with a system that typically does not acknowledge or respond to them in any significant way. Therefore, this group of mothers are disadvantaged by their gender, and mental health status, as well as by the systems they interact with (e.g. mental health and criminal justice). This disadvantage has serious implications for their ability to plan the care of their children; over one-half of children had no care arrangements in place when their mother was imprisoned. No care arrangements can result in a crisis for the family unit; there is typically no time to plan, and significant others often stepped in to make care arrangements rather than the mother. Furthermore, the initial care arrangements made are often unstable over time, resulting in multiple moves for children during their mothers’ imprisonment. This present study however cannot comment on the quality and suitability of the resulting placements, as data was not gathered from the carers or the children.

8.1.1 Individual factors: Pre-existing problems, and mental health trajectories

Research highlights that women enter the criminal justice system with a wide variety of interlinked pre-existing problems, typically economic marginalisation (Baldry et al. 2006; Bloom et al. 2002; Corrections Victoria 2005, 2011; Holtfreter, Reisig & Morash 2004), substance use (Greene, Haney & Hurtado 2000; Johnson 2004a; Langan & Pelissier 2001; Laux et al. 2011), mental health issues (Australian Institute of Health and Welfare 2010; Butler et al. 2005, 2006; Fazel & Danesh 2002; Tye & Mullen 2006), and histories of victimisation (DeHart et al. 2014; Greene, Haney & Hurtado 2000; Johnson 2004a; Messina & Grella 2006; Messina et al. 2007). However, research examining the experiences of imprisoned mothers generally does not acknowledge these factors beyond noting them as demographic characteristics, whilst research examining imprisoned women typically does not

examine such factors in relation to the lives of the families pre-prison or with regard to the care planning process for children. While Flynn's (2008) research raised the possible impact of mental illness on care planning, highlighting that untreated or unacknowledged mental health issues hampered this process, this finding was based on an analysis of just six cases. The conclusion, therefore, was tentative.

Research that specifically examines the experiences of imprisoned mothers with a mental illness is limited, disjointed, and siloed. For example, three studies focus on parenting responsibilities within forensic settings (Chao & Kuti 2009; Cormac et al. 2010; Parrott, Macinnes & Parrott 2015); two focus on access to gender-responsive prison practice (Birmingham et al. 2006; Gregoire et al. 2010); and the remaining eight explore the relationship between experiences of distress and the mothers' separation from children (Fogel & Martin 1992; Houck & Loper 2002; Hurley & Dunne 1991; Lindquist & Lindquist 1997; Loper 2006; Loper et al. 2009; Roxburgh & Fitch 2013), or infrequent contact with children (Poehlmann 2005). There is only one study that specifically examines the pre-prison experiences of this group of mothers – Laux et al. (2011). That study limited its focus however to examining engagement with the mental health system, and noting areas for professional intervention. Therefore, this small body of research has tended to focus on the experiences during imprisonment, rather than key decision-making points in the criminal justice system, leading up to imprisonment. Once a mother is imprisoned, it is arguably too late, and too difficult, to plan the care of her children. Therefore, the current research fills this research gap in two ways. It represents the first study to specifically examine the intersection between motherhood and mental illness within the criminal justice system, by examining the key decision-making points of pre-prison, arrest, sentencing, and imprisonment. It also examines the impact of mental illness on the mothers' ability to negotiate care plans for their children. This study shows that mental illness, especially low prevalence disorders such as Schizophrenia, is a mediator of the mothers' trajectories through the criminal justice system.

Pathways research notes both motherhood and mental illness as contributing in some way to women's offending and imprisonment (Berry et al. 2009; Brennan et al. 2012; Lynch et al. 2012; Ross, Khashu & Wamsley 2004; Salisbury & Van Voorhis 2009; Salisbury, Van Voorhis & Spiropoulos 2009; Van Voorhis et al. 2010). This present study finds that a larger number of mothers with a mental illness attributed their experiences of personal distress to their offending pathways, rather than to their parenting responsibilities and children. This is due to the interlinked nature of personal distress with other individual and social factors such

as substance use, and informal supports, all which accumulate to provide women with individualised pathways into prison. The most commonly reported offence committed by this group of mothers was property crime, such as theft, deception, and handling stolen goods. These crimes may have an economic basis as only five mothers reported legal employment prior to their imprisonment. This supports previous research which highlights that mothers are more likely to be imprisoned for economically-driven crimes, rather than for other crimes such as violent offending, and drug offences (Berry et al. 2009; Ferraro & Moe 2003; Loper 2006). Therefore, this present study contributes to pathways research; it specifically examines the experiences of mothers with a mental illness as they intersect with the criminal justice system, and highlights the high levels of personal distress that underpins their offending. It also shows that property crimes are an important feature of this groups' offending.

The present study finds that mothers with a mental illness prior to imprisonment, at arrest, and sentencing, experience high levels of personal distress. This is evident in their narratives as well as in their self-reported level of mental health functioning at these stages. In comparison, previous studies simply focused on the stress associated with the possibility of a prison sentence (Healy, Foley & Walsh 2000, 2001; Laux et al. 2011; Zalba 1964). Lilburn (2000) however, highlights responsibility for children as a source of distress for mothers that distracts them from negotiating the criminal justice system; with mothers who had plans in place for their children having an 'easier' process at arrest, sentencing, and imprisonment. Therefore, this present study provides both quantitative and qualitative evidence of the distress experienced by mothers as they traverse the entire criminal justice system, particularly pre-prison, at arrest, and at sentencing. This study also finds that the mothers with a mental illness experience high levels of personal distress despite access to both informal and formal support prior to imprisonment.

8.1.2 Individual resources: Informal and formal assistance

Previous research highlights that imprisoned mothers negotiate multiple and often independent systems, including the mental health system (Lilburn 2000; Laux et al. 2011), prior to prison. They often have access to informal support, typically family members (Arditti & Few 2008; Hairston 2009; McIvor, Trotter & Sheehan 2009). Such resources are important as they can contribute to the care planning process for children. The findings from the present study offer support for this, and highlight that the mothers with a mental illness similarly have access to a range of informal supports such as partners, other family members, and friends, as well as to formal supports such as the mental health system.

8.1.2.1 Relationships with informal supports

Research highlights that imprisoned women often rely on informal support networks to care for their children during imprisonment (Glaze & Maruschak 2008; Hairston 2009; Mumola 2000; Trotter et al. 2015), however relationships with these supports are often ambivalent or strained (Arditti & Few 2008; Cunningham & Baker 2003; Enos 2001; Flynn 2012, 2013; Martin 1997; Sharp & Marcus-Mendoza 2001). This is evident in the present study. Whilst all mothers reported some form of informal support, typically from their own parents, partners, and significant others, these supports often made the women's lives more complex. This was because their relationships were often marred by conflict between the mother and significant others, or by other issues within the extended family network, such as imprisonment, substance abuse, or experiences of victimisation. Therefore, the mothers' relationships with others often compound the difficulties they experience. Despite these difficult relationships, the vast majority of children in this present study were placed with family members, highlighting the reliance on informal kinship care. Although not examined specifically in this study, these care patterns arguably support previous research which highlights that imprisoned mothers are generally mistrustful of services and are worried that children will be placed into foster care (Enos 2001; Healy, Foley & Walsh 2000, 2001).

When examining children's specific care arrangements, care by fathers was typically secure and underpinned by a clear care planning process. Care provided by grandparents, other family members, or statutory child protection services however, generally occurred as a response to a crisis: when there were no care arrangements in place upon the mothers' imprisonment. This suggests that fathers were generally not called on in a crisis but were able to be more actively involved when there was time and a clear care planning process. This represents a unique finding, as previous research generally focuses on care arrangements with grandparents; there is only a small body of evidence specifically examining the role of fathers (Enos 2001; Flynn 2012). This study provides evidence that fathers are involved, participate in arranging care, and then provide care for their children. Data indicates that mothers are generally satisfied with this process, and the resulting care arrangements. In contrast, Flynn (2012), reporting on her study with a small sample of adolescent children found that while fathers provided the majority of the children's care, both the mothers and their children expressed dissatisfaction or mixed feelings regarding these arrangements. As this present study did not include children, no comment can be made on the quality of these care arrangements from a children's perspective. In contrast, Enos (2001) noted that placements

with fathers generally occurred when there was no other option, with such placements generally not desired by the mothers. According to Enos (2001) this was because fathers were not involved in their children's lives prior to imprisonment, or were not seen to be adequate for the task of parenting. Indeed, many of the women in this present study described conflicted relationships with the fathers of their children.

This study provides evidence that fathers are typically not available in a crisis, but get involved when there is time and a planning process. Grandparents respond to the crisis, but they may not be able to sustain care arrangements over the longer term. Therefore, the care arrangements when there is no clear care planning process are more dispersed, with women having to negotiate with and rely on a range of people from within their extended family network. In addition to informal supports, the women also received support from mental health professionals pre-prison.

8.1.2.2 Access to mental health support

Previous research has highlighted that experiences of victimisation pre-date mental health issues, and that mental health issues predict offending (DeHart et al. 2014; Lynch et al. 2012). This suggests that successfully addressing mental health issues could potentially divert these women away from the criminal justice system. Previous research indicates that the majority of incarcerated women with a mental illness receive some form of mental health treatment prior to their imprisonment (Faust & Magaletta 2010; James & Glaze 2006; Lynch et al. 2012; Mundt et al. 2015; Sodhi-Berry et al. 2014). This trend is also noted specifically for imprisoned mothers (Laux et al. 2011), and is reflected in the present study. This present study however, and as well as previous research (Lynch et al. 2012; Mundt et al. 2015), also finds that service utilisation does not always appear to divert women away from the criminal justice system.

In the previous research, information regarding the specific service/s accessed is missing. For example, service use is often referred to in very general terms such as 'inpatient' or 'outpatient' treatment (Faust & Magaletta 2010; Mundt et al. 2015); or in more depth by acknowledging medication use; or engagement with an undisclosed mental health professional (James & Glaze 2006; Laux et al. 2011; Lynch et al. 2012). This is problematic as it implies that all services are 'equal'; providing the same treatment and bringing the same level of expertise into responding to the needs of incarcerated women. There is a need to understand the type and quality of services used as access does not always equate to

appropriateness. The present study explores what services the mother went to for mental health support pre-prison. It finds that the mothers generally access their local general practitioner (GP), a service that is not specifically acknowledged in the previous research on imprisoned women. This pattern reflects broader trends in service use by women in the community in relation to their mental health (ABS 2008). However, little is known about why women in the current study generally accessed their GP over any other mental health service. This therefore represents an area for future research.

In Australia, GPs are primary healthcare providers and act as gatekeepers to the larger health system, including the mental health system. Therefore, they are often the first health service accessed, and can provide mental health related care such as mental health care plans, medication, counselling, and advice (Britt et al. 2014). What becomes evident in this study is that this service responds poorly to the needs of imprisoned mothers with a mental illness. This is most likely due to the complexity underpinning this specific group, as well as to the limited time available for GP consultations, long waitlists for specialists, a practice workload that is broad in nature, and inadequate GP knowledge of mental illness (Richards et al. 2004). This present study finds that access does not appear to help reduce distress, or respond to issues such that mothers are diverted away from offending. Indeed, this study showed that high levels of distress evident prior to imprisonment, and at arrest and sentencing despite service utilisation. This is likely to be linked to the women's pre-prison contexts, which noted considerable substance use and experiences of victimisation, amongst other issues. Given the methodology underpinning this study, this study cannot claim that access to services does not reduce the mother's levels of distress, only that high levels of distress are evident despite service utilisation. The results from this present study suggest that GPs need to be better at asking the 'right questions' and linking appropriately to accessible and responsible services. Women may go to what is easily available, such as their local GP, not necessarily, what is best.

This present study also represents the first to ask if mental health services accessed responded in any way to the women's offending or parenting needs. The majority of the mothers report a general invisibility of these two issues within mental health service provision. This result again highlights the importance of service providers asking the 'right questions' in consultations, and having the time to hear the answers, and respond appropriately. For example, the majority of the mothers used prescribed medication prior to their imprisonment, with a large number reporting problematic substance use. A small number of mothers report

that the side effects of medications play a role in their offending, as well in their level of distress. Asking the right questions becomes important, considering the side effects and possible interactions between medication and drug use. Furthermore, asking the right questions allows the mental health system to identify such issues, and possibly divert the women away from the criminal justice system.

This finding also reflects the research and other scholarly literature highlighting the siloed nature of Australia's service system. Services are often limited to addressing single issues, with parenting needs and children invisible in adult-focused services (Canaway & Merkes 2010; Department of Human Services 2013; Hunter & Price-Robertson 2014; Walsh, Tilbury & Osmond 2013). Indeed, this study extends this finding to include the invisibility of crime and offending. Responding to these two issues is important as a large number of the imprisoned mothers with a mental illness in this present study report that high levels of distress contribute to difficulties experienced pre-prison, and to their subsequent offending behaviours. It creates a situation, as noted in previous research, whereby service utilisation does not appear to divert women away from the criminal justice system (Lynch et al. 2012; Mundt et al. 2015). This suggests a need for a 'no wrong door' approach to service provision.

In the state of Victoria, advances have been made in the mental health system, particularly in incorporating a child and family focus into their policy and practice (COPMI 2014; Cuff & Morgan 2015; Goodyear et al. 2015; Solantaus et al. 2009, 2010), as well as within legislation (e.g. the *Mental Health Act* 2014). However, it seems that such advances are not filtering down to the specific services used by the current study, such as the GP, psychiatrist, or psychologist. Initiatives such as 'Services Connect' in Victoria (Department of Human Services 2011, 2013), the Australian 'Child Aware' approaches (Hunter & Price-Robertson 2014), and 'Think Family' in the UK (Diggins et al. 2011; Social Exclusion Task Force 2008a, 2008b; Roscoe, Constant & Ewart-Boyle 2012) highlight the need for services to respond to the complexity evident within families, with adult services including a child-and-parent focus. Indeed, this focus also needs to occur within the criminal justice system.

8.1.3 The responses of the criminal justice system

Poor systemic responses have also been shown to contribute to unplanned, informal, and haphazard care plans for children (Flynn 2008; Healy, Foley & Walsh 2000, 2001; Hounslow et al. 1982; Zalba 1964). Previous research has consistently highlighted over time that imprisoned mothers' care planning is often underpinned by limited agency involvement

(Zalba 1964), a lack of trust or a mistrust of services (Hounslow et al. 1982; Zalba 1964), and a lack of acknowledgement of parenting responsibilities at arrest and sentencing (Flynn 2008; Nieto 2002; VACRO & Flat Out 2006). This study extends these results, highlighting that at arrest and sentencing, mothers with a mental illness experience a double vulnerability – with general invisibility of their mental health issues, as well as inconsistent responses to their parenting responsibilities.

8.1.3.1 The invisibility of mental health issues at arrest and sentencing

The present study shows that high levels of personal distress underscore the mothers' experiences at arrest and sentencing, as evident in their narratives as well as in their self-reported level of mental health functioning at these stages. However, their experiences of personal distress generally go unrecognised by the criminal justice system.

In responding to offenders who have a mental illness, the Victorian Police's 'Protocol for Mental Health' (Department of Health 2010) outlines the roles, responsibilities, and procedures for the police when they encounter someone who has a mental illness. This includes encounters with people who are a threat to themselves or others, those with welfare and safety concerns, or who require transport to hospital, as well as the responsibilities of the police in determining fitness for interview (e.g. ability to understand and follow questioning) (Department of Health 2010). An implied critique, first discussed in Chapter Two, was that this protocol typically focuses heavily on offenders who experience low prevalence disorders such as Schizophrenia, where the behaviour is obvious and often publicly problematic. Offenders who experience high prevalence disorders, such as Affective and Anxiety Disorders, more common in women, where the signs and symptoms are not always visible, are more easily overlooked. However, this was not the case in the present study. Findings indicate that this protocol and associated police practice overlooks all mental illness – high and low prevalence disorders. Although the study did not gather comparison data from men, it would seem that gender is the key.

High prevalence disorders are the most commonly reported mental health issues within this study. The mothers typically report these mental disorders as unrecognised by the police, with this lack of awareness having important consequences for their participation in the police interview. The mothers' report difficulty understanding or remembering the interview due to their high levels of personal distress often combined with substance use. Although, often considered as 'less serious', high prevalence disorders have an impact on the mothers'

capacity to understand and engage with the police officers. They are subsequently less aware of these legal discussions. The within-groups analysis evident in Chapter Seven, however, found that mothers who report low prevalence disorders had even greater difficulty at arrest, in terms of engaging with the police during their interview. Therefore, taken together, these results suggests that the gender-neutral language used within this protocol, and the associated responses by the police, overlooks women with a mental illness. It fails to draw attention to the distinct needs of this population. This result may also reflect day-to-day policing, with arresting officers encountering much larger numbers of male offenders with a mental illness than female offenders.

In contrast, the present study found that the mental health of the mothers was more visible at sentencing, with their mental health issues often raised as a mitigating factor by their legal representative. However, it is not possible to comment on the extent to which mental illness reduced in any way the sentence length, as this question was not asked, and therefore represents a limitation of this study. However, not one mother in this present study reported using health and wellbeing programs located at the Magistrates' Court of Victoria. As noted in Chapter Two, accused persons with a mental illness have access to case management, as well as an Assessment and Referral Court List (also called a mental health court), amongst other programs (The Magistrates' Court of Victoria 2014). Whilst this may reflect the limitations of self-report data, and women's limited recall of events at this time, it could also mean that the mothers in the present study were not offered access to such programs, as the courts simply could not identify them. This may be an outcome of the large number of participants reporting high prevalence disorders, where the signs and symptoms are not always visible. Furthermore, this result could also mean that these mothers simply did not know that such programs existed. Indeed, limited knowledge of criminal justice policies and practices was raised as an issue by a small number of participating mothers. Therefore, the mothers with a mental illness simply 'did not know what they did not know'.

8.1.3.2 Inconsistent responses to primary carer status at arrest and sentencing

The 'Victorian Police Manual' (Victoria Police 2013) and the 'Protocol between the Department of Human Services (Child Protection) and the Victorian Police' (Victorian Government 2012) provide no guidance for police on how to respond to the parenting responsibilities of arrestees, nor do they outline the responsibilities of statutory bodies with regards to this group of children. This is because these documents only acknowledge children as victims of crime (e.g. victims of abuse or neglect, and witnesses of domestic violence) or

as an alleged offender. This is also a noted limitation of the Victoria Police's 'Protocol for Mental Health' (Department of Health 2010), discussed previously, which made no mention of the parenting responsibilities of those who have a mental illness. Perhaps unsurprisingly, recent Australian research has uncovered, using police officers as participants, their limited awareness of their formal responsibilities regarding children of arrestees (Flynn et al. 2015; VACRO & Flat Out 2006). Broader research from the US similarly reports that the parenting responsibilities of female arrestees were often not seen as part of policing (Nieto 2002).

The findings from the present study mirror this. This study shows that as an outcome of this lack of guidance, the police were inconsistent in how they respond to the parenting responsibilities of mothers' with a mental illness, despite generally knowing that the woman has children. Such variable responses are problematic for mothers, as their high levels of distress mediate their engagement with this system, rendering them unable to initiate discussion and advocate on their own behalf. Therefore, when the police do not respond to women's parenting responsibilities, it compounds the difficulties experienced by this group of mothers and subsequently their children. This highlights the need for the system to ask the right questions.

Previous research has acknowledged that imprisoned mothers often hold unrealistic expectations regarding the likely outcomes of their court case (Flynn 2008; Healy, Foley & Walsh 2000, 2001; Zalba 1964), which suggests that the relationship with the legal representative and the information provided to the mother is important. In the present study, whilst only a small number of mothers described a positive relationship with their legal representative, the majority reported that they had discussed the possibility of a prison sentence. However, such discussions did not often leave the women feeling prepared: they were either not adequately informed about sentence length, or had unrealistic expectations regarding the likely outcomes of the hearing. This could be related to a number of factors. For example, the legal representative being unclear about the length of the possible prison sentence, with the mother therefore holding overly optimistic expectations about the court outcome. This has been noted in previous research (Healy, Foley & Walsh 2000, 2001). Furthermore, discussions with the legal representative may not have included the importance of organising children's care prior to the court date, as this is not a professional 'core role'. Indeed, Scott (2009) in advocating for adult-focused services to 'think family, think child' encouraged services to broaden their 'core roles' to include a wide range of client needs. In addition, the restricted amount of time the women actually spend with their legal

representative may suggest the focus of contact would be on the court case and the women's legal issues rather than their parenting responsibilities. However, the women's preparedness for court and sentencing is also likely related to their distress levels. Mothers did report that their levels of distress, often combined with substance use, affected their participation with the police: this may have transferred over to their experiences at sentencing, and complicate the uptake of information. Indeed, high levels of distress were evident at sentencing. However, a limitation of this study is that this was not specifically asked.

The relationship between feelings of preparedness, the communication between the mother and her legal representative, as well as the impact of mental illness on participation requires further examination. Whilst this present study did seek some information regarding these factors, such as discussions with legal representative regarding the court case, and what was presented during the hearing, the data provided by the mothers is rather limited. This is likely due to the limitations of a structured interview schedule, as well as to the limitations of self-report and the memory of the participants. However, 'poor memory' could simply reflect women's lack of engagement within the criminal justice system due to their high levels of distress. Furthermore, women's low educational attainment noted in previous research (Corrections Victoria 2005, 2011; Holtfreter & Morash 2003), could also affect the participants' ability to understand and participate in their hearing. Indeed, the legal process often uses complicated legal jargon.

8.1.3.2 Relationship between policy and the visibility of women's issues – prisons as proxy mental health services

Unlike the stages of arrest and sentencing, Victorian female prisons are underpinned by the 'Standards for the Management of Women Prisoners in Victoria' (Corrections Victoria 2009, 2014) and the associated gender-responsive policy 'Better Pathways' (Corrections Victoria 2005). This standard and associated policy aim to address the distinct needs of imprisoned women, including their mental health and parenting responsibilities, in order to reduce women's offending and reoffending (Corrections Victoria 2005, 2009, 2014). The evaluations of this policy and associated practice indicate the general helpfulness of resulting programs and prison infrastructure. The longer term implications of participation in such programs is however, limited by the disconnection between prison and community-based services, as well as the lack of integration and coordination between the programs offered (DOJR 2016; PricewaterhouseCoopers 2009).

This present study finds somewhat surprisingly that the mothers' experiences of personal distress improve during their imprisonment, compared to their experiences pre-prison, and at arrest and sentencing. This reflects a small body of knowledge that rather controversially suggests that imprisonment is associated with good mental health (Bonta & Gendreau 1990; Bradley & Davino 2002; Ferraro & Moe 2003). This is typically explained as being due to access to programs, the provision of a stable environment, and respite from the chaotic lifestyles that underpin the lives of mothers prior to imprisonment. Harner and Riley (2013) report that mental health may improve, become worse, or remain the same during imprisonment, due to the interplay between the individual, social, and systemic factors. Whilst a clear limitation of the present study is that the mothers were not asked for their views on why their mental health improved, it is hypothesised that this is an outcome of gender-responsive services. The majority of the imprisoned mothers access some type of specialised mental health program, as well as report using prescribed medication during imprisonment. More broadly, gender-responsive practice saw all mothers maintaining some form of connection with their children during their imprisonment. This was typically via telephone, letter writing, and/or visits, and reflects previous research (Maruschak, Glaze & Mumola 2010). Furthermore, a large number of the mothers participated in a program that supported their primary carer status, such as parenting programs, accessing the Family Support Worker, and visiting programs. Van Wormer (2010) suggested that mental illness is not the core business of prisons, given the focus on security and punishment, yet the results from this study lends support to the notion that prisons have become a proxy mental health service (Dalley 2014; Kinsler & Saxman 2007). This is likely due to the provision of gender-responsive programs. It is important to note here, that whilst improved mental health at imprisonment may be linked to access to mental health and parenting programs, this study cannot claim causation.

8.1.4 Conclusion: What this study achieved

This study focused attention on mothers with a mental illness entering the criminal justice system, given the lack of research examining their specific experiences. It represents the first Australian study to do so. In answering the core research question: 'What are the experiences of mothers with a mental illness as they navigate the criminal justice system?' this study found that this group of women negotiate multiple, and largely independent systems, including the criminal justice and the mental health systems. Their ability to engage with and participate in these systems to plan the care of their children is influenced by the interplay

between what the mother brings into these systems (e.g. individual factors and resources) and how the system responds to them. This interplay dictates whether the mothers' have secure or no care arrangements in place for their children upon imprisonment.

This study reports five important findings in relation to the experiences of mothers with a mental illness. When mothers enter the criminal justice system, they look very similar to the larger population of imprisoned mothers. The key difference lies in how they interact with the system to plan the care of their children, with lower levels of involvement compared to mothers without a mental illness. Their experiences at crisis points, when important care planning decision-making needs to occur, are marked by high levels of distress, combined with other interlinked issues, such as substance use, grief and loss, and experiences of victimisation. These women receive support from their informal networks, but engage with a mental health system that often responds to single issues. They then intersect with the criminal justice system, which typically does not see their parenting responsibilities or mental illness until the point of imprisonment. For this specific group of mothers to become visible, to ensure their mental health issues no longer provide a barrier, their role as participants in the criminal justice needs to be acknowledged in both criminal justice policy and practice.

8.2 Implications of this study: Responding better to imprisoned mothers with a mental illness

This study highlights how mothers' engagement with and participation in the criminal justice system is dependent on the interplay between their individual factors and resources, and systemic responses. Therefore, how systems respond to this group of mothers is a key area for intervention; thus, this study has important implications for policy and practice. Current policies and practices typically focus on imprisonment, which is arguably too late. Therefore, the focus must be on prevention or 'universal precautions', such as asking the 'right questions', at the points of pre-prison, arrest, and sentencing. Such an approach broadly reflects the concept of 'justice reinvestment', which argues for the reinvestment of criminal justice funds into community-based services to prevent offending and recidivism (Brown, Schwartz & Boseley 2012). This would require a significant paradigm shift for the Victorian government, which despite the shift from the conservative Liberal government in 2014 to Labor, continues to focus on expanding prisons to meet the growing prison population.

8.2.1 Acknowledging complexity within criminal justice practice

A major finding of this study is that imprisoned mothers with a mental illness look very similar to mothers without a mental illness. It is not until further analysis do differences become apparent. Furthermore, within the group of mothers with a mental illness, there are also differences in their experiences. Therefore, this study shows the importance of responding to individual needs, and to the heterogeneity evident within the female criminal justice population. This findings supports the United Nation's (2015, p. 8) more recent 'Standard Minimum Rules for the Treatment of Prisoners' (also called the Nelson Mandela Rules) which states:

“In order for the principle of non-discrimination to be put into practice, prison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings. Measures to protect and promote the rights of prisoners with special needs are required and shall not be regarded as discriminatory”.

Therefore, the results from this study highlight the need to respond to complexity within the group of imprisoned mothers who have a mental illness, particularly to mothers who report low prevalence disorders, such as Schizophrenia. This group of women appear to have an extra level of difficulty navigating the criminal justice system. They are more likely to be arrested in an unplanned way, outside of the home where their primary carer status is hidden. They are more likely to report that their mental health issues affect their engagement with the police during the interview. These experiences accumulate to ensure that their children are more likely to have no care arrangements in place upon imprisonment, with the mothers dissatisfied with the care planning process. Therefore, the needs of this group require specific attention.

8.2.2 Gender-responsive policy at arrest and sentencing

The conclusions of this study also support the need for arrest and sentencing practices to embrace a gender-responsive approach. This present study shows the direct link between criminal justice policies and the experiences of mothers with a mental illness as they navigate the criminal justice system. For example, Chapter Two examined the legislation, policies, and practice that underpin the Victorian criminal justice system. This chapter noted the gender-neutral language used within these policies, and the invisibility of parenting responsibilities at arrest. Whilst issues pertaining to gender and children are acknowledged at sentencing, the

critique in Chapter Two emphasised the lack of concrete guidelines for the judiciary. In contrast, Chapter Two showed that prisons may be better equipped to respond to the needs of mothers with a mental illness due to gender-responsive prison practice and the associated 'Better Pathways' policy (Corrections Victoria 2005). The research examined in Chapter Three also supported the discussion in Chapter Two. The narratives of the participating 21 mothers with a mental illness, as they discussed their experiences at arrest, sentencing, and imprisonment, reinforcing the conclusions evident in Chapters Two and Three. This suggests that upon amendment of current criminal justice policy and associated practice, this group of women will have vastly different experiences, showing the potential power of good, and bad, policy.

Policies and practices at arrest

As previously mentioned, three policy documents are relevant to the mothers' experiences at arrest: The 'Victorian Police Manual' (VPM) (Victoria Police 2013), the 'Protocol for Mental Health' (Department of Health 2010), and the 'Protocol between the Department of Human Services (Child Protection), and the Victorian Police' (Victorian Government 2012). These policy documents use gender-neutral language, largely rendering the needs of women, particularly their mental health status or parenting responsibilities, invisible. It is likely that this is an outcome of the 'gender ratio problem' (Daly & Chesney-Lind 1988) that is evident in both the forensic and prison systems, whereby men are the standard. Therefore, the policies and practices at arrest may be designed to respond to men, rather than women. In order to promote equity rather than equality, such policies need to be framed as gendered, include gendered language drawing attention to the specific needs of these women, particularly their mental health issues. The results from this present study show the need for universal precautions; for example, asking a female arrestee if she has a mental illness regardless of her presentation. If she says yes, then the police can enact their roles, responsibilities, and procedures under the 'Protocol for Mental Health' (Department of Health 2010). This is important as the majority of the mothers in this present study reported that their mental health, irrespective of presentation, has consequences for their understanding of and participation in the interview with the police.

Recent international examples show how children and parenting responsibilities can be incorporated into legislation and policy at arrest. For example, the protocol developed by US International Association for Chiefs of Police (IACP) (2014) provides concrete examples of

how to incorporate the parenting responsibilities of arrestees into policy and practice, and provides step-by-step guidelines for how the police can respond to the children of arrestees. This protocol incorporates parenting responsibilities and children into the guidelines for all stages of the arrest process, beginning with interagency coordination, and police training. It also includes: pre-arrest planning and when making an arrest; determining an appropriate placement for children and interacting with children; during booking of the parent and follow up to ensure the safety and well-being of the child; and lastly, incorporating children into police documentation (IACP 2014). Importantly, this protocol uses a mixture of gendered (e.g. he/she) and gender-neutral (e.g. arrestee and parent) language. This calls attention to the parenting needs of both men and women. It is highly likely that this protocol could be extrapolated to the Australian context given that it is written in general terms therefore can amended to reflect jurisdictional differences. However, the effectiveness of this protocol and others like it (e.g. Child safety policy 380 from the Anaheim Police Department 2013) remains unclear as they have not been evaluated. Such protocols however highlight the need for taking universal precautions, asking every female arrestee about her children, and her associated care plans. This ensures the police are ‘child aware’.

An important finding from this study is that mothers with a mental illness have no time to plan the care of their children when they were remanded into custody following arrest, or are taken into custody for a ‘breach of parole offence’. There are no within-group differences in terms of the time available to plan care, or the experiences of custody following interaction with the police. This suggests that having ‘no time’ is a universal experience for mothers with a mental illness who were taken into custody, regardless of their diagnosis. Time constrains, particularly as an outcome of police responses, was also noted in previous research (Flynn 2008). Whilst balancing the need to protect the community, and respond to children, it may be worthwhile providing this group of women with some time to arrange the care of their children. The UN Commission on Women and the Criminal Justice System (2009) referenced good practice from the Sussex Police in the UK, where the police station provides specialised rooms for parents and their children to remain together until suitable care arrangements can be made. Such practices can ensure that the removal of primary carer mothers does not result in an immediate crisis, where the wellbeing of children becomes a concern. The extreme case example presented in Chapter Six highlights the possible trauma experienced by Claire, an adolescent child, who had to get herself home after her mother was arrested at a parole meeting, while Claire waited in the car. Claire went home to an empty house, with little to no

food, as Claire and her mother had plans to go grocery shopping after the parole meeting. Scott (2009) advocates for adult-focused services, such as the police, to ‘think child, think family’ in order to address the needs of complex families, such as mothers with a mental illness. This could reduce the vulnerability of children like Claire.

Policies and practices at sentencing

The ‘Victorian Sentencing Manual’, despite acknowledging that dependent children can be taken into consideration when sentencing defendant mothers (Judicial College of Victoria 2013), provides little direction on how to do this. This has shown to be the case in Victoria in recent years (Flynn et al. 2015) and is also evident in the UK (Minson & Condry 2015), with inconsistent responses common in the current study, with regards to women’s mental health and parenting status. Recent international examples show how children and parenting responsibilities can be incorporated into legislation and policy at sentencing, such as the need to consider the impact of parental custody on children when determining a sentence (Fee 2015).

As this study finds that mothers with a mental illness typically commit non-violent offences, reflecting broader prison data (ABS 2013; DOJR 2015), alternatives to custodial sentences may be relevant. For example, the US state of Washington has recently created two alternatives to custodial sentences for parents who commit non-violent offences. The sentencing alternatives include a community-based supervision and treatment order, or electronic monitoring at home for the duration of the sentence (Department of Corrections Washington State 2014). However, Victoria abolished home detention in 2012, which creates difficulty extending such alternatives to this jurisdiction.

Corrections Victoria’s (2005) ‘Better Pathways’ policy also suggests criminal justice responses at sentencing. For example, providing information to judges and magistrates on the effectiveness of sentencing orders for women, and sharing research with defence lawyers regarding the needs of imprisoned women. ‘Better Pathways’ also includes an objective to improve women’s access to legal information and advice (Corrections Victoria 2005). However, these objectives aimed at reducing women’s imprisonment, are general in nature, and it is unclear if these initiatives were achieved under this policy. The evaluations of this policy, as discussed in Chapter Two, examined women’s experiences at imprisonment and post-release. There was no mention in the publicly available evaluations about the initiatives at sentencing (DOJR 2016; PricewaterhouseCoopers 2009). Such initiatives were also

recommended by the UN Commission on Women and the Criminal Justice System (2009) in their examination of the UK criminal justice system.

The results from this study reflect in many ways a need for the sentencing initiatives proposed within the 'Better Pathways' policy, highlighting a need for legal representation, or a court related service, to provide mothers with information regarding the possibility of a prison sentence and the need to plan the care of their children. Particularly important as the participants from the current study report that conversations with legal representations do not always leave them feeling prepared, with a small number of mothers highlighting the need for better knowledge of criminal justice policies and practices. The UN Commission on Women and the Criminal Justice System (2009) recommended the development of a court role to assist mothers to make care arrangements for their children. This could also be extended to providing education around the criminal justice system. A recently published evaluation of a family support service in a regional Victorian Magistrates' Court, highlights that courts are suitable locations for the provision of support to families, and play an important role in providing information and timely responses (Hastrich 2015). This ensures that the court is also 'child aware'.

8.2.3 'Joining up' of community-based and prison services

Practices around Australia highlight the need to have a 'child aware' and connected service system (Hunter & Price-Robertson 2014; Department of Human Services 2013) in order to respond to the complexity within families, and promote the health and wellbeing of children (Scott 2009). McDonald and Rosier (2011, 2013), in their review of interagency collaboration within Australia, US, and the UK, suggest that collaboration is most effective when there are complex problems within families, such as offending and mental illness. This is because collaboration provides seamless access to a broad range of services. According to McDonald and Rosier (2011, 2013) inter-professional relationships play an important role in collaboration, with poor relationships between agencies and families leading to mistrust and conflict around referrals. A number of authors have called attention to the need for interagency and cross-sector responses to prisoners and their families (Saunders & McArthur 2013; Sheehan 2013; Trotter et al. 2015; Zalba 1964), essentially advocating for the 'joining up' of prison and community services. Currently there is no coordinated planning within and between the criminal justice and community-based services (Flynn et al. 2015), with only one study available that piloted such a 'joining up' of services within the US (Abram & Linhorst 2007). Abram and Linhorst (2007) report that interagency collaboration works best with

training and careful planning. Indeed, Ellen's extreme case example discussed in Chapter Six, highlights the importance of cross-sector partnerships. Ellen's legal representative and psychologist worked in partnership to ensure that Ellen was aware of her possible prison sentence. This allowed the psychologist and her family to engage in a care planning process, ensuring that upon Ellen's imprisonment, secure care plans were in place for her daughter. Ellen was the only participant in this present study who reported such inter-agency partnerships.

The current study also supports previous research describing the problems ensuing from a specialised and fragmented service system, which is often limited to addressing single issues (Canaway & Merkes 2010; Walsh, Tilbury & Osmond 2013). The mothers experienced high levels of personal distress prior to imprisonment, despite accessing a range of mental health services. Furthermore, such services typically do not respond to the women's parenting or offending issues. This suggests that there is difficulty responding to the complexity evident within this population. Addressing such issues is of particular importance considering the *Mental Health Act 2014* provides the legislative basis for incorporating holistic responses into this system. Laux et al. (2011) advocated for mental health services and treatment to take on a multisystem perspective when responding to imprisoned mothers with a mental illness. Programs such as the Victorian 'Services Connect' model highlight that multiple and complex problems that underpin families cannot be addressed by one service alone (Department of Human Services 2013, 2013). While Australia's 'Child Aware' approaches highlight the need for adult-services to take a child-focus in order to better respond to the health and wellbeing of children and families (Hunter & Price-Robertson 2014). This is important considering this group of mothers' parent within such challenging and multi-problem circumstances. This is due to their experiences of grief and loss, victimisation, and substance use, amongst other issues, within a context of mental illness and distress. Furthermore, their ability to effectively parent is mediated by the severity of symptoms, medication use and the associated side effects, relapses, and hospital admissions (Blegen, Hummelvoll & Severinsson 2010).

The appropriateness and skill set of services is important considering the mothers in the present study were planning to access these services post-imprisonment. There is a need to address such issues so that prison does not become a 'revolving door' for this group of mothers. Particularly important as approximately one-half of the participants had a history of prior imprisonment, and their narratives indicated that their offending was interlinked with

their high levels of personal distress. Therefore, community-based services, such as the mental health system, have an opportunity to direct the mothers away from the criminal justice system. In order to do so, there is also a need for universal precautions, asking women with a mental illness if they have children, asking about lifestyles, and ensuring that there is enough time to hear the answers, and respond appropriately. This will ensure that mental health services are more targeted and better informed to meet complex needs. Indeed, formal inter-agency partnerships between the mental health and criminal justice system would allow for improved information sharing, and collaboration.

8.3 The strengths and limitations of this study

Although this study has a number of important implications for policy and practice, it is also has a number of strengths and limitations that affect the findings and application of the results. This discussion builds upon the strengths and limitations first acknowledged in ‘Chapter Four: The Methodology and Associated Methods’.

This study interviewed 21 mothers with a mental illness over a one-year period in Victoria. As an outcome of this small sample, there may be an underestimation of mental health problems, as this study did not record details about the potential participants who declined participation, or their reasons for declining. Although this study makes no claims of generalisability, as this was an exploratory study, the results do indicate broad similarity between the sample and the wider Victorian and Australian female prison populations.

In order to reduce the research burden on imprisoned mothers as well as the prison environment, the structured interview schedule used for this study was merged with the interview schedule from the broader study. This ensured that the data collection was contained to one interview, allowing this study to also attend to the practical issues of researching in the prison environment as recording devices are prohibited. However, this design ensured that a number of questions were not included within the schedule; of particular relevance was why the mothers experienced an improvement in their self-reported level of mental health functioning at imprisonment. In many respects, this limitation is an outcome of the need to balance addressing the research question and addressing the needs of the research environment. It also reflects the limitations associated with this present study being nested within a broader research project, whereby the broader study’s researchers, and the associated partner organisations, were involved in the conception, design, and

implementation of this study. Therefore, the researcher had to be mindful of both the implications of the broader and present study on the research environment.

A lack of an alternative perspective from other key informants was noted in Chapter Four. This related to the pragmatic decision to limit recruitment to the general prison population, rather than special prison populations (e.g. management or the mental health unit), or more broadly, to the children of imprisoned mothers with a mental illness or current carers. The exclusion of special interest populations was an outcome of prison staff acting as gatekeepers to these populations; the exclusion of the latter participants reflects the exploratory design of the study. Whilst this study experienced difficulties recruiting forensic mothers, difficulties were also experienced regarding the recruitment of mothers in the community. Therefore, this study cannot make any claims regarding the impact of mental illness on post-release experiences.

This study is framed by intersectionality and complexity theory, which identifies the need to respond to the complexity within human experiences. This is important as the policy, practice, and research underpinning this study is generally siloed, responding to imprisoned mothers and women with a mental illness separately. This is in spite of the interlinked nature of these issues. Therefore, an important strength of this study is that it provides evidence with regard to how quantitative methods can be used to investigate and understand complexity, notably the between-group and within-group differences. This study found that mothers with a mental illness compared to mothers without a mental illness had greater difficulty planning their children's care. Furthermore, mothers who report low prevalence disorders and mothers who did not report substance use having greater difficulty than their counterparts. Therefore, this study attends to and emphasises the heterogeneity evident within the group of mothers with a mental illness. A noted limitation in previous research is that it tended to treat female prisoners as a homogenous population.

8.4 Areas for future research

This study highlights the scarcity of knowledge about imprisoned mothers with a mental illness, with clear gaps evident in the need to further explore their parenting experiences as they navigate the criminal justice system, rather than just at the point of imprisonment. It is important to systematically examine how mothers with a mental illness navigate the criminal justice system, and how they plan the care of their children, considering the potential implications of maternal imprisonment for the health and wellbeing of both mothers (Houck

& Loper 2002; Laux et al. 2011; Lilburn 2000; Loper et al. 2009; Poehlmann 2005; Roxburgh & Fitch 2013) and their children (Murray, Farrington & Sekol 2012; Murray & Murray 2010). In line with the exploratory approach underpinning this study, this study also highlights important areas for future research.

This study highlights in particular the invisibility of forensic mothers, especially within the Australian context. The only research available examines parenting responsibilities (Chao & Kuti 2009; Parrott, Macinnes & Parrott 2015) or visiting needs (Cormac et al. 2010) within the UK forensic setting. Chapter Two also highlights the lack of acknowledgement of the parenting status of this group of women within Victorian forensic policies and reports. This study however, had difficulty recruiting forensic mothers due in part to the large number of mothers losing custody of their children prior to their admission, the nature of their offence (often against their children), and to their poor mental health at the time of recruitment. Despite these challenges, more knowledge is needed regarding the parenting needs of this group of mothers, particularly if they were primary carers at the point of arrest. The inclusion of forensic mothers into research is important; they should not be excluded purely because of 'vulnerability'. Indeed, previous research has highlighted that people with a mental illness, and those within the forensic system, are still able participate in research and can provide informed consent (Carpenter et al. 2000; Magyar et al. 2012; Misra et al. 2010; Moser et al. 2002).

To understand the experiences of imprisoned mothers with a mental illness requires a longitudinal view, examining the experiences pre-prison, at arrest, sentencing, imprisonment, and upon their release. While this study aimed to incorporate a longitudinal view by including recently released mothers with a mental illness, recruitment challenges resulted in only two mothers being recruited. Their post-release experiences were excluded from analysis due to the extremely small sample size. Therefore, this represents an important area for future research. It is currently not known if having a mental illness adds extra complexity to imprisoned mothers' reunification experiences with children, as well as to their transition into the community.

Future research also needs to examine the parenting experiences of imprisoned mothers with a mental illness from a wider variety of cultural groups, particularly Aboriginal and Torres Strait Islanders and Vietnamese women. This is particularly important considering these groups make up the next largest proportion of women imprisoned in Victoria following

Caucasians (ABS 2013; DOJR 2015). Due to significant organisational difficulties encountered when organising an interpreter, all the women who participated in this study could speak English. Therefore, whilst this study did not actively exclude women of Vietnamese background, this difficulty did reduce their involvement. Furthermore, this study recruited from the general prison population; whilst Indigenous women were captured, only a small number participated in this present study. Therefore, this suggests that research must incorporate strategies to recruit from these specific populations. This may require the researcher actively working with cultural officers stationed at these prisons or focus only on recruiting these cultural groups.

There is also a need to examine the parenting experiences and outcomes of mothers who access the prison Mother-Baby Unit. Previous research in the UK has shown that mothers with a mental illness tend to get excluded from this unit (Birmingham et al. 2006; Gregoire et al. 2010). Birmingham et al. (2006) concluded this was due to these mothers being unlikely to apply, their behavioural issues being likely to lead to rejection, or having longer sentences and thus not fitting the key selection criteria. In this present study, there was a general similarity between the sentence lengths of mothers with and without a mental illness casting doubt on Birmingham et al. (2006) latter suggestion. Only one mother with a mental illness accessed this unit, with other mothers acknowledging that they did not know this unit existed until their imprisonment or they were declined. However, a limitation of this study is that the mothers were not asked why they were declined. Given the importance of such units in maintaining the mother-child relationship during the prison sentence (Dolan et al. 2013; Goshin, Byrne & Blanchard-Lewis 2014; Shlonsky et al. 2016), and the noted difficulties that the mothers with a mental illness in this present study reported in regards to their parenting contexts pre-prison, this represents an important area for future research. There is no Australia data examining the prevalence of mental health issues within these units.

There is also a need to further examine the experiences of mothers' who have low prevalence disorders and mothers' who do not report substance use. This study provides evidence that low prevalence disorders add an extra level of difficulty when navigating the criminal justice system that has severe consequences for children's care plans. This study also found the surprising result that mothers' without substance use report low involvement in planning their children's care, with statutory services generally making the care decisions. This finding could relate to the role of informal resources in planning children's care, however, it could also relate to the criminal justice system being geared towards responding to substance use

issues (Johnson 2004a, 2004b). Therefore, women who do not have a substance use issue look more stable on the ‘surface’, potentially rendering their needs invisible. Further research is needed, particularly to examine the nuances of their experiences. This study can only provide tentative evidence regarding the likely impact of such issues, given the small sample sizes evident within these sub-groups.

This study highlights the important role fathers play in developing secure care plans, and caring for their children during the mothers’ imprisonment. However, the evidence base about fathers is rather limited; only a handful of studies have looked at the role of fathers (e.g. see: Enos 2001; Flynn 2013). The vast majority of research examines the role of grandparents in informal kinship care arrangements. Therefore, this represents the last area for further research identified by the present study. Further information is needed regarding the care provided by fathers, and the associated levels of satisfaction with these arrangements from multiple perspectives, including the fathers, imprisoned mothers, and their children.

8.5 Concluding comments

Women represent Australia’s fastest growing prison population (ABS 2015). They also represent a resource intense population, as women enter the criminal justice system with a wide variety of interlinked individual, social, and systemic issues (McIvor 2007). Of particular concern are the high levels of mental illness found within this population (AIHW 2010; Tye & Mullen 2006). Furthermore, the vast majority of imprisoned women also report dependent children (Glaze & Maruschak 2008; McIvor, Trotter & Sheehan 2009; Sheehan 2010). Therefore, imprisonment affects families.

Little attention has been paid however to imprisoned mothers with a mental illness. This study represents the first study to examine how mothers with a mental illness negotiate the care plans for their children as they navigate the criminal justice system. This study focused on the critical decision-making points of pre-prison, at arrest, sentencing, and imprisonment. Previous research looking at mothers with a mental illness has tended to focus exclusively on the point of imprisonment, with only one study looking at their pre-prison experiences. Therefore, this study builds upon the rather limited knowledge base, and provides a much needed Australian context.

The focus of this study was due in part to the broader study’s partner organisations who identified, as the result of their direct practice observations, that maternal mental illness was a concern in their practice. The five important findings from this study support this. Mental

illness has a significant impact on the mother's pre-prison lives and added difficulties to their ability to plan the care of their children as they move through the criminal justice system, at arrest, sentencing, and imprisonment. This is due to the interplay between the individual factors and resources that this group of mothers bring into the system, and how the system responds to their distinct needs. Imprisoned mothers with a mental illness come into direct contact with multiple and often independent systems, particularly the criminal justice and mental health systems. Within these systems, their distinct needs are generally unseen and unacknowledged at the stages of arrest, and sentencing.

This study provides evidence of the need for gender-responsive practice to incorporate the stages of arrest and sentencing. It also provides evidence for the need of services to respond to complexity within the criminal justice population, particularly for mothers who have a mental illness, and also for those who have a low prevalence disorder. In line with previous research, this study provides further evidence for the need of a 'joined up' community and correctional system. Acknowledgement of their distinct needs will ensure that mental illness is no longer an invisible barrier to engagement with and participation through the criminal justice. This will promote better care outcomes for mothers and their children.

Given the exploratory nature, this study successfully answered the core research question and the four subsidiary questions. It examined the experiences of a group of mothers who were largely invisible within previous research. Importantly, this study also provided building blocks for future research; this will ensure that this group of women remain 'visible'.

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Mental Health Act 1986 (Vic)

Mental Health Act 2014 (Vic)

Sentencing Act 1991 (Vic)

Victorian Police Act 2013 (Vic)

International legislation:

Assembly Bill (AB) 1942 (Nava) (US)

Support for Children (Impact of Parental Imprisonment) (Scotland) bill

The Appendices

- Appendix 1: Participant Information for Mothers with a Mental Illness (Prison/Forensic)
- Appendix 2: Participant Information for Mothers without a Mental Illness (Prison)
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Appendix 1: Participant Information for Mothers with a Mental Illness (Prison/Forensic)



Explanatory Statement – Mothers

The Impact of Incarceration on Children’s Care: A Strategic Framework for Good Care Planning

The Care Needs of Children of Incarcerated Mothers with Mental Illness

Please keep this information with you

My name is Alannah Burgess and I am a PhD student in the Department of Social Work at Monash University. My project ‘The care needs of children of incarcerated mothers with a mental illness’ is part of a larger project called ‘The impact of incarceration on children’s care: A strategic framework for good care planning’, with the chief researcher on that project being Chris Trotter who is an Associate Professor in the Department of Social Work at Monash University.

The reason for the research

We want to find out what happens to children when their parent goes to prison. We are looking for parents to tell us about their experiences. For my part of the project, I am particularly interested in what happens to children whose mothers have a mental illness.

What is in it for me?

We think that telling us about your experience is an important thing you can do to help other children who have parents in prison. You can be a part in the process of creating a better way of helping children when their parent is taken away. You can also get a copy of the results if you wish, just let us know.

What do I have to do to participate?

You have to agree to 2 (two) interviews with a member of our research team. The first interview will be some time soon and the second one will be in about 12 months. We will not make a note of any information that can identify you, this is an anonymous interview. The interview should take between one to two hours maximum. Participation is completely voluntary, so you do not need to do the interview if you do not want to.

If you say yes and would like to participate we would also like to talk to some of your family members. We understand that this is something that affects the whole family not just one person. We are looking for up to 4 (four) members of your family to talk to about the arrangements made for the care of your children. If you allow us we would also like to talk to your children if they are 12 years or older. We would need their contact details to send them a letter inviting them to participate.

How might I feel?

We understand that talking about your children might be hard for you. If at any stage you wish to stop the interview you can, just tell the researcher you want to stop. We can also tell the prison

welfare workers that you want to talk to someone about how you are feeling. You can talk to a welfare worker, nurse or Chaplain if you wish.

Can I change my mind?

Being in this study is voluntary and you do not have to participate if you don't want to. You can stop the interview at any time you feel like it and you can tell us if you want us to use the information you have already given us. Remember that answers will be written in a completely anonymous way.

Your privacy

No identifiable information about you will be recorded. This is an anonymous interview and the information we get from you will remain that way.

How we keep your answers

We keep the answers you gave us in a safe and secure place; only the research team can see it or use it. It will be kept on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be named in such a report.

Results

If you would like to know what we found out, please contact Alannah Burgess at [REDACTED] or alternatively Doctor Catherine Flynn at Catherine [REDACTED]

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	If you have a complaint concerning the manner in which this research is being conducted, please contact:
Catherine Flynn [REDACTED]	Executive Officer Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 [REDACTED] [REDACTED] [REDACTED] Secretary, Human Research Ethics Committee, Department of Justice [REDACTED] [REDACTED] [REDACTED]

Thank you,

Alannah Burgess, Associate Professor Christopher Trotter and Doctor Catherine Flynn.

Appendix 2: Participant Information for Mothers without a Mental Illness (Prison)



Participant Information Sheet

Explanatory Statement – Prison

The Impact of Incarceration on Children’s Care: A Strategic Framework for Good Care Planning

Please keep this information with you

My name is Chris Trotter and I am an Associate Professor in the Department of Social Work at Monash University.

The reason for the research

We want to find out what happens to children when their parent goes to prison. We are looking for parents to tell us about their experiences.

What is in it for me?

We think that telling us about your experience is an important thing you can do to help other children who have parents in prison. You can be a part in the process of creating a better way of helping children when their parent is taken away. You can also get a copy of the results if you wish, just let us know.

What do I have to do to participate?

You have to agree to 2 (two) interviews with a member of our research team. The first interview will be some time soon and the second one will be in about 6-12 months. We will not make a note of any information that can identify you, this is an anonymous interview. The interview should take between 30 minutes to one hour. Participation is completely voluntary, so you do not need to do the interview if you do not want to.

If you say yes and would like to participate we would also like to talk to some of your family members. We understand that this is something that affects the whole family not just one person. We are looking for up to 4 (four) members of your family to talk to about the arrangements made for the care of your children. If you allow us we would also like to talk to your children if they are 12 years or older. We would need their contact details to send them a letter inviting them to participate.

How might I feel?

We understand that talking about your children might be hard for you. If at any stage you wish to stop the interview you can, just tell the researcher you want to stop. We can also tell someone on your unit that you want to talk to someone about how you are feeling. You can talk to a welfare worker, nurse or Chaplain if you wish.

Can I change my mind?

Being in this study is voluntary and you do not have to participate if you don't want to. You can stop the interview at any time you feel like it and you can tell us if you want us to use the information you have already given us. Remember that answers will be written in a completely anonymous way.

Your privacy

No identifiable information about you will be recorded. This is an anonymous interview and the information we get from you will remain that way.

How we keep your answers

We keep the answers you gave us in a safe and secure place; only the research team can see it or use it. It will be kept on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be named in such a report.

Results

If you would like to know what we found out, please contact Doctor Catherine Flynn at

████████████████████

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	If you have a complaint concerning the manner in which this research is being conducted, please contact:
Catherine Flynn C ████████████████████	Executive Officer Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 ██████████ ██████████ ██████████ Secretary, Human Research Ethics Committee, Department of Justice ██████████ ██████████ ██████████

Thank you.

Associate Professor Christopher Trotter

Doctor Catherine Flynn

Appendix 3: Consent Form for Mothers with a Mental Illness



Consent Form – Mothers

The Impact of Incarceration on Children’s Care: A Strategic Framework for Good Care Planning

The Care Needs of Children of Incarcerated Mothers with Mental Illness

NOTE: This consent form will remain with the Monash University researcher for their records

I say yes to take part in the Monash University research project/s specified above. I have had the project explained to me, and I have read the **Explanatory Statement**, which I keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed by the researcher Yes No

I agree to be available for a further interview if required Yes No

and

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can change my mind at any stage of the project without being penalised or disadvantaged in any way.

and

I understand that any information that the researcher gets from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

and

I understand that any information I give is confidential, and that no information that could lead to the identification of any person will be shown in any reports on the project, or to any others.

and

I understand that information from the interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

Participant’s name

Signature

Date

Appendix 4: Consent Form for Mothers without a Mental Illness



Consent Form - Prisoners

The Impact of Incarceration on Children's Care: A Strategic Framework for Good Care Planning

NOTE: This consent form will remain with the Monash University researcher for their records

I say yes to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the **Explanatory Statement**, which I keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed twice by the researcher Yes No

I agree to be available for a further interview if required Yes No

and

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can change my mind at any stage of the project without being penalised or disadvantaged in any way.

and

I understand that any information that the researcher gets from the interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

and

I understand that any information I give is confidential, and that no information that could lead to the identification of any person will be shown in any reports on the project, or to any others.

and

I understand that information from the interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

Participant's name

Signature

Dat

Appendix 5: Community-based Recruitment Flyer



A Monash University Study: What are the needs of your children?

Monash University is carrying out a project to **better understand how primary carer parents plan the care for their children** when they are arrested, sentenced, imprisoned and released. We are particularly interested in the **care needs of children who have a mother with a mental illness**.

Who can participate?

Women who:

- Had **children** that were aged from birth to 17 years when they were last in prison; where their imprisonment resulted in either a **new carer** being introduced, and/or the child/ren **moving house** to live with a carer and/or the child/ren having **no carer**.
- Were released from prison from **June 2011** onwards.
- Are on **straight release** or **are no longer on parole**.
- Have a diagnosed **mental illness**.

What does the project involve?

Each interview will take about **one hour**. We will come to you at a time and place that is good for you. You will receive a **Coles-Myer gift card** for your participation. Participation in this project is confidential.

To find out more or to get involved:

Please see <insert name of person in your organisation>.

If you are interested in participating please talk to Alannah Burgess on 0459 290 215.

Appendix 6: Participant Information for Mothers with a Mental Illness (Community)



Participant Information Sheet – Mothers in the Community

The Impact of Incarceration on Children’s Care: A Strategic Framework for Good Care Planning

The Care Needs of Children of Incarcerated Mothers with Mental Illness

Please keep this information with you

My name is Alannah Burgess and I am a PhD student in the Department of Social Work at Monash University. My project ‘The care needs of children of incarcerated mothers with a mental illness’ is part of a larger project called ‘The impact of incarceration on children’s care: A strategic framework for good care planning’, with the chief researcher on that project being Chris Trotter who is an Associate Professor in the Department of Social Work at Monash University.

The reason for the research

We want to find out what happens to children when their parent goes to prison. We are looking for parents to tell us about their experiences. For my part of the project, I am particularly interested in what happens to children whose mothers have a mental illness.

What is in it for me?

We think that telling us about your experience is an important thing you can do to help other children who have parents in prison. You can be a part in the process of creating a better way of helping children when their parent is taken away. You will receive a \$30 Coles-Myer gift card for your participation. You can also get a copy of the results if you wish, just let us know.

What do I have to do to participate?

The study involves an interview that will take about one hour. The interview will occur at a time and place that is good for you. We will not make a note of any information that can identify you; this is an anonymous interview. Participation is completely voluntary; so you do not need to do the interview if you do not want to. During the interview, we will be asking you questions around the following topics: did your mental illness impact on you planning the care for your children, who supported you and what happened with your children during your arrest and imprisonment.

How might I feel?

We understand that talking about your children might be hard for you. If at any stage you wish to stop the interview you can, just tell the researcher you want to stop. We can also tell you about welfare workers available to you in the community if you want to talk to someone about how you are feeling.

Can I change my mind?

Being in this study is voluntary and you do not have to participate if you don’t want to. You can stop the interview at any time. If the interview is over and you don’t want us to use the information you have given us, just let us know. Remember that answers will be written in a completely anonymous way.

Your privacy

No identifiable information about you will be recorded. This is a confidential interview and the information we get from you will remain that way. However, there are some instances where we cannot guarantee confidentiality of your information, if:

- We think you are going to seriously harm yourself,
- We think you are going to seriously harm someone else,
- We are required by the court of law.

You should not tell us about illegal activities for which you have not gone before the court of law. Furthermore, if during the interview we become concerned that your child is at risk of harm including physical and emotional harm, we will discuss our concerns with you. We may have to let the Department of Human Services know about our concerns.

How we keep your answers

All your answers will be recorded by hand on an interview schedule. You can review what we have written at the end of the interview. We keep the answers you gave us in a safe and secure place; only the research team can see it or use it. It will be kept t on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be named in such a report.

Results

If you would like to know what we found out, please contact Alannah Burgess at [REDACTED] or alternatively, Doctor Catherine Flynn at [REDACTED]

If you would like to contact the researchers about any aspect of this study, please contact:	If you have a complaint concerning the manner in which this research is being conducted, please contact:
Catherine Flynn [REDACTED]	Executive Officer Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800 [REDACTED] [REDACTED] [REDACTED] Secretary, Human Research Ethics Committee, Department of Justice Postal address: 21/121 Exhibition St, Melbourne VIC 3000 [REDACTED] [REDACTED] [REDACTED]

Thank you.
 Alannah Burgess

Appendix 7: Interview Schedule used in the Broader Study

Children of Prisoners – care planning study

Pre- interview screening questions

1. Are you the parent of a dependent child/ren (birth – 17 years)?
 - No - ineligible
 - Yes – please answer Q2

2. When you were remanded/imprisoned, did any of the following things happen in relation to the care of your child/ren?
 - A new carer (this could be a relative, friend, associate etc) took over the care of your child or children **in your home**
 - Your child or children moved **house to live with a different carer**
 - Your child had **no carer**

If at least one of the above (in Q2) is ticked, respondents are eligible for participation in the study. If no boxes are ticked in Q2, respondents are ineligible.

Interview Schedule for Parents (Interview 1)

Date of interview	Participant code
Location (prison)	D.O.B.

BACKGROUND

1. M/F/Other	2. Age (in years)
3. What country were you born in? <input type="checkbox"/> Australia <input type="checkbox"/> Other - Specify _____	
4. What is your ethnic or cultural background?	
5. Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal and Torres Strait Islander	6. What is your first language? <input type="checkbox"/> English <input type="checkbox"/> Other – Specify _____
7. How many children do you have?	
Age of child (Years – oldest to youngest)	Sex of child (M/F)
Child 1:	
Child 2:	
Child 3:	
Child 4:	
Child 5:	
Child 6:	
Child 7:	
Child 8:	
Child 9:	
Child 10:	
Child 11:	
Child 12:	

Section i - BEFORE PRISON

1. Family constellation (genogram) (please note if the partners or ex-partners of the participants have been incarcerated)			
Living arrangements/locations of ALL children (including biological, step, adoptive, or those in your informal care)			
	Child 1	Child 2	Child 3
2. Relationship to child (biological, step, adoptive, informal carer)			
3. Where was your child/ren living before you went to prison? (this time) 1. with you 2. not with you			
4. If the child/ren was not with you , where was child living? 1. Other parent – (current/past partner) 2. Grandparent/s 3. Other family member – Specify: 4. Friends 5. Self 6. Out of home care – specify (foster/kinship/resi) 7. Other –Specify:			
Questions 5 to 8 refer to child/ren who were not with the parent			
5. How long had the child been living there when you went to prison?			
6. What is the key reason your child is living there (only give one reason)?			

<p>7. In this living arrangement, was the child living with:</p> <ol style="list-style-type: none"> 1. Other sibling(s) 2. On own, sibs also placed on their own 3. On own, sibs placed together 4. On own, sibs various 5. On own, have no sibs 			
<p>8. For children not living with you, what happened to them when you went to prison?</p> <p>How did you find out about any changes that took place?</p>			
<p>9. Can you describe a typical day just before you went to prison (Prompt re general circumstances – parenting, mental health, housing, employment, \$, AOD, etc.)</p>			

10. What were the circumstances that led up to you going to prison? (prompt type of offence)

11. What is the length of your sentence? _____ months

12. When are you due for release?

13. Follow up interview likely to be in prison Yes No

Section ii - ARREST

<p>1. Can you tell me about the circumstances of your arrest? (Prompts: time; location - at home, in community, by summons; were children present etc.)</p>
<p>2. Was the arresting police officer aware that you were a primary carer of dependent children?</p> <p><input type="checkbox"/> No - Why not? (Prompt Did they not ask? Did you not disclose?)</p> <p><input type="checkbox"/> Yes - How did they become aware (prompt did they ask? Did you advise?)</p>
<p>3. Did the arresting police officer discuss with you if there was a suitable person to care for your child/children?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes – outline info received and how suitability was assessed and by whom</p>
<p>4. Did the Station Sergeant discuss with you your primary carer responsibilities and how these could be managed and the child/ren's safety ensured?</p> <p><input type="checkbox"/> No -Why not? (They did not ask? You did not disclose?)</p> <p><input type="checkbox"/> Yes – outline info received</p>
<p>5. How long were you held in the police cells? (please note if they were held in the custody centre)</p>
<p>6. Were you remanded into custody?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - where did your child/children go immediately?</p>
<p>7. If yes in Q6 how long were you held on remand?</p>

8. If yes in Q6 did you maintain contact with your children during that time?

No – why not?

Yes - how was this able to occur?

Section iii - **SENTENCING**

1. Were you on a community based disposition before going to prison? (note if they were on suspended or deferred sentence)

- No (skip to Q 3)
- Yes - what discussion did the Community Corrections Officer (CCO) have with you about the possibility of a prison sentence?

2. Did you have a pre-sentence report prepared?

- No
- Yes - did the CCO discuss with you your role as a primary carer in the preparation of the pre-sentence report?

3. What discussion did you have with your legal representative about the likely outcomes from your court appearance? (Prompts: what legal representation did you have (legal aid?), when was your legal representation allocated (e.g. on the day of court or prior?), what time did you spend with them? What did they tell you about the possible outcomes of your court appearance?)

4. Did your legal representative present to the judge/magistrate any 'Hardship' to your children if you were to receive a custodial sentence?

- No
- Yes - If yes, in what terms?

How did the magistrate respond?

Section iv - IMPRISONMENT

FOR ALL CHILDREN FOR WHOM YOU ARE A PRIMARY CARER

	Child 1	Child 2	Child 3
<p>1. Where is your child/ren currently?</p> <p>○ AT HOME – CARED FOR BY</p> <p>1. Other parent – (current/past partner)</p> <p>2. Grandparent/s</p> <p>3. Other family member – Specify:</p> <p>4. Friends/associates</p> <p>5. Self</p> <p>6. Other –Specify</p> <p>○ MOVED – CARED FOR BY</p> <p>7. Other parent – (current/past partner)</p> <p>8. Grandparent/s</p> <p>9. Other family member – Specify</p> <p>10. Friends/associates</p> <p>11. Self</p> <p>12. Out of home care (foster/kinship/resi)</p> <p>13. With me, in prison (CIPP)</p> <p>14. Other –Specify</p>			
<p>2. Was this the first living arrangement they moved to after your imprisonment? No or Yes</p>			
<p>3. How many times has each child moved since you have been in prison (how long)?</p>			
<p>4. Is the child being cared for with:</p> <p>1. Other sibling(s)</p> <p>2. On own, sibs also placed on their own</p> <p>3. On own, sibs placed together</p> <p>4. On own, sibs various</p> <p>5. On own, have no sibs</p>			
<p>5. How long was there to organise care for the children (prompt re remand)?</p>			

6. Who decided who would care for the child/ren while you were in prison? (Prompt Why?)
7. How was this decided? (Prompt: what input did you have into the decision?)
8. To what extent do you agree with the following statement "I was fully involved in planning the placement of my child for the time I was in prison" 1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree
9. If you were not involved in this, how were you kept informed about your child/ren?
10. How do you feel about the child/ren's living arrangements? 1. Very unhappy 2. Unhappy 3. Neither 4. Happy 5. Very happy
11. What are you un/happy about?
12. Overall how would you rate the planning process for the placement of your child? 1. Poor 2. Fair 3. Ok 4. Good 5. Excellent
13. What might have been done differently to improve this process?
14. What plans do you have for caring for your children when you are released? <input type="checkbox"/> No plans <input type="checkbox"/> Children will return to my care (specify: Immediately or is there a transition plan?) <input type="checkbox"/> Children will remain with current carer <input type="checkbox"/> Children will be in shared care with me and my ex-partner <input type="checkbox"/> Children's court will decide <input type="checkbox"/> Family court will decide <input type="checkbox"/> Other – please specify Comment
15. Is this your first time in prison? <input type="checkbox"/> No <input type="checkbox"/> Yes
16. If no, how many times have you been imprisoned previously?

	Child 1	Child 2	Child 3
17. Where did all child/ren for whom you were the primary carer go then? (The <u>first</u> time if jailed more than twice) ○ AT HOME – CARED FOR BY 1. Other parent – (current/past partner) 2. Grandparent/s 3. Other family member – Specify: 4. Friends/associates 5. Self 6. Other –Specify ○ MOVED – CARED FOR BY 7. Other Parent – (current/past partner) 8. Grandparent/s 9. Other family member – Specify 10. Friends/associates 11. Self 12. Out of home care (foster/kinship/resi) 13. With me, in prison (CIPP) 14. Other – Specify			
18. Did you know where your child/ren were when you were taken into the prison this time? <input type="checkbox"/> No <input type="checkbox"/> Yes -If yes, how did you get this information? (Prompt: informal or formal processes?)			
19 What were you asked about the care and safety of your children when you were received into the prison?			
20. What parenting role have you had with your children since you have been in prison? (Prompt re guardianship, general decision making, communication with carer etc.)			

21. What supports/services have you been offered during imprisonment to support your parenting of your children?

22. What contact have you had with your children?

23. Are there any other comments you would like to make or is there anything you feel like we haven't discussed regarding the care planning of your children that you would like to acknowledge?

CONTACT DETAILS

1. Contact details for 12 month follow up interview
Phone (1):
Phone (2):
Phone (3): contact person who may know how to reach you if we cannot contact you
Address:
Email:
2. Contact details for children’s carer: We will only contact your children’s carer to ask them if they are interested in participating in this study if there are no outstanding (Intervention Orders)IVO and if the offence for which you are incarcerated was not committed against a member of your nuclear family (partner, carer, child/ren)
<ul style="list-style-type: none"> ○ Do you have an outstanding (Intervention Order) IVO? <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes (do not contact family)
<ul style="list-style-type: none"> ○ Was the offence for which you were sentenced committed against a member of your family? <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes (do not contact family)
Address:
Phone:

Appendix 8: Interview Schedule used for Mothers with a Mental Illness (Prison and Forensic)

Children of Prisoners – Care Planning Study

Interview Schedule for Mothers at DPFC

Pre- Interview Screening Questions

3. Are you the parent of a dependent child/ren (birth – 17 years)?
- No - ineligible
 - Yes – please answer Q2
4. When you were remanded/imprisoned, did any of the following things happen in relation to the care of your child/ren?
- A new carer (this could be a relative, friend, associate etc) took over the care of your child or children in your home
 - Your child or children moved **house to live with a different carer**
 - Your child had **no carer**

If at least one of the above is ticked, respondents are eligible for participation in the study. If no boxes are ticked in Q 2, respondents are ineligible.

5. Have you been diagnosed with a mental illness?
- Yes
 - No

If the participant reports that they have been diagnosed with a mental illness, they are eligible to participate in the PhD component of the study and answer additional questions throughout the interview.

Interview Schedule for Mothers (DPFC)

Date of interview:	Participant code:
Location: DPFC	D.O.B:

BACKGROUND

8. M/F/Other	9. Age (in years)
10. What country were you born in? <input type="checkbox"/> Australia <input type="checkbox"/> Other - Specify _____	
11. What is your ethnic or cultural background?	
12. Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal and Torres Strait Islander	13. What is your first language? <input type="checkbox"/> English <input type="checkbox"/> Other – Specify _____
PhD1. How is your mental health right now? <input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good <input type="checkbox"/> Very good	PhD2. What is your diagnosed mental health condition? <input type="checkbox"/> Affective Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Schizophrenia and other Psychiatric Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other – Specify: _____ _____
PhD3A. Who first told you that you had a mental health condition? <input type="checkbox"/> Mental Health Nurse <input type="checkbox"/> Doctor <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other – Specify: _____ ----- PhD3B. Were where you at the time: <input type="checkbox"/> Prison <input type="checkbox"/> Thomas Embling Hospital <input type="checkbox"/> Community <input type="checkbox"/> Other – Specify: _____ _____ _____ PhD3C. How old were you?	PhD4A. Prior to prison, what mental health services did you use? <input type="checkbox"/> None (Go to question PhD9A) <input type="checkbox"/> General Practitioner <input type="checkbox"/> Mental Health Nurse <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Social Worker <input type="checkbox"/> Local Mental Health Service <input type="checkbox"/> Outpatient of a Psychiatric Hospital <input type="checkbox"/> Other – Specify: _____ PhD4B. Will you go back to this service after you get out? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure Comments:
PhD5A. Were these services aware of your offending? <input type="checkbox"/> No (Go to question PhD7)	PhD6A. Did anyone in the service talk to you about your offending and the chance of going to prison?

<p><input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>PhD5B. Why/why not?</p>	<p><input type="checkbox"/> No (Go to question PhD7) <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>PhD6B. If yes, what did they discuss?</p>
<p>PhD7. Were these services aware of your children? (Prompts: Able to freely talk about children, encourage you to communicate).</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>Comments:</p>	<p>PhD8A. Did these services respond to your children in any way? (Prompts: Referrals to programs/playgroups/camps, provided information to children, have a family friendly area).</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>Comments:</p> <p>PhD8B. Did this service help you to write up a careplan for your child/ren to help manage in case your mental health symptoms got worse?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>Comments:</p>
<p>PhD9A. Have you ever come into contact with a Crisis Assessment Treatment Team (CATT)?</p> <p><input type="checkbox"/> No (Go to question PhD10A) <input type="checkbox"/> Yes <input type="checkbox"/> Unsure (Go to question PhD10A)</p>	<p>PhD10A. Prior to prison, have you ever been an inpatient in a psychiatric hospital in the community?</p> <p><input type="checkbox"/> No (Go to question PhD11) <input type="checkbox"/> Yes <input type="checkbox"/> Unsure (Go to question PhD11)</p>

	<input type="checkbox"/> Unsure Comments:
PhD13. What mental health services have you used while you have been in prison? <input type="checkbox"/> None – Why?	<input type="checkbox"/> Psychologist <input type="checkbox"/> Mental Health Nurse <input type="checkbox"/> Health Service <input type="checkbox"/> Marmak Inpatient <input type="checkbox"/> Marmak Outpatient <input type="checkbox"/> Thomas Embling <input type="checkbox"/> Other – Specify: _____ _____
PhD14. Were you using drugs and/or alcohol prior to coming to prison? <input type="checkbox"/> None (Go to question PhD15) <input type="checkbox"/> Drugs – Specify: _____ _____ <input type="checkbox"/> Alcohol <input type="checkbox"/> Both	PhD15. Have you ever experienced abuse? (Prompt: Domestic Violence, physical/sexual/emotional abuse). <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Declined to answer
PhD16. Is there anything else you want to tell me more about? (prompt: your mental health)	
14. How many children do you have?	
Age of child (Years – oldest to youngest)	Sex of child (M/F)
Child 1:	
Child 2:	

Child 3:	
Child 4:	
Child 5:	
Child 6:	
Child 7:	
Child 8:	
Child 9:	
Child 10:	
Child 11:	
Child 12:	

Section i - BEFORE PRISON

14. Family constellation (genogram) (please note if the partners or ex-partners of the participants have been incarcerated)			
Living arrangements/locations of ALL children (including biological, step, adoptive, or those in your informal care)			
	Child 1	Child 2	Child 3
15. Relationship to child (biological, step, adoptive, informal carer)			
16. Where was your child/ren living before you went to prison? (this time) 3. with you 4. not with you			
17. If the child/ren was not with you , where was child living? 8. Other parent – (current/past partner) 9. Grandparent/s 10. Other family member – Specify: 11. Friends 12. Self 13. Out of home care – specify (foster/kinship/residential) 14. Other –Specify			
Questions 5 to 8 refer to child/ren who were not with the parent			
18. How long had the child been living there when you went to prison?			

<p>19. What is the key reason your child living there (only give one reason)?</p>			
<p>20. In this living arrangement, was the child living with:</p> <ul style="list-style-type: none"> 6. Other sibling(s) 7. On own, sibs also placed on their own 8. On own, sibs placed together 9. On own, sibs various 10. On own, have no sibs 			
<p>21. For children not living with you, what happened to them when you went to prison?</p> <p>How did you find out about any changes that took place?</p>			
<p>22. Can you describe a typical day just before you went to prison? (Prompt: General circumstances – parenting, mental health, housing, employment, \$, AOD, etc.)</p>			

PhD1. What role did your mental illness play in your day to day activities?
(Prompt: Effect of medication, symptoms on parenting etc)

PhD2A. How was your mental health during this time? (prompt: Before you came to prison)
(Prompts: Symptoms worsened/improved)

- Very poor
- Poor
- Average
- Good
- Very good

PhD2B. Was there anything that affected your mental health at this time?(prompt: Before you came to prison)
(Prompts: Symptoms, medication, services, stigma)

PhD3A. Did you have any plans in place for your children if your mental health symptoms got worse?
(Prompt: care plans developed informally/formally)

- No
- Yes
- Unsure

PhD3B. If yes, who was involved?

PhD4A. Were you happy with your relationship with your child/ren at this time? (prompt: Before you came to prison)

1. Very Unhappy 2. Unhappy 3. Neutral 4. Happy 5. Very Happy

PhD4B. Was there anything that affected the quality of this relationship?

23. What were the circumstances that led up to you going to prison? (Prompt: Type of offence)

PhD5. What role did your mental illness play in these circumstances?

24. What is the length of your sentence? _____ months

25. When are you due for release?

26. Follow up interview likely to be in prison Yes No

Please Note: Follow up interview not relevant for PhD Study. The follow up interview is only relevant for the original study (JHREC - CF/11/7191 and MUHREC - CF/11/1811-2011000997).

Section ii - ARREST

<p>1. Can you tell me about the circumstances of your arrest? (Prompts: Time; location - at home, in community, by summons; were children present etc.)</p>
<p>PhD1. What role did your mental illness play in your arrest, if any?</p>
<p>2. Was the arresting police officer aware that you were a primary carer of dependent children?</p> <p><input type="checkbox"/> No - Why not? (Prompt: Did they did not ask? Did you not disclose?)</p> <p><input type="checkbox"/> Yes - How did they become aware (Prompt: Did they ask? Did you advise?)</p>
<p>PhD2. Was the arresting police officer aware that you had a mental illness?</p> <p><input type="checkbox"/> No - Why not? (Did they not ask? Did you not disclose?)</p> <p><input type="checkbox"/> Yes - How did they become aware (Prompt: Did they ask? Did you advise?)</p>
<p>PhD3A. Do you think your mental illness affected your participation in the interview with the police? (Prompt: Understand and follow the questions, need for legal representation, awareness of where you were).</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure</p>
<p>3. Did the arresting police officer discuss with you if there was a suitable person to care for your child/children?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes – outline info received and how suitability was assessed and by whom</p>
<p>4. Did the Station Sergeant discuss with you your primary carer responsibilities and how these could be managed and the child/ren’s safety ensured?</p> <p><input type="checkbox"/> No -Why not? (Prompt: Did they not ask? Did you not disclose?)</p> <p><input type="checkbox"/> Yes – Outline info received</p>

5. How long were you held in the police cells? (please note if they were held in the custody centre)
PhD4. If required, did you receive your prescribed mental health medication while you were held in the police cells? <input type="checkbox"/> No, I did not receive <input type="checkbox"/> No, not required <input type="checkbox"/> Yes, I did receive <input type="checkbox"/> Unsure Comments:
6. Were you remanded into custody? <input type="checkbox"/> No <input type="checkbox"/> Yes - Where did your child/children go immediately?
7. If yes in Question 6, how long were you held on remand?
8. If yes to Question 6, did you maintain contact with your children during that time? <input type="checkbox"/> No – why not? <input type="checkbox"/> Yes - how was this able to occur? (visits, telephone calls, letters)
PhD5A. How was your mental health during this time? (prompt: At arrest) (Prompts: Symptoms worsened/improved during arrest/remand/bail) <input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good <input type="checkbox"/> Very good PhD5B. Was there anything that affected your mental health at this time? (prompt: At arrest) (Prompt: Symptoms, medication, services, stigma)
PhD6. Were your mental health needs met while you where on bail/remand? (Prompts: Symptoms worsened/improved, received medication, access to counselling/psychologist etc) <input type="checkbox"/> No <input type="checkbox"/> Yes

Unsure

PhD7. During your arrest and bail/remand, was there anything that could have improved the situation for you and your child/ren? (Prompt: Services, accessibility)

Section iii - SENTENCING

5. Were you on a community based disposition before going to prison? (note if they were on suspended or deferred sentence)

- No (**Go to Question 3**)
- Yes - What discussion did the Community Corrections Officer (CCO) have with you about the possibility of a prison sentence?

6. Did you have a pre-sentence report prepared?

- No
- Yes - Did the CCO discuss with you your role as a primary carer in the preparation of the pre-sentence report?

7. What discussion did you have with your legal representative about the likely outcomes from your court appearance? (Prompts: What legal representation did you have (legal aid?), when was your legal representation allocated (e.g. on the day of court or prior?), what time did you spend with them? What did they tell you about the possible outcomes of your court appearance?)

8. Did your legal representative present to the judge/magistrate any 'Hardship' to your children if you were to receive a custodial sentence?

- No
- Yes - If yes, in what terms?

How did the magistrate respond?

PhD1. Did anyone ask about your mental illness during your court case?

(Prompt: legal representative, judge, magistrate)

- No
- Yes
- Unsure

PhD2A. How was your mental health during this time? (prompt: Upon sentencing)

(Prompts: Symptoms worsened/improved)

- Very poor
- Poor
- Average
- Good
- Very good

PhD2B. Was there anything that affected your mental health at this time? (prompt: Upon sentencing)

(Prompt: Symptoms, medication, services, stigma)

PhD3. During sentencing, was there anything that could have improved the situation for you and your child/ren?

(Prompt: Services, accessibility)

Section iv – IMPRISONMENT

FOR ALL CHILDREN FOR WHOM YOU ARE A PRIMARY CARER

	Child 1	Child 2	Child 3
5. Where is your child/ren currently? <input type="radio"/> AT HOME – CARED FOR BY 7. Other parent – (current/past partner) 8. Grandparent/s 9. Other family member – Specify: 10. Friends/associates 11. Self 12. Other –Specify <input type="radio"/> MOVED – CARED FOR BY 20. Other parent – (current/past partner) 21. Grandparent/s 22. Other family member – Specify 23. Friends/associates 24. Self 25. Out of home care (foster/kinship/resi) 26. With me, in prison (CIPP) 14. Other –Specify			
6. Was this the first living arrangement they moved to after your admission to prison? No or Yes			
7. How many times has each child moved since you have been in prison (how long)?			
PhD1. How many times has each child changed schools since you have been in prison?			
8. Is the child being cared for with: 19. Other sibling(s) 20. On own, sibs also placed on their own 21. On own, sibs placed together 22. On own, sibs various 23. On own, have no sibs			

<p>5. How long was there to organise care for the children (prompt re remand)?</p>		
<p>24. Who decided who would care for the child/ren while you were in prison? (Prompt: Why?)</p>		
<p>25. How was this decided? (Prompt: what input did you have into the decision?)</p>		
<p>26. To what extent do you agree with the following statement "I was fully involved in planning the placement of my child for the time I was in prison" 1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree</p>		
<p>27. If you were not involved in this, how were you kept informed about your child/ren?</p>		
<p>PhD2. To what extent do you agree with the following statement "My mental illness negatively impacted on my ability to be involved in the planning the placement of my child/ren for the time I was in prison" 1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree</p>		
<p>PhD3. Why do you think this?</p>		
<p>28. How do you feel about the child/ren's living arrangements? 1. Very unhappy 2. Unhappy 3. Neither 4. Happy 5. Very happy</p>		
<p>29. What are you un/happy about?</p>		

30. Overall how would you rate the planning process for the placement of your child? 1. Poor 2. Fair 3. Ok 4. Good 5. Excellent			
31. What might have been done differently to improve this process?			
32. What plans do you have for caring for your children when you are released? <input type="checkbox"/> No plans <input type="checkbox"/> Children will return to my care (specify: Immediately or is there a transition plan?) <input type="checkbox"/> Children will remain with current carer <input type="checkbox"/> Children will be in shared care with me and my ex-partner <input type="checkbox"/> Children’s court will decide <input type="checkbox"/> Family court will decide <input type="checkbox"/> Other – please specify			
33. Is this your first time in prison? <input type="checkbox"/> No <input type="checkbox"/> Yes			
34. If no, how many times have you been admitted previously?			
	Child 1	Child 2	Child 3
17. Where did all child/ren for whom you were the primary carer go then? (The first time if jailed more than twice) <input type="radio"/> AT HOME – CARED FOR BY 1. Other parent – (current/past partner) 2. Grandparent/s 3. Other family member – Specify 4. Friends/associates 5. Self 6. Other –Specify <input type="radio"/> MOVED – CARED FOR BY 7. Other parent – (current/past partner) 8. Grandparent/s 9. Other family member – Specify, 10. Friends/associates 11. Self 12. Out of home care (foster/kinship/resi) 13. With me, in prison (CIPP) 14. Other –Specify			

18. Did you know where your child/ren were when you were taken into prison this time? <input type="checkbox"/> No <input type="checkbox"/> Yes -If yes, how did you get this information? (Prompt: Informal or formal processes?)			
20 What were you asked about the care and safety of your children when you were received into the prison?			
24. What parenting role have you had with your children since you have been in prison? (Prompt: Guardianship, general decision making, communication with carer etc.)			
25. What supports/services have you been offered during imprisonment to support your parenting of your children? <input type="checkbox"/> None (Go to Question 22) <input type="checkbox"/> Out if the Dark Program <input type="checkbox"/> Mother and child program worker <input type="checkbox"/> Fun with Mum <input type="checkbox"/> Parenting program <input type="checkbox"/> Shine for Kids <input type="checkbox"/> Other – Specify: _____			
PhD4. Have these supports/services been helpful? Unhelpful? Why?			
26. What contact have you had with your children? (Prompts: Visits, telephone calls, letters)			

PhD5A. Right now, are you happy with your relationship with your child/ren?

1. Very Unhappy 2. Unhappy 3. Neutral 4. Happy 5. Very Happy

PHD5B. Is there anything that affected the quality of this relationship?
(Prompt: Symptoms, medication, services, stigma, relationship with carer)

PhD6. What changes are you aware of in the daily routine of your child/ren since you have come to prison?
(Prompt: Contact with friends, involvement in after school activities like sports, changes to bed/meal times and contact with siblings).

PhD7A. Have there been any changes to your child/ren's behaviour?

- No
- Yes
- Unsure

PhD7B. And health?

- No
- Yes
- Unsure

PhD8. Have there been any changes to your child/ren's performance at school?

- No
- Yes
- Unsure

PhD9A. Does your child/ren's school know that you are in prison?

- No
- Yes
- Unsure

PhD9B. Why? Why not?

PhD10. Have there been any changes to your child/ren's friendship group?

- No
- Yes
- Unsure

PhD11A. Do you know if any supports/services have been offered to the carer of your child/ren?
(Prompt: Centrelink, formal or informal).

- No
- Yes
- Unsure

PhD11B. How do you know this? (prompt: How were you informed? Who told you?)

PhD12A. Do you know if supports/services have been offered or available to your child/ren?
(Prompt: Who were they able to tell, informal/formal).

- No
- Yes
- Unsure

PhD12B. How do you know this? (prompt: How were you informed? Who told you? I.e school)

PhD13. What supports do you think your children need right now?

PhD14. How do you think having a mental illness has impacted on your child/ren?

PhD15. How do you think being in prison has impacted on your child/ren?

PhD16. Right now is there anything that could improve the situation for you and your child/ren?

27. Are there any other comments you would like to make or is there anything you feel like we haven't discussed regarding the care planning of your children that you would like to acknowledge?

CONTACT DETAILS

<p>3. Contact details for 12 month follow up interview Please Note: The follow up interview is not relevant for PhD Study. The follow up interview is only relevant for the original study (JHREC - CF/11/7191 and MUHREC - CF/11/1811-2011000997).</p>
Phone (1):
Phone (2):
Phone (3): contact person who may know how to reach you if we cannot contact you
Address:
Email:
<p>Contact details for children's carer: Please Note: Interviews with carer's are not relevant for PhD Study. Interviews with carer's are relevant for the original study (JHREC - CF/11/7191 and MUHREC - CF/11/1811-2011000997).</p> <p>We will only contact your children's carer to ask them if they are interested in participating in this study if there are no outstanding (Intervention Orders)IVO's and if the offence for which you are incarcerated was not committed against a member of your nuclear family (partner, carer, child/ren)</p>
<p><input type="radio"/> Do you have an outstanding (Intervention Order) IVO? <input type="checkbox"/> No <input type="checkbox"/> Yes (do not contact family)</p>
<p><input type="radio"/> Was the offence for which you were sentenced committed against a member of your family? <input type="checkbox"/> No <input type="checkbox"/> Yes (do not contact family)</p>
Address:
Phone:

Appendix 9: Interview Schedule used for Mothers with a Mental Illness (Community)

Children of Prisoners – Care Planning Study

Interview Schedule for Mothers

Pre- Interview Screening Questions

1. Are you the parent of a dependent child/ren (birth – 17 years)?
 - No - ineligible
 - Yes – please answer Q2

2. When you were remanded/imprisoned, did any of the following things happen in relation to the care of your child/ren?
 - A new carer (this could be a relative, friend, associate etc) took over the care of your child or children in your home
 - Your child or children moved house to live with a different carer
 - Your child had no carer

If **at least one** of the above is ticked, respondents are eligible for participation in the study. If no boxes are ticked in Q 2, respondents are ineligible.

3. Have you been diagnosed with a mental illness?
 - Yes
 - No

If the participant reports that **they have been diagnosed with a mental illness**, they are eligible to participate in the PhD component of the study and answer additional questions throughout the interview.

Interview Schedule for Mothers (Community)

Date of interview:	Participant code:
Location: Community	D.O.B:

BACKGROUND

1. M/F/Other	2. Age (in years)
3. What country were you born in? <input type="checkbox"/> Australia <input type="checkbox"/> Other - Specify _____	
4. What is your ethnic or cultural background?	
5. Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal and Torres Strait Islander	6. What is your first language? <input type="checkbox"/> English <input type="checkbox"/> Other – Specify _____
PhD1. How is your mental health right now? <input type="checkbox"/> Very Poor <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good <input type="checkbox"/> Very Good	PhD2. What is your diagnosed mental health condition? <input type="checkbox"/> Affective Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Schizophrenia and other Psychiatric Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other – Specify: _____ _____
PhD3A. Who first told you that you had a mental health condition? <input type="checkbox"/> Mental Health Nurse <input type="checkbox"/> Doctor <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other – Specify: ----- PhD3B. Were where you at the time: <input type="checkbox"/> Prison <input type="checkbox"/> Community <input type="checkbox"/> Other – Specify: _____ _____ PhD3C. How old were you?	PhD4A. Prior to prison, what mental health services did you use? <input type="checkbox"/> None (Go to question PhD9A) <input type="checkbox"/> General Practitioner <input type="checkbox"/> Mental Health Nurse <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Social Worker <input type="checkbox"/> Local Mental Health Service <input type="checkbox"/> Outpatient of a Psychiatric Hospital <input type="checkbox"/> Other – Specify: _____ PhD4B. Will you go back to this service after you get out? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Comments:

<p>PhD5A. Were these services aware of your offending? <input type="checkbox"/> No (Go to PhD7) <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>PhD5B. Why/why not?</p>	<p>PhD6A. Did anyone in the service talk to you about your offending and the chance of going to prison? <input type="checkbox"/> No (Go to PhD7) <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>PhD6B. If yes, what did they discuss?</p>
<p>PhD7. Were these services aware of your children? (Prompts: Able to freely talk about children, encourage you to communicate).</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>Comments:</p>	<p>PhD8A. Did these services respond to your children in any way? (Prompts: Referrals to programs/playgroups/camps, provided information to children, have a family friendly area).</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p>Comments:</p> <p>PhD8B. Did this service help you to write up a careplan for your child/ren to help manage in case your mental health symptoms got worse?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure</p> <p>Comments:</p>

<p>PhD9A. Have you ever come into contact with a Crisis Assessment Treatment Team (CATT)?</p> <p><input type="checkbox"/> No (Go to question PhD10A)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure (Go to question PhD10A)</p> <p>PhD9B. If yes, what were the circumstances?</p> <p>PhD9C. How did CATT respond to your children?</p>	<p>PhD10A. Have you ever been an inpatient in a psychiatric hospital?</p> <p><input type="checkbox"/> No (Go to question PhD11)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure (Go to question PhD11)</p> <p>Comments:</p> <p>PhD10B. Did this service respond to your children? (Prompt: Family friendly, activities for children, play equipment, access to toilets/food, access to information)</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure</p> <p>Comments:</p> <p>PhD10C. Did this service help you to write up a careplan for your child/ren to help manage in case you end up in hospital again?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure</p> <p>Comments:</p>
<p>PhD11. Were you on any medication for your mental health condition prior to prison?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure</p>	<p>PhD12. Were you prescribed medication or did your medication change when you entered prison? If so, what effect did it had on you?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure</p> <p>Comments:</p>

PhD13. What mental health services have you used while you were in prison? <input type="checkbox"/> None – Why?	<input type="checkbox"/> Psychologist <input type="checkbox"/> Mental Health Nurse <input type="checkbox"/> Health Service <input type="checkbox"/> Marmak Inpatient <input type="checkbox"/> Marmak Outpatient <input type="checkbox"/> Thomas Embling <input type="checkbox"/> Other – Specify: _____
PhD14. Were you using drugs and/or alcohol prior to coming to prison? <input type="checkbox"/> None (Go to question PhD15) <input type="checkbox"/> Drugs – Specify: _____ _____ <input type="checkbox"/> Alcohol <input type="checkbox"/> Both	PhD15. Have you ever experienced abuse? (Prompt: Domestic Violence, physical/sexual/emotional abuse). <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Declined to answer
PhD16. Is there anything else you want to tell me more about? 	
7. How many children do you have?	
Age of child (Years – oldest to youngest)	Sex of child (M/F)
Child 1:	
Child 2:	
Child 3:	
Child 4:	
Child 5:	
Child 6:	
Child 7:	
Child 8:	
Child 9:	
Child 10:	
Child 11:	
Child 12:	

Section i - BEFORE PRISON

27. Family constellation (genogram) (please note if the partner or ex-partners of the participants have been incarcerated).			
Living arrangements/locations of ALL children (including biological, step, adoptive, or those in your informal care)			
	Child 1	Child 2	Child 3
28. Relationship to child (biological, step, adoptive, informal carer)			
29. Where was your child/ren living before you went to prison? (this time) 5. with you 6. not with you			
30. If the child/ren was not with you, where was child living? 15. Other parent – (current/past partner) 16. Grandparent/s 17. Other family member – Specify: 18. Friends 19. Self 20. Out of home care – specify (foster/kinship/residential) 21. Other –Specify:			
Questions 5 to 8 refer to child/ren who were not with the parent			
31. How long had the child been living there when you went to prison?			

<p>32. What is the key reason your child is living there (only give one reason)?</p>			
<p>33. In this living arrangement, was the child living with:</p> <ul style="list-style-type: none"> 11. Other sibling(s) 12. On own, sibs also placed on their own 13. On own, sibs placed together 14. On own, sibs various 15. On own, have no sibs 			
<p>34. For children not living with you, what happened to them when you went to prison?</p> <p>How did you find out about any changes that took place?</p>			
<p>35. Can you describe a typical day just before you went to prison? (Prompt: General circumstances – parenting, mental health, housing, employment, \$, AOD, etc.)</p>			

PhD1. What role did your mental illness play in your day to day activities?
(Prompt: Effect of medication, symptoms on parenting etc)

PhD2A. How was your mental health during this time?
(Prompts: Symptoms worsened/improved)

- Very poor
- Poor
- Average
- Good
- Very good

PhD2B. Was there anything that affected your mental health at this time? (Prompt: Before you came to prison)
(Prompts: Symptoms, medication, services, stigma)

PhD3. Did you have any plans in place for your children if your mental health symptoms got worse?
(Prompt: Care plans developed informally/formally)

- No
- Yes
- Unsure

PhD3B. If yes, who was involved?

PhD4A. Were you happy with your relationship with your child/ren at this time?

1. Very Unhappy 2. Unhappy 3. Neutral 4. Happy 5. Very Happy

PhD4B. Was there anything that affected the quality of this relationship? (Prompt: Before you came to prison?)

36. What were the circumstances that led up to you going to prison? (Prompt: Type of offence)

PhD5. What role did your mental illness play in these circumstances?

37. What was the length of your sentence? _____ months
PhD6. When were you released?

Section ii - ARREST

<p>1. Can you tell me about the circumstances of your arrest? (Prompts: Time; location - at home, in community, by summons; were children present etc.)</p>
<p>PhD1. What role did your mental illness play in your arrest, if any?</p>
<p>2. Was the arresting police officer aware that you were a primary carer of dependent children?</p> <p><input type="checkbox"/> No - Why not? (Prompt: Did they did not ask? Did you not disclose?)</p> <p><input type="checkbox"/> Yes - How did they become aware (Prompt: Did they ask? Did you advise?)</p>
<p>PhD2. Was the arresting police officer aware that you had a mental illness?</p> <p><input type="checkbox"/> No - Why not? (Prompt: Did they not ask? Did you not disclose?)</p> <p><input type="checkbox"/> Yes - How did they become aware (Prompt: Did they ask? Did you advise?)</p>
<p>PhD3. Do you think your mental illness affected your participation in the interview with the police? (Prompt: understand and follow the questions, need for legal representation, awareness of where you were).</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Unsure</p>
<p>3. Did the arresting police officer discuss with you if there was a suitable person to care for your child/children?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes – outline info received and how suitability was assessed and by whom</p>

4. Did the Station Sergeant discuss with you your primary carer responsibilities and how these could be managed and the child/ren's safety ensured?

No -Why not? (Prompt: Did they not ask? Did you not disclose?)

Yes – Outline info received

5. How long were you held in the police cells? (please note if they were held in the custody centre)

PhD4. If required, did you receive your prescribed mental health medication while you were held in the police cells?

No, I did not receive

No, not required

Yes, I did receive

Unsure

Comments:

6. Were you remanded into custody?

No

Yes - Where did your child/children go immediately?

7. If yes in question 6, how long were you held on remand?

8. If yes to question 6, did you maintain contact with your children during that time?

No – why not?

Yes - how was this able to occur? (visits, telephone calls, letters

PhD5A. How was your mental health during this time? (Prompt: At arrest)

(Prompts: Symptoms worsened/improved during arrest/remand/bail)

Very poor

Poor

Average

Good

Very Good

PhD5B. Was there anything that affected your mental health at this time? (Prompt: At arrest)

(Prompt: Symptoms, medication, services, stigma

PhD6. Were your mental health needs met while you were on bail/remand?
(Prompts: Symptoms worsened/improved, received medication, access to counselling/psychologist etc).

- No
- Yes
- Unsure

PhD7. During your arrest and bail/remand, was there anything that could have improved the situation for you and your child/ren?
(Prompt: Services, accessibility)

Section iii - SENTENCING

1. Were you on a community based disposition before going to prison? (note if they were on suspended or deferred sentence)

- No (Go to question 3)
- Yes - What discussion did the Community Corrections Officer (CCO) have with you about the possibility of a prison sentence?

2. Did you have a pre-sentence report prepared?

- No
- Yes - Did the CCO discuss with you your role as a primary carer in the preparation of the pre-sentence report?

3. What discussion did you have with your legal representative about the likely outcomes from your court appearance? (Prompts: What legal representation did you have (legal aid?), when was your legal representation allocated (e.g. on the day of court or prior?), what time did you spend with them? What did they tell you about the possible outcomes of your court appearance?)

4. Did your legal representative present to the judge/magistrate any 'Hardship' to your children if you were to receive a custodial sentence?

- No
- Yes - If yes, in what terms?

How did the magistrate respond?

PhD1. Did anyone ask about your mental illness during your court case?
(Prompt: Legal representative, judge, magistrate)

- No
- Yes
- Unsure

PhD2A. How was your mental health during this time? (Prompt: Upon sentencing)
(Prompts: Symptoms worsened/improved)

- Very poor
- Poor
- Average
- Good
- Very good

Comments:

PhD2B. Was there anything that affected your mental health at this time? (Prompt: Upon Sentencing)
(Prompt: Symptoms, medication, services, stigma)

PhD3. During sentencing, was there anything that could have improved the situation for you and your child/ren?
(Prompt: services, accessibility)

Section iv - IMPRISONMENT

FOR ALL CHILDREN FOR WHOM YOU ARE A PRIMARY CARER

	Child 1	Child 2	Child 3
1. Where is your child/ren currently? <input type="radio"/> AT HOME – CARED FOR BY 1. Other parent – (current/past partner) 2. Grandparent/s 3. Other family member – Specify: 4. Friends/associates 5. Self 6. Other –Specify <input type="radio"/> MOVED – CARED FOR BY 1. Other parent – (current/past partner) 2. Grandparent/s 3. Other family member – Specify 4. Friends/associates 5. Self 6. Out of home care (foster/kinship/resi) 7. With me, in prison (CIPP) 14. Other –Specify			
2. Was this the first living arrangement they moved to after your imprisonment? No or Yes			
3. How many times has each child moved since you have been in prison (how long)?			
PhD1A. How many times did each child change schools while you were in prison? PhD1B. How many times has each child changed schools since your release?			

<p>4. Is the child being cared for with:</p> <ol style="list-style-type: none"> 1. Other sibling(s) 2. On own, sibs also placed on their own 3. On own, sibs placed together 4. On own, sibs various 5. On own, have no sibs 			
<p>5. How long was there to organise care for the children (Prompt: Remand)?</p>			
<p>6. Who decided who would care for the child/ren while you were in prison? (Prompt: Why?)</p>			
<p>7. How was this decided? (Prompt: What input did you have into the decision?)</p>			
<p>8. To what extent do you agree with the following statement "I was fully involved in planning the placement of my child for the time I was in prison"</p> <p style="text-align: center;">1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree</p>			
<p>9. If you were not involved in this, how were you kept informed about your child/ren?</p>			
<p>PhD2. To what extent do you agree with the following statement "My mental illness negatively impacted on my ability to be involved in the planning the placement of my child/ren for the time I was in prison"</p> <p style="text-align: center;">1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly Agree</p>			
<p>PhD3. Why do you think this?</p>			

10. How did you feel about the child/ren's living arrangements? 1. Very unhappy 2. Unhappy 3. Neither 4. Happy 5. Very happy			
11. What are you un/happy about?			
12. Overall how would you rate the planning process for the placement of your child? 1. Poor 2. Fair 3. Ok 4. Good 5. Excellent			
13. What might have been done differently to improve this process?			
14. What happened to your children when you were released? <input type="checkbox"/> Children returned to my care (specify: Immediately or was there a transition plan?) <input type="checkbox"/> Children remained with current carer <input type="checkbox"/> Children are shared care with me and my ex-partner <input type="checkbox"/> Children's court will decide <input type="checkbox"/> Family court will decide <input type="checkbox"/> Other – please specify Comment:			
15. Was this your first time in prison? <input type="checkbox"/> No <input type="checkbox"/> Yes			
16. If no, how many times have you been imprisoned previously?			
	Child 1	Child 2	Child 3
17. Where did all child/ren for whom you were the primary carer go then? (The <u>first</u> time if jailed more than twice) <input type="radio"/> AT HOME – CARED FOR BY 1. Other parent – (current/past partner) 2. Grandparent/s 3. Other family member – Specify 4. Friends/associates 5. Self 6. Other –Specify <input type="radio"/> MOVED – CARED FOR BY 7. Other Parent – (current/past partner) 8. Grandparent/s 9. Other family member –			

Specify 10. Friends/associates 11. Self 12. Out of home care (foster/kinship/resi) 13. With me, in prison (CIPP) 14. Other – Specify			
19. Did you know where your child/ren were when you were taken into the prison this time? <input type="checkbox"/> No <input type="checkbox"/> Yes -If yes, how did you get this information? (Prompt: Informal or formal processes?)			
20. What were you asked about the care and safety of your children when you were received into the prison?			
28. What parenting role did you have with your children when you were in prison? (Prompt: Guardianship, general decision making, communication with carer etc.)			
29. What supports/services were you offered during your imprisonment to support your parenting of your children? <input type="checkbox"/> None (Go to question 22) <input type="checkbox"/> Out of the Dark Program <input type="checkbox"/> Mother and child program worker <input type="checkbox"/> Fun with Mum <input type="checkbox"/> Parenting program <input type="checkbox"/> Shine for Kids <input type="checkbox"/> Other – Specify: _____			
PhD4. Have these supports/services been helpful? Unhelpful? Why?			
30. What contact did you had with your children while you were in prison? (Prompts: Visits, telephone calls, letters) PhD22B. Now?			

PhD5A. While you were in prison, are you happy with your relationship with your child/ren?

1. Very Unhappy 2. Unhappy 3. Neutral 4. Happy 5. Very Happy

PhD5B. Was there anything that affected the quality of this relationship? (Prompt: During prison sentence)

(Prompt: Symptoms, medication, services, stigma, relationship with carer)

PhD5C. Right now, are you happy with your relationship with your child/ren?

1. Very Unhappy 2. Unhappy 3. Neutral 4. Happy 5. Very Happy

PhD5D. Was there anything that affected the quality of this relationship? (Prompt: At release)

(Prompt: Symptoms, medication, services, stigma, relationship with carer, children's behaviour)

PhD6A. What changes are you aware of in the daily routine of your child/ren while you were in prison? (Prompt: Contact with friends, involvement in after school activities like sports, changes to bed/meal times and contact with siblings).

PhD6B. Since your release?

PhD7A. Were there any changes to your child/ren's behaviour while you were in prison?

- No
- Yes
- Unsure

PhD7B. And health?

- No
- Yes
- Unsure

PhD7C. Since your release?

PhD8A. Where there any changes to your child/ren's performance at school while you were in prison?

- No
- Yes
- Unsure

PhD8B. Since your release?

PhD9A. During your sentence, did your child/ren's school know that you were in prison?

- No
- Yes
- Unsure

PhD9B. Why? Why not?

PhD10A. Have there been any changes to your child/ren's friendship group while you were in prison?

- No
- Yes
- Unsure

PhD10B. Since your release?

PhD11A. Do you know if any supports/services were offered to the carer of your child/ren while you were in prison? (Prompt: Centrelink, formal or informal).

- No
- Yes
- Unsure

PhD11B. How did you know this? (Prompt: How were you informed? Who told you?)

PhD12A. Do you know if supports/services were offered/available to your child/ren while you were in prison? (Prompt: who were they able to tell, informal/formal).

- No
- Yes
- Unsure

PhD12B. How did you know this?

PhD13A. What supports did you think your children needed while you were in prison?

PhD13B. Right now?

PhD14. How do you think having a mental illness has impacted on your child/ren?

PhD15. How do you think being in prison has impacted on your child/ren?

PhD16A. While you were in prison, was there anything that could have improved the situation for you and your child/ren?

PhD16B. Right now?

31. Are there any other comments you would like to make or is there anything you feel like we haven't discussed regarding the care planning of your children that you would like to acknowledge?

Appendix 10: Certificate of Approval from MUHREC



Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date: 20 December 2012

Project Number: CF12/3118 - 2012001576

Project Title: The care needs of children of incarcerated mothers with mental illness

Chief Investigator: Dr Catherine Flynn

Approved: From: 20 December 2012 To: 20 December 2017

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.



Professor Ben Canny
Chair, MUHREC

cc: Mrs Kay Madelon McCauley, Assoc Prof Christopher John Trotter, Ms Alannah Margaret Anne Burgess

Appendix 11: Certificate of Approval from JHREC



Department of Justice

Justice Human Research Ethics Committee

Planning Performance and Projects
Level 28
121 Exhibition Street
Melbourne, Victoria 3000
GPO Box 633A
Melbourne, Victoria 3001
Telephone: (03) 8661 1514
Facsimile: (03) 8661 1525
DX 219071

19 March 2013

Reference: CF/13/906

Dr Catherine Flynn
Monash University

Re: The Impact of Incarceration on Children's Care - A Strategic Framework for Good Care Planning: The Care Needs of Children of Incarcerated Mothers with Mental Illness

Dear Dr Flynn,

The Department of Justice Human Research Ethics Committee (JHREC) considered your application in relation to the project *The Impact of Incarceration on Children's Care - A Strategic Framework for Good Care Planning: The Care Needs of Children of Incarcerated Mothers with Mental Illness* out of session and granted **full approval** for the duration of the investigation. The Department of Justice reference number for this project is CF/13/906. Please note the following requirements:

- To confirm JHREC approval sign the Undertaking form attached and provide both an electronic and hardcopy version within ten business days.
- The JHREC is to be notified immediately of any matter that arises that may affect the conduct or continuation of the approved project.
- You are required to provide an Annual Report every 12 months (if applicable) and to provide a completion report at the end of the project (see the Department of Justice Website for the forms).
- Note that for long term/ongoing projects approval is only granted for three years, after which time a completion report is to be submitted and the project renewed with a new application.
- The Department of Justice would also appreciate receiving copies of any relevant publications, papers, theses, conferences presentations or audiovisual materials that result from this research.
- All future correspondence regarding this project must be sent electronically to ethics@justice.vic.gov.au and include the reference number and the project title. Hard copies of signed documents or original correspondence are to be sent to The Secretary, Justice Human Research Ethics Committee, PO Box 4356, Melbourne, Victoria, 3001.

If you have any queries regarding this application you are welcome to contact me on (03) 8664 1514 or email: ethics@justice.vic.gov.au.

Yours sincerely,

Ms Nicole Wilson, Secretary,
Department of Justice Human Research Ethics Committee



Department of Justice Human Research Ethics Committee

UNDERTAKING

Project Title: The Impact of Incarceration on Children's Care - A Strategic Framework for Good Care Planning: The Care Needs of Children of Incarcerated Mothers with Mental Illness

Reference No. CF/13/906

I acknowledge that I have read the conditions outlined in the current guidelines of the Department of Justice Human Research Ethics Committee (JHREC), and undertake to abide by them.

Reporting requirements:

- RE: Amendments: I will ensure that an Amendment Request Form is submitted to the JHREC if amendments to the project are required (e.g. staff changes, extension of completion date and adjustments to aims/methodology).
- RE: Amendment: If my JHREC application included a Department of Justice (DOJ) letter of support, I will advise the DOJ contact officer of proposed amendments before an amendment request is submitted to the JHREC.
- RE: Annual Reports: I will ensure that annual reports are provided if my project extends 12 months in duration.
- RE: Completion Reports: I will ensure that a completion report is provided at the conclusion of the research.
- RE: Long Term/ Ongoing Projects: I acknowledge that if my project is an ongoing/ long-term project I need to provide a completion report at the end of every three-year period and renew by submitting a new JHREC application.

Name of Principal Researcher: _____

Signed (Principal Researcher): _____

Date: 20/3/2013 _____

Appendix 12: Chapter Six – Five-Point Likert Scale Examining Mental Health Functioning

Chapter six, ‘Section 6.3.1 Programs that acknowledge health and welfare’ provided the median responses to the five-point Likert scale (one to five) which allowed the primary mothers to quantify their self-reported level of mental health functioning prior to, at arrest, during their trial and sentencing, and at imprisonment. Figure 12.1 below provides the frequency of the primary mothers’ responses to this Likert scale.

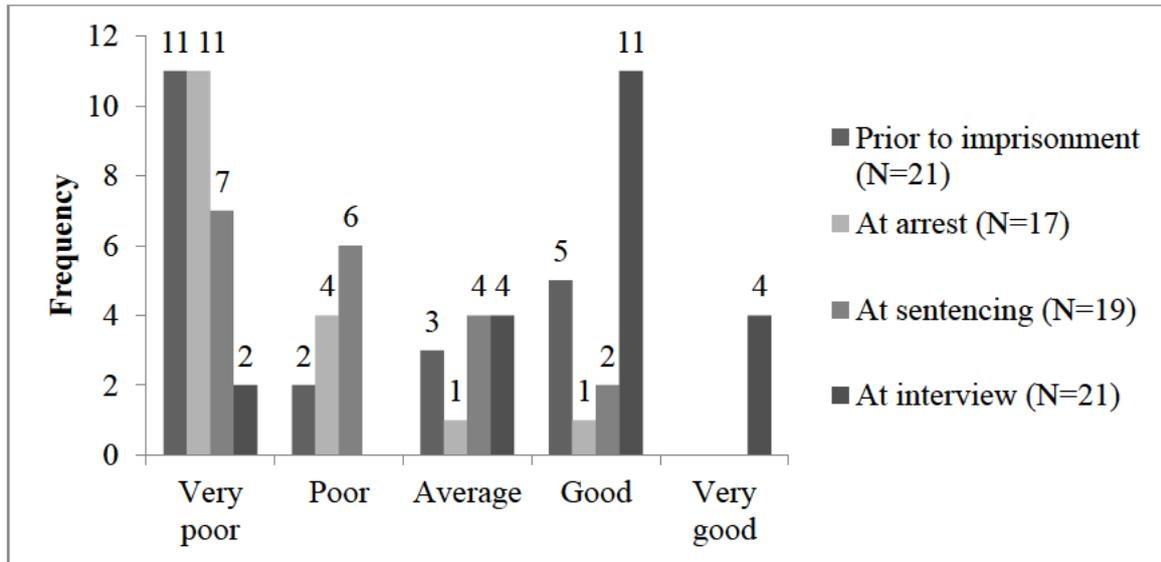


Figure 12.1. The primary mother’s self-reported level of mental health functioning as they navigated the criminal justice system.

Appendix 13: The Non-Significant Results from ‘Chapter Seven’

This appendix presents the non-significant results from the analysis present in ‘Chapter Seven’.

Appendix 13.1 Association between the primary mother subgroups

Table 13.1.1 The non-significant association between Sub-group one and the remaining sub-groups.

Primary mother sub-groups	Did not report comorbid mental illness		Reported comorbid mental illness		Fisher’s Exact Test	
	n	(%)	n	(%)	<i>p</i>	ϕ
2 Low prevalence disorders	4	(66.7)	2	(33.3)	.66	.12
	8	(53.3)	7	(46.7)		
3 Did not report problematic substance use	3	(50)	3	(50)	.100	.09
	9	(60)	6	(40)		

Table 13.1.2. The non-significant association between Sub-group two and the remaining sub-groups.

Primary mother sub-groups	Low prevalence disorders		High prevalence disorders		Fisher’s Exact Test	
	n	(%)	n	(%)	<i>p</i>	ϕ
1 Did not report comorbid mental illness	4	(33.3)	8	(66.7)	.66	.12
	2	(22.2)	7	(77.8)		
3 Did not report problematic substance use	2	(33.3)	4	(66.7)	1.00	.07
	4	(26.7)	11	(73.3)		

Table 13.1.3. The non-significant association between Sub-group three and the remaining sub-groups.

Primary mother sub-groups		Did not report problematic substance use		Reported problematic substance use		Fisher's Exact Test	
		n	(%)	n	(%)	p	φ
1	Did not report comorbid mental illness	3	(25)	9	(75)	1.00	.09
	Reported comorbid mental illness	3	(33.3)	6	(66.7)		
2	Low prevalence disorders	2	(33.3)	4	(66.7)	1.00	.07
	High prevalence disorders	4	(26.7)	11	(73.3)		

Appendix 13.2 Participation within the criminal justice system

Table 13.2.1. Time available to the primary mothers to organise their children's care.

Primary mother sub-groups		No time		Had some time		Fisher's Exact Test	
		n	(%)	n	(%)	p	φ
1	Did not report comorbid mental illness	7	(58.3)	5	(41.7)	.67	.13
	Reported comorbid mental illness	4	(44.4)	5	(55.6)		
2	Low prevalence disorders	4	(66.7)	2	(33.3)	.64	.18
	High prevalence disorders	7	(46.7)	8	(53.3)		
3	Did not report problematic substance use	3	(50)	3	(50)	1.00	.03
	Reported problematic substance use	8	(53.3)	7	(46.7)		

Table 13.2.2. Outcomes of the interaction with the police by the three primary mother sub-groups.

Primary mother sub-groups	Received bail		Taken into custody		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	5	(41.7)	7	(58.3)	.67	.14
	5	(55.6)	4	(44.4)		
2 Low prevalence disorders	2	(33.3)	4	(66.7)	.64	.18
	8	(53.3)	7	(46.7)		
3 Did not report problematic substance use	3	(50)	3	(50)	1.00	.03
	7	(46.7)	8	(53.3)		

Responses of the criminal justice system to mental illness and motherhood

Table 13.2.2. Arresting police officer awareness of mental illness by the three primary mother sub-groups.

Primary mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	7	(77.8)	2	(22.2)	.62	.24
	5	(55.6)	4	(44.4)		
2 Low prevalence disorders	1	(25)	3	(75)	.08	.47
	11	(78.6)	3	(21.4)		
3 Did not report problematic substance use	2	(50)	2	(50)	.57	.19
	10	(71.4)	4	(28.6)		

Table 13.2.3. Acknowledgment of mental illness during the court case by the three primary mother sub-groups.

Primary mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	2	(18.2)	9	(81.8)	.32	.33
	Reported comorbid mental illness	4	(50)	4		
2 Low prevalence disorders	1	(25)	3	(75)	1.00	.07
	High prevalence disorders	5	(33.3)	10		
3 Did not report problematic substance use	1	(25)	3	(75)	1.00	.07
	Reported problematic substance use	5	(33.3)	10		

Table 13.2.4. Arresting police officer awareness of primary carer status by the three primary mother sub-groups.

Primary mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	1	(9.1)	10	(90.9)	.29	.30
	Reported comorbid mental illness	3	(33.3)	6		
2 Low prevalence disorders	2	(40)	3	(60)	.25	.30
	High prevalence disorders	2	(13.3)	13		
3 Did not report problematic substance use	1	(16.7)	5	(83.3)	1.00	.06
	Reported problematic substance use	3	(21.4)	11		

Table 13.2.5. Arresting police officer inquiry into suitable care arrangements by the three primary mother sub-groups.

Primary mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	7	(77.8)	2	(22.2)	1.00	.12
	Reported comorbid mental illness	6	(66.7)	3		
2 Low prevalence disorders	2	(66.7)	1	(33.3)	1.00	.06
	High prevalence disorders	11	(73.3)	4		
3 Did not report problematic substance use	5	(100)	-	-	.25	.39
	Reported problematic substance use	8	(61.5)	5		

Table 13.2.6. Station officer inquiry into suitable care arrangements by the three primary mother sub-groups.

Participant mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	5	(55.6)	4	(44.4)	.62	.20
	Reported comorbid mental illness	6	(75)	2		
2 Low prevalence disorders	2	(50)	2	(50)	.58	.17
	High prevalence disorders	9	(69.2)	4		
3 Did not report problematic substance use	4	(80)	1	(20)	.60	.21
	Reported problematic substance use	7	(58.3)	5		

Table 13.2.7. The presence of children during their mothers arrest by the three primary mother sub-groups.

Primary mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	8	(80)	2	(20)	.32	.31
	4	(50)	4	(40)		
2 Low prevalence disorders	4	(100)	-	-	.24	.38
	8	(57.1)	6	(42.9)		
3 Did not report problematic substance use	3	(50)	3	(50)	.34	.25
	9	(75)	3	(75)		

Outcomes for the primary mothers and their children

Table 13.2.9. Impact of mental illness on the care planning process by the three primary mother sub-groups.

Primary mother sub-groups	No		Yes		Fisher's Exact Test	
	n	(%)	n	(%)	p	φ
1 Did not report comorbid mental illness	9	(81.1)	7	(18.2)	.34	.29
	5	(55.6)	4	(44.4)		
2 Low prevalence disorders	5	(83.3)	1	(16.7)	.61	.19
	9	(64.3)	6	(35.7)		
3 Did not report problematic substance use	4	(66.7)	2	(33.3)	1.00	.05
	10	(71.4)	4	(28.6)		